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 prévue le Loi de 2007 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 Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Apr 06, 2016;	2016_260521_0004 (A1)	000862-16	Resident Quality 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 ON BONNIE PLACE
15 Bonnie Place St Thomas ON N5R 5T8

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

Ontario

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REBECCA DEWITTE (521) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Please see new compliance date of CO #002 for April 29, 2016.

Issued on this 20 day of April 2016 (A1)

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

Original report signed by the inspector.

Ontario

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

REBECCA DEWITTE (521) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 25, 26, 27, 28, 29, 2016 and February 1, 2, 3, 4, 5, 8, and 9, 2016.

The following inspections were completed concurrently with the Resident Quality Inspection: Complaints log #032175-15 Pertaining to care issues, 030349-15 pertaining to care issues, 034262-15 pertaining to infection prevention,035514-15 pertaining to care issues, 032139-15 pertaining to continence care issues and Critical Incident System logs #026751-15/2730-000013-15 Pertaining to alleged abuse, 033802-15/2730-000017-15 pertaining to alleged abuse, 030013-15/2730-000016-15 pertaining to a resident fall and 035065-15/10730 SAC report pertaining to neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, one Registered Nurse, eight Registered Practical Nurse's, the RAI Coordinator, the Resident Care Coordinator, the Nutritional Manager, the Maintenance Manager, the Recreational Coordinator, twenty Personal Support Workers, one Dietary Aide, one Activity Assistant and over forty residents.

During the course of the inspection, the inspector(s) toured all resident home areas, the medication room, observed dining service, medication pass, provision of resident care, recreational activities, staff/resident interactions, infection prevention and control practices, reviewed resident clinical records, posting of required information and relevant policies and procedures, as well as minutes

pertaining to resident and family council meetings.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

- **18 WN(s)**
- **13 VPC(s)**
- **2 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

This area of noncompliance was previously issued as a written notification and compliance order on July 23, 2014, inspection number 2014_232112_0042;

Resident observations on January 26, 27, and 28, 2016, during stage 1 of the Resident Quality Inspection revealed 15 of 40 or 37.5% of residents had one or more bed rails in use.

Record review of the resident clinical records revealed the absence of a documented resident assessment for the use of bed rails.

The Director of Care confirmed that the bed entrapment audits had been completed but the home had not completed the bed assessment for all residents using bed rails. [s. 15. (1) (a)]

2. The licensee has failed to ensure steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During an observation of a resident bed system it was noted that the resident mattress was not secure.

Inspector #610 was able to move the mattress creating a gap between the mattress and the rail. A further inspection showed that one of three straps of the mattress keeper was being used to secure the bed.

The Director of Care confirmed the risk of entrapment where the bed rails were used.

A review of the entrapment inspection sheet dated January 27, 2016, revealed a mattress had failed its audit and had been replaced with another mattress and rails added to the bed system.

A review of the Policy and Procedure for Entrapment revealed:
"For individual residents at risk for entrapment, implement appropriate changes to the bed (for example, the use of retrofit kits, bed rail netting, clear padding, Velcro or anti-skid mats) to reduce the risk of entrapment."

The Director of Care confirmed it was the homes expectation that steps should be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee developed and implemented an interdisciplinary continence care and bowel management program that promoted continence and ensured that residents were clean, dry and comfortable.

A record review of a resident file revealed there was a medical directive. A further review revealed there was no continence assessment completed.

An interview with the Resident Care Coordinator #109 revealed the resident did not have an assessment as the licensee had failed to have a leader to implement the program that would provide the assessments and strategies to maximise residents' independence, comfort and dignity.

The interview also revealed that there was no annual evaluation of resident's satisfaction with the range of products as there was no implementation of the program. [s. 48. (1) 3.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

During stage one of the RQI the Resident Assessment Instrument (RAI) Coordinator #105 indicated that the a resident did not use side rails.

The Director Of Care #102 confirmed that the resident did use side rails to prevent the resident from falling out of the bed.

A review of the plan of care revealed the rails were not documented in the plan of care.

A review of the PASD Policy and Procedure revealed:

"All residents who require the use of a PASD to perform daily living activities shall

have this documented in the Plan of Care".

The DOC #102 confirmed that the rails should have been added to the care plan and should be part of the plan of care. [s. 6. (1) (c)]

2. During observations it was noted a resident had a blue dot next to the resident's name.

The Registered Practical Nurse (RPN) #118 revealed that the blue dot was to alert staff that about the residents health.

A review of Resident chart revealed the details were inaccurate.

The RPN #118 and DOC #102 confirmed that the resident should not have had blue dot.

An interview with Resident Care Coordinator #109 revealed that the plan of care should have provided clear directions to staff. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A clinical record review of the plan of care for a resident revealed that a treatment would be monitored daily.

A further review of the treatment administration record revealed that six days did not have a signature on this treatment.

An interview with the RAI coordinator #105 confirmed that there was no documented evidence that the checks were completed and the care in the plan of care was not provided and documented accordingly.

The RAI Coordinator #105 confirmed that it was the home's expectation that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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 plan of care sets out clear direction to staff and other who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act and was complied with.

Observations during the Resident Quality Inspection revealed the presence of ants were noted.

A review of the home's Policy - Pest Control, dated August 2015, revealed that all staff are to "report to the administrator any insects or bugs seen (and their location) while doing daily rounds. This information will be communicated to the outside agency that routinely sprays".

A review of the cleaning guidelines procedures with Administrator #100 revealed that

housekeeping staff are to clean residents' rooms daily.

An interview with the Administrator #100 also confirmed that the expectations would be that staff would clean the resident's room daily and staff would report the presence of pests to the Administrator.

The Administrator #100 confirmed that the administrator was not aware of the pests and the staff did not comply with the home's policy of reporting the presence of pests. [s. 8. (1) (b)]

2. An interview with the Administrator #100 revealed the homes protocol pertaining to continence care and catheters is to follow the National Health Service (NHS) Best Practice Statement – June 2004, Urinary Catheterisation and Catheter Care.

A review of the National Health Service (NHS) Best Practice Statement – June 2004, Urinary Catheterisation and Catheter Care document revealed "when an overnight bag is required a new, single-use 2 litre bedside bag is used and is emptied and discarded each morning. An audit of practice includes bag emptying technique and products used."

Observations revealed a residents overnight leg bag was stored in the utility room after it was emptied.

An interview with Personal Support Worker #133 revealed the process to store the overnight bag had recently changed and the current practice was to store the overnight bag in the utility room.

An interview with Administrator #100 confirmed the National Health Service (NHS) Best Practice Statement, protocol – June 2004, Urinary Catheterisation and Catheter Care was not complied with. [s. 8. (1) (b)]

3. An observation of a group of residents revealed there was a blue dot next to their names.

A review of the Infection Control Policy and Procedure did not include the blue dot protocol.

An interview with Registered Practical Nurse (RPN) # 118 and the Personal Support Worker revealed that the blue dot was a protocol.

A review of Resident Health Care Records (HCR) in Point Click Care (PCC) and the paper chart showed that some residents did not require the blue dot.

An interview with the Resident Care Coordinator # 109, revealed that staff should be following the protocol related to the infection prevention and control management. [s. 8. (1) (b)]

4. Observations of a resident in stage one of the RQI revealed a resident's bed had one bed rail up.

An interview with a Personal Support Worker #113 revealed that the resident used two bed rails when in bed as a Personal Assistive Service Device (PASD).

An interview with RPN # 112 revealed that the resident did not have a consent for use of the bedrails as a Personal Assistive Service Device (PASD) or approval for the use of the PASD.

A review of the Personal Assistive Service Devices (PASD) Policy and Procedure revealed:

a) "Caressant Care utilizes the use of PASD's to assist residents with routine activity of daily living and this includes bed rails".

b) "The use of a PASD must be approved and part of the plan of care".

c) "Consent must be obtained by the resident".

An interview with the Director of Care confirmed that there was no approval for the use of bilateral bed rails for the resident or consent to use the bed rails as a PASD and that it should be part of the plan of care. [s. 8. (1) (b)]

5. The licensee failed to ensure policy - "Documentation in Resident Health Record" was complied with.

A stage one interview with a resident revealed oral care was not provided to the resident twice a day.

Observations of resident's teeth revealed white substance from along the gumline

down the teeth.

An interview with the resident revealed oral care was usually completed twice a week and oral care had not been completed in the last few days.

Further observations of the resident's teeth revealed continued white substance on their teeth from the gums down the teeth.

An interview with Personal Support Worker #136 revealed oral care was not provided to the resident on that date although documentation revealed it had been completed by the interviewed staff.

A review of policy Documentation in Resident Health Record dated May 2015, revealed “all documentation in the health record will be complete and accurate."

An interview with Personal Support Worker #136 confirmed the documentation was not accurate and that the Documentation in Resident Health Record policy was not complied with. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone and ensure that residents were not neglected by the licensee or staff.

A stage one interview with a resident revealed staff were rough when they were dressing the resident.

A record review of a staff file revealed several complaints had been made regarding the staff's behaviour.

A review of Abuse and Neglect –Staff to Resident, Policy dated May 2015, revealed "Psychological /Emotional Abuse is any verbal or nonverbal behaviour which demonstrates disrespect."

An interview with the Administrator #100 confirmed staff's behaviour constituted for Psychological / Emotional Abuse and it was the home's expectation that residents were to be protected from abuse by anyone. [s. 19. (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 protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class.

Observations on two dates revealed a resident was restrained.

An interview with RPN's #118 and #119 confirmed the use of restraint for the resident and that there was no order for the restraint by the physician or the registered nurse in the extended class.

A record review revealed there was no order by the physician or the registered nurse in the extended class.

A review of the home's policy Safety Plan – May 2015, revealed "it was the home's expectation that the restraint plan of care included an order by the physician or the registered nurse in the extended class". [s. 31. (2) 4.]

2. The licensee has failed to ensure that the restraint plan of care included the consent by the resident or if the resident was incapable, by the SDM.

An interview and observations with a resident revealed the resident was unable to release the restraint.

A record review revealed there was no consent for the use of restraints by the resident or the resident substitute decision maker in resident plan of care.

A review of the home's policy Safety Plan – May 2015, revealed "it was the home's expectation that the resident plan of care should include the consent of the resident substitute decision maker or the resident".

An interview with RPN #118 and #119 confirmed the use of restraints and that there was no consent on file for the resident and it was the home's expectation that the restraint plan of care included the consent by the resident or if the resident was incapable, by the SDM. [s. 31. (2) 5.]

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 restraint plan of care included an order by the physician or the registered nurse in the extended class and a consent by the resident or if the resident is incapable, by the SDM, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was bathed, at a minimum, twice a week by the method of his or her choice.

An interview with a resident revealed that the tub chair had been broken and the resident had not been given the choice of having a bath.

An interview with Administrator #100 revealed that the tub chair had broken. The Administrator confirmed that a choice of using the hoyer lift to transfer a resident to the tub was viable option to staff.
The administrator also confirmed that staff did not provide the resident with a bathing method of their choice.

The Administrator confirmed that it was the home's expectations that residents be given a choice of their method of bathing. [s. 33. (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 a resident is bathed, at a minimum, twice a week by the method of his or her choice, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included mouth care in the morning and evening, including the cleaning of dentures.

A stage 1 interview with a resident revealed oral care was not provided to the resident twice a day.

Observations of resident's teeth revealed a white substance from the gumline down the teeth.

A record review revealed documentation for oral care was recorded as only provided daily for three days.

An interview with the resident revealed oral care was usually completed twice a week and oral care had not been completed in the last few days.

An interview with Personal Support Worker #136 revealed oral care was not provided to the resident on that day. [s. 34. (1) (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 each resident of the home receives oral care to maintain the integrity of the oral tissue that includes mouth care in the morning and evening, including the cleaning of dentures, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's desired bedtime routine was supported and individualized to promote comfort, rest and sleep.

An interview with a resident revealed that the resident was not given the option to choose what time they would get up.

A clinical record review revealed that there was no documentation of the wake up time chosen by the resident.
A further clinical record review revealed no documentation of choices given to resident to choose bedtime routines.

This was confirmed by RAI Corodinator #105, who also confirmed that it was the home's expectation that residents were given the choice of choosing their bedtime routines and those bedtime routines would be documented in the plan of care. [s. 41.]

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 of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A clinical record review revealed that there were no further assessments completed of the resident's altered skin integrity after a treatment had been applied.

An interview with Resident Care Coordinator #109 and Director of Care #102 confirmed that the resident required further assessments.

Both confirmed that it was the home's expectation to complete a skin and wound assessment. [s. 50. (2) (b) (i)]

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 resident exhibiting skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A review of assessments revealed that the resident was incontinent but had not received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

An interview with Resident Care Corodinator #109 confirmed the resident had not received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require. [s. 51. (2) (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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for, cleaning of the home including resident bedrooms and floors.

A review of the cleaning guidelines procedures revealed that housekeeping staff were to clean resident rooms daily.

On January 27 and 28, 2016, Inspector #523 observed and took photographs of a band aid cover and dust on the floor by the main door of the resident's room.

An interview with the Administrator #100 revealed that the expectation was for housekeeping staff to clean resident's bedrooms and furnishings on a daily basis including dry and wet mopping of the floors.

Administrator #100 was shown two photographs taken on January 27 and 28, 2016, in a resident's room of a band aid cover and dust on the floor by the main door of the resident's room.

The Administrator confirmed the observations and revealed that there have been challenges with some housekeeping staff implementing the home's policy and completing their daily tasks of thoroughly cleaning the resident's rooms and furnishings.

The Administrator confirmed that it was the home's expectations that staff implement the home's policies and procedures. [s. 87. (2) (a)]

2. An observations of Hallway B and C in front of the nursing station revealed two air intake ceiling vents with thick accumulation of dust, the air flow vent and ceiling tiles

around it were very dusty. There was an accumulation of dirt in the hallway by the door frames and the side of the hallways by the walls did not look to be clean as in the middle of the hallway.

A review of the homes policies Cleaning Guidelines - Resident Rooms and Common / General Areas dated February 2013 describes a detailed procedure for cleaning both resident rooms and common / general areas.

This was confirmed by Administrator #100.

Administrator stated that they are working on a process to ensure thorough cleaning of resident's rooms and common areas and to ensure that staff implement the home's policy. [s. 87. (2) (a)]

3. The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including common areas.

Observations in the common room on C wing revealed a sticky puddle 30 centimetres (cm) by 30 cm on the floor under a window. Continued observations at 1130 hours, 1400 hours and 1612 hours revealed the sticky puddle continued to remain on the floor.

Observations the next day at 0930 hours in the common room on C wing revealed the sticky puddle had dried into a sticky film.

The observations were seen by the Administrator #100 who confirmed the floor was dirty and the spill had been present long enough to dry into a sticky film. The interview with Administrator revealed that as part of the organized program of housekeeping, procedures had not been developed and implemented for cleaning the home including the common areas. [s. 87. (2) (a) (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 procedures are developed and implemented for cleaning of the home, including common areas, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

Observations on two dates revealed a resident was restrained.

A record review revealed there was no documented evidence to support the resident was monitored while the resident was restrained.

A review of the home's policy Safety Plan – Resident, May 2015, revealed it was the homes expectation that the resident was monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff.

An interview with Registered Practical Nurses #118, #119 and Personal Support Worker's #120 and #121 confirmed the resident was restrained and the staff were not monitoring the resident hourly while the resident was restrained.

The Registered Practical Nurses confirmed it was the home's expectation that a resident was monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff. [s. 110. (2) 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 residents are monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A record review revealed on a specific date two residents received their 0800 hours medications between 1130 hours and 1444 hours.

A review of the prescribed medications revealed the medications were to be given at 0800 hours to the residents and were not commenced until 1130 hours and completed at 1444 hours.

An interview with the Director of Care confirmed the drugs were not administered to the resident's in accordance with the directions for use specified by the prescriber and that it was the home's expectation that drugs were to be administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #15: 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 staff participated in the implementation of the infection prevention and control program.

During the initial tour of the home on January 25, 2016, observation of the tub room in B wing revealed that there were three plastic containers with the following infection control issues

- Seven black combs had hair insitu that were unlabeled
- Two pairs of nail clippers unlabeled
- Mouth basin
- Tena product
- 12 nail sticks

Observation of the Tub room in the short B wing revealed two plastic containers had the following infection control concerns

- Two black plastic combs with hair insitu unlabeled
- Two pairs of nail clippers unlabeled

The Administrator #101 and the Resident Care Coordinator #109 confirmed that the care items had been used by multiple residents and were not labeled. They also confirmed the items should have been labeled and put away to ensure that staff participate in the infection prevention and control program. [s. 229. (4)]

2. Observations revealed Registered Practical Nurse (RPN) #129 completed documentation, moved the medication cart, accessed supplies from the medication cart, locked the medication cart, and then went to a resident to deliver a treatment.

Observations of the Registered Practical Nurse #129 revealed the RPN did not wear

gloves when carrying out the treatment duties.

Returning to the medication cart the Registered Practical Nurse #129 cleansed both hands with alcohol. Registered Practical Nurse #129 then completed further documentation. Registered Practical Nurse #129 reached in the pockets of her uniform and used the keys to unlock the medication cart. Registered Practical Nurse #129 gathered items for another resident's medication pass.

The Registered Practical Nurse #129 placed the items to be used in the staff's pocket while the staff member assisted the resident with their walker.

Once the resident was seated the Registered Practical Nurse proceeded to carry out the treatment. The Registered Practical Nurse #129 did not wear gloves.
The Registered Practical Nurse #129 then administered a medication without following the infection prevention and control measures.

Registered Practical Nurse #129 returned to the medication cart and cleansed both hands with alcohol. Registered Practical Nurse #129 then completed documentation. Registered Practical Nurse #129 reached in the pockets of her uniform and used the keys to unlock the medication cart. Registered Practical Nurse #129 touched her hair, electronic pen and then gathered items for another resident's medication pass.

A review of the home's policy describes the procedure and identifies the nurse should have cleansed the skin with an alcohol swab.

A review of the home's policy 3-12 reference, the Centres for Disease Control and Prevention also required staff in long term care to wear gloves, not to carry supplies and medications in pockets and to perform hand hygiene between procedures.

An interview with the Director of Care revealed it was the home's expectation that the staff change gloves and perform hand hygiene treatments.

An interview with the Resident Care Manager revealed it was the home's expectation that the staff cleanse the skin with an alcohol swab before injecting the skin. [s. 229. (4)]

3. A) Resident informed the Inspector that some used supplies were stored inappropriately.

An interview with Personal Support Worker #133 confirmed the supplies were stored inappropriately.

B) Observations in the annex of the large dining room revealed a container holding food utensil scoops. In the container it was observed to have a role of tape, six individual jam preserves, one glove, a used alcohol wipe and a packet of wet wipes. Further observations of the lids to the hot plates in the serveries revealed the lids were soiled with old dried food debris and ink from pens.

An interview with the Administrator #100 confirmed the items in the scoop container should not have been with the utensils scoops used for food and it was the home's expectation that the staff participate in the implementation of the infection prevention and control program. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act was fully respected and promoted.

Observations during the dining observation revealed that a list including resident's names, room numbers, type of diet, texture, portion, adaptive devices, supplements, risks, high energy or protein diets and notes. This list was clipped to a magnet and attached to the hand towel box over the sink accessible by anyone in the dining room.

An interview with the Director of Care #102 confirmed that the Personal Health Information was not kept confidential. [s. 3. (1) 11. iv.]

2. Observations revealed the electronic medical administration record (eMar) screen was left unlocked and open in the front entrance revealing resident name and prescriptions to residents and visitors who were coming in and out of the building.

An interview with Registered Practical Nurse #139 confirmed the eMar record had been left unlocked and open in the front entrance and it was the home's expectation that that personal health information of residents should be kept confidential in accordance with the Act.

Observations in the dining room revealed a hand written note pad on the counter accessible to all people in the dining room, containing a log of a resident's behaviours recorded daily and a spread sheet containing resident's diet requirements including type of diet, texture, portion size and risks.

An interview with the Administrator #100 confirmed the personal health information was not protected or kept confidential in accordance with the Act and it was the home's expectation that the personal health information should have been protected in accordance with the Act. [s. 3. (1) 11. iv.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker (SDM).

A record review revealed a resident was admitted to the home.

A further review revealed there was no documentation that identified that the resident had had an admission care conference within six weeks of their admission.
A review of records revealed resident had not had annual care conferences for two years.

An interview with Registered Practical Nurse #112 confirmed there were no records of any care conferences having been completed for the resident since the admission.

An interview with the Director of Care #102 confirmed the resident had not had an admission care conference or an annual care conference and it was the home's expectation that a care conference of the interdisciplinary team was to be held to discuss the plan of care and any other matters of importance to the resident and his or her SDM, if any within six weeks of the admission of the resident, and at least annually. [s. 27. (1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was assisted with getting dressed as required, and was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

Observations on two dates revealed a resident had their trousers pulled up to their pelvis but not pulled up to their waist. The product the resident was wearing was exposed.

The observations were confirmed by Personal Support Workers #108 and #116.

A record review revealed the resident was totally dependent for all aspects of dressing.

An interview with Personal Support Worker #116 confirmed it was the home's expectation that the resident should have received the assistance required to dress.

An interview with the Administrator confirmed that each resident of the home should be assisted with getting dressed as required, and dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. [s. 40.]

Issued on this 20 day of April 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de sions de longue durée

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : REBECCA DEWITTE (521) - (A1)

Inspection No. / No de l'inspection : 2016_260521_0004 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 000862-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Apr 06, 2016;(A1)

Licensee / Titulaire de permis : CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

LTC Home / Foyer de SLD : CARESSANT CARE ON BONNIE PLACE
15 Bonnie Place, St Thomas, ON, N5R-5T8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Colleen Wilson

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee will ensure: a) every resident using bed rails is assessed using an appropriate assessment tool. These assessments will be documented and plans of care reviewed and revised consistent with the completed assessments. b) that steps are taken to prevent entrapment on resident #023's bed.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

This area of noncompliance was previously issued as a written notification and compliance order on July 23, 2014, inspection number 2014_232112_0042;

Resident observations on January 26, 27, and 28, 2016, during stage 1 of the Resident Quality Inspection revealed 15 of 40 or 37.5% of residents had one or more bed rails in use.

Record review of the resident clinical records revealed the absence of a documented resident assessment for the use of bed rails.

The Director of Care confirmed that the bed entrapment audits had been completed but the home had not completed the bed assessment for all residents using bed rails. [s. 15. (1) (a)]

(610)

2. 2. The licensee has failed to ensure steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During an observation of a resident bed system it was noted that the resident mattress was not secure.

Inspector #610 was able to move the mattress creating a gap between the mattress and the rail. A further inspection showed that one of three straps of the mattress keeper was being used to secure the bed.

The Director of Care confirmed the risk of entrapment where the bed rails were used.

A review of the entrapment inspection sheet dated January 27, 2016, revealed a mattress had failed its audit and had been replaced with another mattress and rails added to the bed system.

A review of the Policy and Procedure for Entrapment revealed:
"For individual residents at risk for entrapment, implement appropriate changes to the bed (for example, the use of retrofit kits, bed rail netting, clear padding, Velcro or anti-skid mats) to reduce the risk of entrapment."

The Director of Care confirmed it was the homes expectation that steps should be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]The scope of this issue was widespread. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did have a history of non-compliance with sub-section of the regulation. This area of non-compliance was previously issued as a written notification and compliance order on July 23, 2014, inspection number 2014_232112_0042 and put back into compliance on September 19, 2014. (610)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Apr 08, 2016

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

(A1)

The licensee will implement an interdisciplinary continence care and bowel management program.

This program will specify a lead staff person to monitor the program and will include: a) catheter care; b) annual evaluation of resident s satisfaction with continence care products and c) monitoring system to ensure all continence assessments are completed per policy.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that the licensee developed and implemented an interdisciplinary continence care and bowel management program that promoted continence and ensured that residents were clean, dry and comfortable.

A record review of a resident file revealed there was a medical directive. A further review revealed there was no continence assessment completed.

An interview with the Resident Care Coordinator #109 revealed the resident did not have an assessment as the licensee had failed to have a leader to implement the program that would provide the assessments and strategies to maximise residents' independence, comfort and dignity.

The interview also revealed that there was no annual evaluation of resident.

The scope of this was issue was widespread. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did have a related non-compliance with sub-section of the regulation. On September 2, 2014, a written notification and a voluntary plan of correction were issued in a Critical Incident System report #2014_303563_0027. (521)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Apr 29, 2016(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

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La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20 day of April 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : REBECCA DEWITTE - (A1)

Service Area Office /
Bureau régional de services : London