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**
**Direction de l'amélioration de la performance et de la conformité**

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 3, 2016 | 2015_360111_0023 | O-001939-15 | Follow up |

### 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 MCLAUGHLIN ROAD
114 McLaughlin Road LINDSAY ON K9V 6L1

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

LYNDA BROWN (111), BAIYE OROCK (624)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Follow up inspection.**

**This inspection was conducted on the following date(s): October 19 22, 2015**

**The following inspections were completed concurrently during this inspection: follow-up related to insufficient staffing (#001939-15);critical incident related to abuse (#002904-15); critical incidents related to missing residents (#002085-15 & #002367-15); a critical incident related to falls (#016273-15); and a complaint related to continence care and staffing (#002345-15).**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Resident Care Coordinator(RCC), Registered Nurses(RN, Registered Practical Nurses(RPN), and Personal Support Workers (PSW), and Residents. Reviewed resident health care records, bath and staffing schedules,**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Critical Incident Response**
**Prevention of Abuse, Neglect and Retaliation**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **6 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 31. (3) | CO #001 | 2015_365194_0007 | 111 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 31. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 31. (3) The staffing plan must,**
**(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).**
**(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).**
**(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).**
**(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).**
**(e) 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. 31 (3).**

**Findings/Faits saillants :**

The licensee has failed to ensure that the staffing plan provided for a staffing mix that is consistent with residents' assessed care and safety needs.

Related to log # 001939-15:

A follow up inspection related to insufficient staffing that resulted in baths not provided to residents, an interview of DOC was conducted. The DOC indicated that the monitoring process to ensure baths were provided to resident 2 x per week included: the Resident Care Coordinator (RCC) & DOC meet each morning to determine which residents have not received their assigned baths and actions taken to resolve the issue. The DOC indicated there is a bath shift PSW on days and evenings who is responsible for completing all assigned baths and the DOC attempts to replace all "bath shifts" whenever there is a call in, using agency staff as needed. The DOC indicated at times when the bath cannot be provided due to staffing shortages, the resident is offered an alternative bath (either the following shift/day or the following week). The DOC stated "there have been some gaps though" in the bathing shifts which resulted in 17 residents not receiving their assigned baths.

Interview of the RCC indicated the bath shift PSW's are assigned residents to be bathed on days and evening shifts and the PSW's are to sign off on the "bathing shift sheet" when the bath has been completed. The RCC indicated she reviews the "bathing shift sheet" each day to determine which residents have not had their assigned bath signed for, and if she notes any entries that are not signed for, she will check with staff to see if the resident received their assigned bath, and if they did, then she will "sign" for the bath as received.

Review of the "PSW Bath Shift Schedules" for a four month period indicated the bath shift was not filled on seven specified dates and times.

Review of the "bathing shift sheet" for the same four month period, indicated 17 residents did not receive their two assigned baths as per their plan of care. Review of the health care records for those 17 residents also did not indicate why the bath was not provided, and it was unclear when the bath was completed, and by whom. There was also no clear indication when the baths were not provided, whether alternatives were offered or if baths were provided on alternative days/shifts.

A Voluntary Plan of Correction(VPC) was issued under O.Reg.79/10, s.33(1) on December 17, 2014 during inspection # 2014_365194_0024 and a Compliance Order (CO) # 001 was also issued during the same inspection under O.Reg.79/10, s. 31(3) for insufficient staffing which resulted in bathing not being provided as per the residents plan of care (with a compliance date of February 5, 2015). On April 10, 2015 a CO was issued again for O.Reg.79/10, s. 31(3) regarding sufficient staffing mix that was consistent with residents' assessed care needs related to bathing, during inspection # 2015_365194_0007 (with a compliance date of June 30, 2015). [s. 31. (3)]

***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 LTCHA, 2007 S.O. 2007, c.8, 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 :**

The licensee failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to the resident, regarding responsive behaviors.

Related to log #002085-15:

A critical incident report (CIR) was received for a missing resident less than 3 hours. The CIR indicated that on a specified date, a co-resident reported to a staff member that Resident #003 was observed outside of the home. Resident #003 was immediately located and returned to the home uninjured.

A review of the progress notes for Resident #003 at the time of the incident, revealed that Resident #003 was experiencing increased cognitive impairment and demonstrating high risk responsive behaviours, and staff suspected the resident had a change in condition.

A review of Resident #003 plan of care (in place prior to the incident) related to responsive behaviours of elopement had interventions that included: document each episode, give item or task, or involve in activity program to attempt to distract, give medication as prescribed, and praise for demonstrating desired/acceptable behaviour. After the incident, an alarming device was provided and additional intervention of "monitor closely and spend 3mins 1-2x/day talking to resident to redirect".

Interview of S#112 stated "monitoring closely referred to every 15 minute checks". In an interview of S#119 and S#116 both stated “monitoring closely” was dependent on the resident. All three staff indicated that the “monitor closely” should be more specific.

2.Related to log #002367-15:

A critical incident report (CIR)was received for a missing resident less than 3 hours. The CIR indicated that on a specified date, staff were notified that Resident #002 was observed outside the home. Staff returned the resident back to the home without any injuries. The CIR indicated Resident #002 had a history of exit seeking and previous elopements since admission.

A review of Resident #002 plan of care (in place at time of the incident) related to responsive behaviours of exit seeking/elopement/wandering included interventions of: wears an alarming device to specified area and to mobility aide, "monitor whereabouts", and staff to place an 'Out of service' sign at elevator when exit seeking.

Interview of S#116 indicated the resident was found off the unit by the front entrance which activated the alarming device. S#116 indicated Resident #002 was redirected from the front entrance and then the alarm was deactivated to allow visitors to leave. S#116 acknowledged Resident #002 was not supervised after that point. S#116 and S#120 provided different responses to what “monitor whereabouts” meant. Both S#116 and S#114 were not aware how Resident#002 left the unit and came to the front entrance.

Interview of DOC indicated “monitor closely” and “monitor whereabouts” depended on the resident/situation and stated “probably needed to be more specific”.

Interview of Environmental Manger (EM) by Inspector #111 indicated if a resident with an alarming device approached the front entrance, the alarm will sound to alert staff and the door will remain locked. The EM indicated the nursing staff can only deactivate the alarming device by placing the alarm on “bypass which lasts approximately 40 seconds”, and can only be deactivated at the nursing station which is not within site of the front entrance. The EM indicated that the resident with the alarming device should be monitored while the alarm is on bypass until the alarm is re-engaged as the device will not alarm during that time.

2. The licensee failed to ensure that care set out in the plan of care was provided to the resident, as specified in the plan, related to responsive behaviours.

Related to log #002367-15:

A critical incident report (CIR) was received for a missing resident less than 3 hours. The CIR indicated that on a specified date, staff were notified that Resident #002 was observed outside of the home and the resident was returned without any injuries. The CIR indicated Resident #002 had a history of exit seeking and previous elopements since admission.

A review of Resident #002 plan of care (at the time of the incident) related to responsive behaviours of exit-seeking and elopement indicated interventions that included monitor whereabouts, and staff to place a sign at elevator stating "Out of service", at staff discretion when resident was exit seeking.

Interviewed S#114 indicated prior to the incident, the resident had returned from an outing and immediately began demonstrating exit-seeking responsive behaviors. S#114 acknowledged an "out of service" sign was not placed at the elevator at that time despite indicated on the plan of care. S#114 stated “I had no idea how the resident may have ended up" at the front entrance, and despite the plan of care indicating to monitor resident's whereabouts.

***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 the written plan of care sets out clear directions to staff and others who provide direct care to the residents related to responsive behaviours and to ensure the plan of care is provided to the resident related to responsive behaviours, to be implemented voluntarily.***

---

**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following occurred, immediately reported the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to log #002904-15:

A critical incident report (CIR) was received on a specified date for a staff to resident verbal abuse incident towards Resident #010 that occurred two days earlier at a specified time by S#112.

Interview of the DOC indicated the incident of suspected staff to resident verbal abuse occurred on a specified date but was not immediately reported to the charge nurse until the following day. The DOC indicated the charge nurse also did not notify the DOC until the day after being notified and then the DOC reported the allegation to the Director. The DOC confirmed late reporting to the Director.

The licensee has been issued ongoing non-compliance related to LTCHA, 2007, s.24(1) as indicated on January 18, 2012 during inspection # 2012_043157_0004, on June 6, 2013 during inspection # 2013_220111_0009, on January 17, 2014 as a Compliance Order with a compliance date of January 30, 2014, and again as a Compliance Order on July 13, 2014. The Compliance Order was complied with on September 9, 2014. [s. 24. (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 when a person has reasonable grounds to suspect abuse of a resident by the licensee or staff, that resulted in risk of harm was immediately reported to the Director, to be implemented voluntarily.***

---

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

**Specifically failed to comply with the following:**

**s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,**
**(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and**
**(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).**

**s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).**

**Findings/Faits saillants :**

The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Related to log #002904-15:

A critical incident report (CIR) was received on a specified date for a staff to resident verbal abuse incident towards Resident #010 that occurred two days earlier by S#112. The CIR indicated the SDM was contacted but the CIR was completed two days after the incident occurred.

Review of the progress notes for Resident #010 indicated the incident was documented the day after the incident occurred. There was no documented evidence the SDM was contacted regarding the incident from the day it actually occurred up to when it was reported to the Director 2 days later.

The licensee also failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse investigation immediately upon completion.

Review of the home's investigation and interview of staff indicated the investigation was completed eight days later and the home determined the allegations to be founded for staff to resident verbal abuse towards Resident #010 by S#112. There was no documented evidence the SDM was notified of the outcome of the investigation.

***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 the resident's SDM and any other person specified by the resident is immediately notified upon becoming aware and of the results of the investigation immediately upon completion of any alleged, suspected or witnessed incidents of abuse or neglect of the resident that causes distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.***

**WN #5: 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,**
**(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(h) residents are provided with a range of continence care products that,**
**(i) are based on their individual assessed needs,**
**(ii) properly fit the residents,**
**(iii) promote resident comfort, ease of use, dignity and good skin integrity,**
**(iv) promote continued independence wherever possible, and**
**(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

The licensee has failed to ensure that continence care products are available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

Related to log #002345-15:

Interview of the DOC indicated the RCC manages the incontinence products in the home, the RCC fills the bins for each unit for each shift, the charge nurse and RCC only have access to the main supply room on the first floor if staff need extra incontinence supplies.

Interview of RCC stated "restocks the incontinence bins for each shift, for each unit daily" (Monday to Friday) and also "restocks the reserve bins every Monday". The RCC indicated she will add extra incontinence products to reserve bins "when staffs ask for extra" via the sign out book. The RCC indicated no awareness of the amount of each incontinence product that is put in each of the reserve bins but "stocks it full". The RCC stated she "frequently gets extra incontinence product when staff call her or she will give

the key to staff to pick up what they need in main storage room”. The RCC indicated the “resident profile worksheet for incontinence products” is completed on admission and the “Tena product change forms” are to be used by staff when requesting extra incontinence products and/or a change of incontinence product. The RCC indicated these 'product change forms' are available on each unit and RCC only approves the request "based on staff documenting in POC the frequency of toileting". The RCC indicated that staff are also to use the green incontinence sign out binder (kept in the clean utility rooms) to indicate extra products used from the reserve bin and reason. The RCC indicated staff frequently indicate "not enough briefs" available for the residents but that does not generate extra brief/pads for the resident if staff are not documenting electronically in Point of Care (POC) to support that the resident is receiving extra toileting. When asked where the sign out book for unit one was? the RCC stated “staff may have thrown the book out".

Unit one:
Observation of the clean utility room (on Monday) indicated the “reserve bin” had no briefs available and had only a small amount of yellow and blue pads. The linen cart also had no pads or briefs available. There was no 'incontinence sign out' binder available.

Interviews of S#100 & #101 both indicated they are frequently short of incontinence supplies for the residents. They both indicated the process is the night staffs are to leave the incontinence products for the residents in the residents’ room (the type and amount) for the day shift. If the staff uses that product, they are to go to the clean utility room to the “reserve bin” for extra's and use 'sign out' book which incontinence product were removed, who it was for, and why. They both indicated that there frequently aren't any incontinence product available in the reserve bin that the resident is supposed to have, so they either have to borrow from another resident's supply, or use a different product, or ask the charge nurse to get more from the storage room on the first floor. They both indicated the 'sign out' book was missing and indicated they do not ask the charge nurse for continence products because they would have to spend time trying to find them and the process “just took too long” and “resident’s would have to wait”. Interview of S#106 stated “there are more residents on 2nd floor who wear briefs compared to pads and there is frequently insufficient supply of incontinence products on the second floor”.

Unit two (second floor):
Observation of the clean utility room indicated there was only small white pads and blue pads available in the 'reserve bin'. There were also blue pads available on the linen cart but no other pads or briefs available. The incontinence 'sign out' binder was available.

Interview of S#104 indicated most of the residents are given only one incontinence product for each shift, but some residents require more than one incontinence product per shift. S#104 stated “frequently running out of incontinence supplies for the residents, some of those residents have skin breakdown issues, the reserve bin never has enough extra continence supplies that the residents are supposed to have, and this past weekend had no extra pads to use”. S#104 stated “sometimes even borrow incontinence products from other residents, or from other shifts, which then leaves those resident's short incontinence supplies”. S#104 stated “was just informed that [staff] are supposed to ask the charge nurse on the first floor for extra's if they needed them”.

Unit three(second floor):
Observation of the clean utility room indicated the 'reserve bin' had blue and yellow pads available and yellow pads available on the carts. There were no white pads or any briefs available. The incontinence 'sign out' book was available.

Interview of S#105 stated “sometimes has to substitute yellow for blue pads or blue pads for yellow pads, the reserve bin is frequently low but can ask the charge nurse for extra incontinence products if needed”. Interview of Resident #004 & #011 both indicated they wear incontinence products. Resident #004 stated frequently "incontinent of urine" and “sometimes wets quite heavy” and "the staff give me either yellow or blue pads, whatever they have, but the yellow ones don't work as well because I soak right through them, I prefer the blue ones". Resident #011 also indicated they are offered different incontinence products depending on what is available.

Interview of S#103 (charge nurse) indicated that if the staff run out of incontinence products then they are to access the 'reserve bin' in clean utility rooms for extra's or ask the charge nurse for incontinence products and who will get them from the main supply room on the first floor. S#103 stated “very rarely has to get extra supplies from the main supply room”. S#103 indicated the RCC is responsible to refilling the incontinence supplies for each floor and each shift and also responsible to restocking the reserve bins on each unit. S#103 indicated only the charge nurse and RCC have access to the main supply room where the incontinence supplies are kept. S#103 was not aware that the reserve bins did not have adequate supply of incontinence products available.

---

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:**
**3. Actions taken in response to the incident, including,**
**i. what care was given or action taken as a result of the incident, and by whom,**
**ii. whether a physician or registered nurse in the extended class was contacted,**
**iii. what other authorities were contacted about the incident, if any,**
**iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and**
**v. the outcome or current status of the individual or individuals who were involved in the incident.**
**O. Reg. 79/10, s. 107 (4).**

**Findings/Faits saillants :**

The licensee has failed to ensure that a physician or registered nurse in the extended class was contacted after two residents went missing from the home for less than three hours.

Related to log #002085-15:

A Critical incident report (CIR) was received for a missing resident less than 3 hours. The CIR indicated that on a specified date, a co-resident reported to a staff member that Resident #003 was observed outside the home. Resident #003 was immediately returned to the home with no injury. The CIR did not indicate that the physician was notified of the incident.

A review of the progress notes for Resident #003 on the day of the incident, indicated Resident #003 was experiencing increased cognitive impairment and staff suspected a change in condition. There was no indication the physician was notified.

2. Related to log #002367-15:

A Critical incident report (CIR)was received for a missing resident less than 3 hours. The CIR indicated that on a specified date, staff were notified that Resident #002 was observed outside the home. S#116 returned the resident back to the home without any injuries. The CIR did not indicate that the physician was notified of the incident.

Interview with S#116 indicated that S#116 responded to both incidents (involving Resident #002 & #003)and indicated the physician was not contacted because “both residents returned with no injuries and that physicians usually get angry when called for incidents where there was no injury to the resident”. Interview of S#114 indicated that on date of incident involving Resident #002 stated an “oversight if physician was not called, must have just forgotten". Both S#116 & S#114 indicated they would have communicated incidents of elopement to the physician via the physician communication book.
A review of the physician communication book and health records of Resident #002 & #003 had no documented evidence the physician was notified of the two incidents of elopement.

**Issued on this 3rd day of February, 2016**

| |
|---|
| **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**

**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

**Ministére de la Santé et des Soins de longue durée**

**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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | LYNDA BROWN (111), BAIYE OROCK (624) |
| **Inspection No. / No de l'inspection :** | 2015_360111_0023 |
| **Log No. / Registre no:** | O-001939-15 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Feb 3, 2016 |
| **Licensee / Titulaire de permis :** | CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED<br>264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9 |
| **LTC Home / Foyer de SLD :** | CARESSANT CARE ON MCLAUGHLIN ROAD<br>114 McLaughlin Road, LINDSAY, ON, K9V-6L1 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Kyle Cotton |

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) (b)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) 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. 31 (3).

**Order / Ordre :**

The licensee shall prepare, implement and submit a plan or corrective action to include the following:
When staffing issues arise related to bath shifts not covered and resulting in a disruption of the resident's bathing routines:
-revise the procedure of monitoring of the 'daily bath lists' as completed by PSW's and currently reviewed by ADOC/DOC, to ensure the residents are provided a minimum of two baths per week, as per the residents plan of care, to include monitoring by the registered nursing staff in charge on a daily basis,
-when the 'daily bath lists' indicate the baths were not provided, revise the procedure to ensure the list clearly indicates why the bath was not provided, and clearly indicates when an alternate bath date/time will be provided, within that same week period, or an alternate to the bath, as specified by the resident, is to be provided,
-when the resident refuses the bath, the reason for the refusal is clearly indicated, where and how that is documented, and/or alternatives offered,
-all nursing staff to be retrained on the revised procedures on resident bathing requirements and the documentation practices of same, to ensure resident baths are provided minimum of twice a week as per the residents care requirements, and documentation that clearly reflects when the resident did not receive the bath, why, when alternate date was provided or what alternative to the bath was provided, and/or when the resident refuses,
-the plan will include who will be responsible for each task and completion dates.

The plan is to be submitted to Lynda Brown by February 15, 2015 via email to OttawaSAO.MOH@ontario.ca

**Grounds / Motifs :**

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that is consistent with residents' assessed care and safety needs.

Related to log # 001939-15:

A follow up inspection related to insufficient staffing that resulted in baths not provided to residents, an interview of DOC was conducted. The DOC indicated that the monitoring process to ensure baths were provided to resident 2 x per week included: the Resident Care Coordinator (RCC) & DOC meet each morning to determine which residents have not received their assigned baths and actions taken to resolve the issue. The DOC indicated there is a bath shift PSW on days and evenings who is responsible for completing all assigned baths

and the DOC attempts to replace all "bath shifts" whenever there is a call in, using agency staff as needed. The DOC indicated at times when the bath cannot be provided due to staffing shortages, the resident is offered an alternative bath (either the following shift/day or the following week). The DOC stated "there have been some gaps though" in the bathing shifts which resulted in 17 residents not receiving their assigned baths.

Interview of the RCC indicated the bath shift PSW's are assigned residents to be bathed on days and evening shifts and the PSW's are to sign off on the "bathing shift sheet" when the bath has been completed. The RCC indicated she reviews the "bathing shift sheet" each day to determine which residents have not had their assigned bath signed for, and if she notes any entries that are not signed for, she will check with staff to see if the resident received their assigned bath, and if they did, then she will "sign" for the bath as received.

Review of the "PSW Bath Shift Schedules" for a four month period indicated the bath shift was not filled on seven specified dates and times.

Review of the "bathing shift sheet" for the same four month period, indicated 17 residents did not receive their two assigned baths as per their plan of care. Review of the health care records for those 17 residents also did not indicate why the bath was not provided, and it was unclear when the bath was completed, and by whom. There was also no clear indication when the baths were not provided, whether alternatives were offered or if baths were provided on alternative days/shifts.

A Voluntary Plan of Correction(VPC) was issued under O.Reg.79/10, s.33(1) on December 17, 2014 during inspection # 2014_365194_0024 and a Compliance Order(CO) # 001 was also issued during the same inspection under O.Reg.79/10, s. 31(3) for insufficient staffing which resulted in bathing not being provided as per the residents plan of care (with a compliance date of February 5, 2015). On April 10, 2015 a CO was issued again for O.Reg.79/10, s. 31(3) regarding sufficient staffing mix that was consistent with residents' assessed care needs related to bathing, during inspection # 2015_365194_0007 (with a compliance date of June 30, 2015). [s. 31. (3)] (111)

Ontario

**Ministry of Health and Long-Term Care**

**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

**Ministére de la Santé et des Soins de longue durée**

**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

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Apr 30, 2016

## 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
Performance Improvement and Compliance 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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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 3rd day of February, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** LYNDA BROWN

**Service Area Office /**
**Bureau régional de services :** Ottawa Service Area Office