Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 22, 2021	2021_792659_0025	019456-21	Proactive Compliance Inspection

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

Long-Term Care Home/Foyer de soins de longue durée

Caressant Care Listowel Nursing Home
710 Reserve Avenue South Listowel ON N4W 2L1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JANETM EVANS (659), KATHERINE ADAMSKI (753)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): December 6, 7, 8, 9, 13, 14 and 15, 2021.

The following intake was included in this inspection: Log #019456-21, related to a Proactive Compliance Inspection

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), interim Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Nutrition Manager, Maintenance, Housekeeper, Office Manager, Ward Clerk, Physiotherapist, Physiotherapy Assistant (PTA),Occupational Therapist, family members and residents.

Observations were made of dining and snack service, infection prevention and control practices, medication administration, and staff to resident interactions. A review of documentation was completed including but not limited to programs, policies and procedures, medication incidents and relevant clinical records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

8 WN(s)
8 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the organized program required under sections 8 - 16 of the Act and section 48 of the regulation related to falls prevention, that there was a written description of the program that included its objectives and methods to reduce risk

The Fall Management Program Policy documented the goals of the program but did not identify the program objectives or methods to reduce risk of falls.

The ED said they believed there was documentation which identified the program objectives and methods to reduce the risk of resident falls, but they could not locate this.

The risk of not having the Falls Prevention Program objectives and methods to reduce the risk of falls documented or readily available in the home, is that team members may not receive a consistent message about the home's program objectives and preferred methods to reduce the risk of falls for residents, which could result in ongoing falls and potential injury for residents.

Sources: Fall Management Program Policy NP -S10-10.0, Fall Management Program - Post Fall Management NP-S10.20.0, Post Fall Head Injury Routine NP-S10-20.1 and Neurological Vital Signs Head Injury NP-S10-20.2, Interviews with ED, interim DOC and staff. [s. 30. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Falls Prevention Program objectives and the methods to reduce the risk of falls are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that if there is no Family Council, the licensee shall on an ongoing basis advise families and persons of importance to the resident of their right to establish a Family Council and would convene a semi-annual meeting to advise families and persons of importance to the residents of their right to establish a Family Council.

There was no Family Council established at the home.

Families received a welcome package at the time of a resident's admission which provided information about Family Council but it did not indicate that they could establish a Family Council.

Semi annual meetings did not show any documentation related to Family Council.

The ED acknowledged they had not advised families and persons of importance to the resident on an ongoing basis, of their right to establish a Family Council nor had this been done during the semi annual meetings.

The risk of not advising families and persons of importance to the resident, of their right to establish a Family Council is potentially a missed opportunity opportunity for new comers to become involved and establish a Family Council.

Sources: Welcome package, minutes from semi-annual meeting, agenda for semi-annual meeting December 16, 2021, interview with ED [s. 59. (7) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that meetings are convened semi annually to advise family members and persons of interest of their right to establish a Family Council and that there is communication on an ongoing basis to advise residents families and persons of importance to the residents of their right to establish a Family Council, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that they consulted regularly with the Residents' Council, at least every three months.

Review of the Residents' Council minutes for a three month period did not show evidence that the licensee had consulted with the Residents' Council.

The Activation manager and the ED confirmed that the licensee had not consulted with the Residents' Council in the last four months.

Failure of the licensee to consult regularly with the Residents' Council risks the licensee's opportunity to interact with the residents and hear first hand of any potential concerns or areas for improvement or any successes the home has achieved.

Sources: Resident Council minutes, interviews with ED and Activation Manager [s. 67.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee consults regularly with the Residents' Council, and at minimum this should be done every three months, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (2) A licensee shall make every reasonable effort to act on the results of the survey and to improve the long-term care home and the care, services, programs and goods accordingly. 2007, c. 8, s. 85. (2).

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every reasonable effort to act on the results of the satisfaction survey and to improve the long-term care home and care, services, programs and goods accordingly

Highlights of the 2020 resident and family satisfaction survey showed 25 residents and 17 family members completed the survey. Potential areas for improvement included items with scores of 44% - 68%, such as residents could explore new skills and interests, residents could bathe or shower anytime, that staff would engage residents in friendly conversation.

The ED said there had been no quality improvement initiatives related to the results of the 2020 survey.

Not making every reasonable effort to act on the results of the survey to improve the long

term care home and care, services, programs and goods could result in resident dis-satisfaction or concerns related to the care, service, programs or goods.

Sources: Council minutes, survey highlights, interview with ED and residents. [s. 85. (2)]

2. The licensee has failed to ensure that the advice of the Residents' Council was sought in developing and carrying out the satisfaction survey.

A survey was in progress at the time of the inspection with staff observed interviewing residents in the hallway.

Resident council minutes for a three month period in 2021, did not show documentation that resident input was sought in developing and carrying out the survey for 2021.

A resident was uncertain about Residents' Council input into the development and carrying out of the survey.

The Activation Manager and ED said that the Residents' Council advice or input was not sought in the development and carrying out of the survey.

Not including the Residents' Council in the development and carrying out of the annual survey risks the opportunity for the licensee to ensure the residents' needs or preference are heard related changes to the care or services.

Sources: observations, Council minutes, survey highlights, interviews with two residents, Activation manager and ED. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the advice of the Residents' Council is sought in developing and carrying out the satisfaction survey and that the home makes every reasonable effort to act on the results of the survey to improve the long term care home and the services, programs and goods accordingly, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meet at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The Professional Advisory committee (PAC) which included the above noted persons, met in June 2021, and completed a quarterly review of the effectiveness of the medication management system and recommendations of changes to improve the system.

Interim Director of Care #116 stated there had been a PAC meeting scheduled for the third quarter but it had been cancelled. The meeting was not rescheduled.

Failure to have the interdisciplinary team including the Medical Director, the Administrator, the Director of Care and the pharmacy service provider, meet at least quarterly to evaluate the effectiveness of the medication system and recommend any changes necessary to improve the system may result in potential medication incidents or missed opportunities for review of new best practice related to the medication management systems.

Sources: Quarterly Professional Advisory Committee Report, Medical Pharmacies Visit report, interview with interim DOC [s. 115. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an interdisciplinary team which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meet at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review are implemented, and
(c) a written record is kept of everything provided for in clause (a) and (b).

The last quarterly review of all medication incidents and adverse drug reactions occurred during the Professional Advisory Committee (PAC) meeting in June 2021.

After the June PAC meeting there were three medication incidents between July to September 2021.

There was no documentation provided to the inspector related to a quarterly review of all medication incidents and adverse drug reactions had occurred in the home during the third quarter.

The ED and Interim DOC said there had been no PAC in the third quarter.

Failure to complete a quarterly review of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review and implement changes and improvements, may potentially put the resident at risk for further medication incidents or adverse drug reactions that could have been prevented.

Sources: Quarterly Professional Advisory Committee report, Medical Pharmacies visit report, Care RX Quality assurance summary report, Interview with ED and interim DOC. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b)., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that they maintained a record of the names of the persons who participated in the evaluations, and the dates improvements were implemented.

a) Quality Program Evaluation for 2021: Pain Management documented program successes and program improvements but there were no dates for implementation of these items.

b) Quality Program Evaluation for 2021: Fall prevention documented the physiotherapist as the lead and a participant in the evaluation. The Physiotherapist, said they were not involved in the program evaluation for this year.

The home documented successes and program improvements but there were no dates documented for the implementation of these items.

c) Quality Program Evaluation for 2021: Skin and Wound care documented the successes and program improvements but there were no dates for implementation of these items.

The ED acknowledged there were no dates documented for the successes and program improvements listed and that a name of the participants in the fall program evaluation was incorrect.

Sources: Quality Program Evaluations for pain, skin and wounds and falls prevention, interviews with Pain Lead, Skin and Wound lead, Physiotherapist, ED and other staff. [s. 228. 4. ii.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee maintains a record of persons who participated in the evaluations and the dates any improvements were implemented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff fully participated in the implementation of the infection prevention and control program (IPAC) in relation to performing hand hygiene for residents.

The home's Hand Hygiene policy (last revised September 2020) stated that the hands of residents were to be cleaned before assisting with meals or snacks, and before and after ending an activity in common areas.

Observations on several occasions showed residents were not reminded, encouraged, or assisted in performing hand hygiene before being offered their morning snack.

A staff member stated that they weren't aware that they were to encourage and assist residents with hand hygiene at snack time, nor were they provided training or direction related to this and they said they had not observed their colleagues doing this either.

The home's IPAC Lead stated that the expectation was for staff to ensure residents performed hand hygiene before and after meals, including snacks.

Not ensuring residents were performing hand hygiene before eating placed staff, essential visitors, and residents at increased risk for disease transmission.

Sources: Observations conducted over three days in December 2021, the home's Hand Hygiene policy (last revised September 2020), Just Clean Your Hands Long Term Care Home Implementation Guide, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition April 2014, interviews with the home's IPAC Lead and other staff. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff fully participate in the implementation of the infection prevention and control procedures related to hand hygiene for residents, to be implemented voluntarily.

Issued on this 22nd day of December, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.