Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 13, 2016	2016_270531_0024	017223-16	Complaint

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 MARMORA
58 BURSTHALL STREET P.O. BOX 429 MARMORA ON K0K 2M0

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

SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 4 and 5, 2016

Log #017223-16 related personal support services.

During the course of the inspection, the inspector(s) spoke with residents, resident families, personal support workers, registered practical nurses, registered nurses, the resident care coordinator, the life enrichment aide, the Director of care and the Administrator.
During the course of the inspection the inspector toured the home, reviewed resident health care records, observed resident care and services and reviewed appropriate policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Legendé 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. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure resident # 05, #07, #06, # 04, #010 and #012 received individualized personal care and grooming, pertaining to evening care preferences.

In reference to log # 017223-16

On July 4, 2016 during an interview with resident #003 and #005 both indicated that they require assistance with personal care and hygiene in the evening in preparing for bed. Both indicated that they are upset that their individualized care can no longer be accommodated at six o'clock because of a new policy implemented two months ago that no resident be put to bed prior to seven o'clock. Both indicated that their care had always been provided right after the evening meal between six and seven o'clock. Resident #005 indicates that he/she requires assistance with personal care and hygiene and is independent with dressing into night attire and getting into bed when ready. Resident #005 indicated that during a conversation with the DOC (director of care) regarding the evening routine change, the DOC recommended that resident #005 dress in night attire during that time and then undress for personal hygiene when staff are available .
Later that same day during an interview with resident #012, the resident indicated that the PSWs are to assist him/her with oral care at approximately six thirty and now resident #012 confirmed that he/she requests assistance from his/her ninety year old roommate who wheels the wheelchair into the bathroom and assists him/her to be positioned to perform oral care.

The evening of July 4, 2016 inspector #531 observed the following:
-at 1745 PSW #112 engaged in a discussion with resident #006 who requested assistance to go to bed. This inspector noted that resident #006 had been assisted into bed dressed in his/her day attire.

-at 1810 PSW #113 approached the charge nurse after responding to resident #010's call for assistance, and requested direction as resident #010 had requested to be transferred to the commode, but was uncertain if she was allowed to transfer the resident via hoyer lift at this time. RN #101 approved the transfer of the resident via hoyer lift.

PSW #112 and #113 where interviewed and both indicated that over the past two months there had been a change made to evening and bed time routine schedules. They both confirmed that the directions are specific to the time frame between six and seven o'clock and include the following:
-toileting of high risk falls residents
-no resident is to be prepared or put into bed prior to seven o'clock with the exception of resident #009
-staff are not to transfer mechanical lift residents during this time, as two staff are required.

PSW #112 indicated that she did place resident #006 into bed at six o'clock this evening with the resident's clothes still on and planned to return after seven o'clock to complete bedtime care.
PSW #112 indicated that a staff member was reprimanded for providing a resident with care and putting the resident to bed prior to seven o'clock.

PSW #110 indicated that resident #013's evening routine has always been to return from the evening meal and ring for assistance with personal care and then be put to bed. PSW #110 indicates that resident #013 is upset with the change in routine and rings constantly prior to seven o'clock to be assisted to bed as per the resident's routine.

PSW #111 indicated that residents who are assisted with an evening bath or shower are required to be redressed into their day attire and assisted into their night attire after seven o'clock. PSW #111 indicates residents have expressed their displeasure with the routine change for evenings between six and seven o'clock.

PSW #108 and PSW #109 indicated during an interview, that resident #004 prefers to be assisted with personal care hygiene needs and placed into bed right after the evening meal. Both indicated that resident #004 propels his/her wheelchair to his/her bedside and starts to undress. They both indicated that resident #004 along with other residents are now transferred from the evening meal into the activity lounge until after seven o'clock when staff are available to provide care.

During an interview with RN #102 she confirmed that the evening routine change is specific to the six to seven o'clock time frame and that a staff member had been reprimanded for not following the directed change.

Subsequently during an interview with the Administrator and the Director of Care and review of the routine for evening shift between six and seven o'clock they confirmed that the routine change was implemented as part of the falls prevention strategies to prevent falls during this period. The Administrator indicated that the routine for evening shift procedure will be reviewed and an action plan developed that provides for individualized evening care for each resident. [s. 32.]

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 each resident receives individualized personal care, including hygiene care and grooming, on a daily basis, to be implemented voluntarily.

Issued on this 13th day of July, 2016

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

Original report signed by the inspector.