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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Oct 17, 2013	2013_24304 _0002	L-000787-13	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 ON MARY BUCKE
4 MARY BUCKE STREET, ST. THOMAS, ON, N5R-5J6

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

DEIRDRE BOYLE (504)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 8th and 9th, 2013.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Maintenance Manager, Registered Nurse, two Registered Practical Nurses, four Personal Support Workers, Laundry Aide, Unit Clerk and six Residents.

During the course of the inspection, the inspector(s) made observations and reviewed the plan of care, bath list and Point of Care for selected Residents,emergency plans, equipment manuals,water temperature logs, the incontinence product ordering sheets, incontinence product supplies in storage, the system for distribution of incontinence products and the incontinence product budget. The Registered Nurse and Registered Practical Nurse schedules were reviewed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The Licensee has failed to ensure that all equipment was used in accordance with manufacturer's instructions.

On September 19th, 2013 the Home's boiler was replaced resulting in no hot water being available in the Home for several hours. The Laundry Staff confirmed that the residents clothing and linens were washed using cold water and not according to the laundry machine manufacturer's instructions.

Through a review of the chemicals used in the machine and review of the laundry machine manual, it was revealed that the recommended water temperature for the machine is 140 degrees Celsius. This was confirmed in an interview with maintenance staff. [s. 23.]

2. The operating manual for the washing machine was not available in the home upon request on October 8, 2013, but was provided on October 9, 2013. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #2: 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 not ensured that each Resident is bathed at a minimum twice per week.

Through interview with the Registered Nurse and review of the documentation of baths and showers on Point of Care, it was revealed that on two days in September, that Residents who were scheduled to receive a bath or shower did not receive a bath or shower. The missed baths and showers were not re-scheduled. [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 with ensuring 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius.

Through a review of the home's Water Temperature Chart it was revealed that on September 17, 2013 that the water temperature on the night shift was 55 degrees Celsius, on September 23 it was 55 degrees Celsius on the day shift, on September 24 it was 52 degrees Celsius on the night shift, on September 25 it was 55 degrees Celsius on the evening shift, on September 29 it was 56 degrees Celsius on the night shift, on October 3 it was 56 degrees on the night shift, on October 5 it was 56 degrees Celsius on the day shift and on October 8 it was 60 degrees Celsius on the night shift. [s. 90. (2) (g)]

2. The Licensee has failed to ensure that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.

The staff of the home who take the water temperatures have not consistently called the maintenance staff when the water temperature exceeds 49 degrees Celsius. This was confirmed by a Registered Nurse and Maintenance staff. The Home's Water Temperature Chart heading directs staff to notify Maintenance when the water temperatures are out of range. [s. 90. (2) (h)]

3. The Licensee failed to ensure that the water temperature is monitored once per shift in random locations where residents have access to hot water.

This was confirmed by a Registered Nurse and the Maintenance staff. The temperature of the water is not checked each shift in areas accessible to residents as evidenced by a review of the Water Temperature Record where the location of the water temperatures that were checked is documented. At times, the temperature is taken in the medication room which is not accessible to residents. [s. 90. (2) (k)]

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Issued on this 17th day of October, 2013

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

Deirdre Boyle