Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 14, 2016	2016_461552_0014	013438-16	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 MCLAUGHLIN ROAD
114 McLaughlin Road LINDSAY ON K9V 6L1

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

MARIA FRANCIS-ALLEN (552), DENISE BROWN (626), LYNDA BROWN (111), SAMI JAROUR (570), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 30 - June 3 and June 6-9, 2016

The following intakes were reviewed and inspected concurrently with the Resident Quality Inspection: #001188-15, 016621-15, 021128-15, 033920-15, 004494-16, 005421-16, 008394-16, 008514-16, 010474-16, 012974-16 and 010534-16.

Summary of intakes:
1) 001188-15 - Critical Incident Report - specific to allegation of resident to resident abuse
2) 016621-15 - Complaint - specific to wound care
3) 021128-15 - Critical Incident Report - specific to allegation of resident to resident abuse
4) 033920-15 - Complaint - specific to responsive behaviour
5) 004494-16 - Follow up - specific to order related to bathing
6) 005421-16 - Complaint - specific to allegation of staff to resident neglect
7) 008394-16 - Complaint - specific to infection control
8) 008514-16 - Critical Incident Report - specific to responsive behavior
9) 010474-16 - Critical Incident Report - specific to allegation of resident to resident abuse
10) 012974-16 - Critical Incident Report - specific to allegation of resident to resident abuse
11) 010534-16 - Complaint - specific to allegation of resident to resident abuse
12) 015462-16 - Complaint - specific to temperature in the home

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Phystiotherapy Assistant (PTA), Food Nutrition Manager, Members of the Behaviour Support Team (BSO), Behavioral Therapist, Environmental Service Manager (ESM), Resident and Family Council presidents, residents and families.

The inspector (s) also toured the home, reviewed resident's clinical health records, observed dining service, observed staff to resident interactions, observed resident to resident interactions, reviewed minutes of both family and resident council meetings, reviewed home specific investigations for identified critical incident reports, reviewed home specific policies and procedures related to Infection Control, Wound Management, Abuse and Neglect, Medication, Post Falls Management, Pain, Personal Assistive Service Devices (PASD) and Safety Plan.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 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_360111_0023	111

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 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

Re: follow-up Log # 004494-16:

Resident #051 was admitted to the home on an identified date. A review of the bath list on indicated, the resident has been offered a bath on seven occasions and had refused each time. The resident has not received a bath since admission.

Interview with Personal Support Worker #125 (PSW) indicated resident #051 prefers baths or showers 2x/week and had stated he/she is used to bathing independently and does not want anyone present. The PSW had offered many different approaches but the resident continued to refuse all baths or showers. The PSW indicated he/she reported the refusals to the Registered Practical Nurse (RPN) and documented the refusals on the bath sheet.

Interview of RPN #114 indicated when the bath shift reports a resident has refused a

bath he/she re-approaches the resident and offers a bath/shower. If the resident still refuses, it is documented in the progress notes. The RPN indicated the Power of Attorney (POA) would be notified the resident is still refusing baths.

Review of care plan for resident #051 indicated under bathing: requires assistance for bathing related to cognitive impairment. Interventions were "physical help in part of bathing activity".

Review of the progress notes for resident #051 from admission to present indicated:
- on an identified date, the Director Of Care (DOC) indicated "resident approached multiple times by two staff to have a bath, resident insisted that he/she sponge baths daily and did not require a bath".
- on an identified date, the DOC indicated late entry for two days earlier, "PSW stated that he/she attempted to let resident know they would only be in the bathroom to supervise, however, resident continued to refuse".

On an identified date the care plan was updated (as a result of the inspection) to include: prefers to bathe independently, staff to provide help with set up only and to remain in room, PRN assistance, physical help with transfer only, see bath schedule for specific day and time, ensure hair is washed and nails are manicured on bathing day. There was no indication whether the resident likes to have a bath or shower, or that the resident's preference was a sponge bath. [s. 6. (1) (c)]

2. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring that the care set out in the plan of care is provided to the resident as specified in the plan.

Related to log #008514-16

Resident #048 has a medical diagnosis that includes cognitive impairment. According to the nursing staff, resident #048 is exit seeking and a wander guard is placed on his/her wrist due to this behaviour.

On an identified date, resident #048 was found outside of the building and was brought back by a family member; the resident was last seen by staff five minutes earlier. The resident was not wearing the wander guard.

The plan of care for the resident directs the following:
- Ineffective coping; repetitive actions related to wandering and attempting to exit seek -

wander guard bracelet applied to right wrist. Staff to ensure bracelet is applied at all times.
- Ineffective coping; elopement risk related to cognitive loss – allow resident to go downstairs when he/she wants as wander guard is applied.

Review of progress notes for resident #048 over a four month period indicated:
- On an identified date wander guard applied to right wrist with no complaint noted from resident.
- Three weeks later wander guard is missing.
Review of the progress notes failed to indicate that a wander guard was applied after documented missing until the elopement incident ten days later.

Interview with PSWs #145 and 128 indicated the resident's wander guard has been on and off from time to time as the resident was able to remove it.

Interview with the DOC indicated that resident #048 is supposed to have the wander guard bracelet on at all times as per care plan and that PSW staff should check that wander guard is in place and document in Point of Care (POC). The DOC confirmed that resident #048 did not have the wander guard when he/she exited the building.. [s. 6. (7)]

3. The licensee has failed to ensure that the plan of care was revised when the resident's care needs changed related to wound care.

During stage 1 of the RQI, interview with RPN # 102 indicated resident # 014 had impaired skin integrity on a specific area which developed in other areas after return from hospital.

Review of the progress for resident #014 indicated:
-on an identified date, the resident returned from hospital and staff noted impaired skin integrity on a specific part of the resident's body. A dressing was applied and referral made to the wound care champion and dietician. The following day, the resident went to the hospital and returned three days later.
-on an identified date, the resident was complaining of discomfort and staff the condition of the resident's skin had deteriorated. New orders were received for wound care which included protective surface areas for both the resident's chair and bed. The resident was added to weekly wound assessments by wound care champion and a second dietary referral was also completed.
- over a two month period, skin assessments were conducted and various interventions

put in place by the physician, dietitian and wound specialist in an attempt to address the impaired skin integrity.

Review of the care plan for resident #014 related to impaired skin integrity indicated a potential ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to: immobility and cognitive impairment. Interventions included:
-Cleanse perineal area well with each incontinence episode, will refuse staff assist and requires staff to encourage the resident to allow staff to assist.
- Document/monitor/report any new openings to Registered Staff.
-Supervise resident's ability to reposition self in bed and/or chair. Report decline in ability.

On an identified date, the care plan was updated to include the interventions put in place over the two month period with the exception of the development of impaired skin integrity to specific parts of the resident's body and the dietary interventions.

Therefore, the written plan of care was not revised when resident #014 care needs changed, related to the development of impaired skin integrity to specific areas of the resident's body. The care plan was also not revised to reflect the change in dietary interventions related to skin impairment. [s. 6. (10) (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 the plan of care sets out clear directions to staff, that the care set out in the plan of care is provided to the resident as specified in the plan and that the plan of care is revised when the resident's care needs change, to be implemented voluntarily.

WN #2: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure when resident #014 returned from hospital, and who exhibited altered skin integrity, received a skin assessment by a member of the registered nursing staff.

Review of the home's policy "Head to Toe Assessment Form" reviewed February 2015 indicated a head to toe assessment is to be completed upon return to the facility from hospital or leave of absence for longer than 24 hours, a complete head to toe assessment of the resident shall be completed by the registered staff on duty, describing any areas of broken skin.

Review of the progress for resident #014 indicated on an identified date, the resident returned from hospital and staff noted impaired skin integrity on a specific area of the resident's body and dressing was applied. The resident was transferred back to hospital again and returned to the home two days later. A head to toe assessment had not been completed on either of the occasions when the resident returned from hospital. Two days later, the resident was complaining of discomfort and staff noted the dressing that was applied five days earlier had not been changed and another area had impaired skin integrity. Over a 4 week period, impaired skin integrity developed on different areas of the resident's body. The resident was sent to hospital for further interventions related to skin integrity. There was no head to toe assessment completed upon return from hospital.

Interview of RPN # 104 and 106 both indicated a head to toe skin assessment is to be completed on Point Click Care (PCC) for all resident's upon return from hospital. RPN #104 confirmed no head to toe assessment was completed on PCC for resident #014 upon return from hospital. [s. 50. (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 residents returning to the home from hospital or leave of absence for longer than 24 hours receive a skin assessment completed by the registered nursing staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 21, whereby the licensee did not ensure that the temperature in the home is maintained at a minimum of 22 degrees Celsius.

Related to log #015462-16

A complaint made to Central Intake Assessment Triage Team (CIATT) by resident #010 POA indicated the temperature in the home is not maintained as required at 22 degrees Celsius.

During the course of the inspection the following was noted:
- Resident #008 indicated to Inspector #623 that his/her room is too cold during both winter and summer
- Resident #010 indicated to Inspector #623 that the temperature in his/her room is really cold at night ; it feels cold in the home and the temperature is 19 degrees in the front lounge.

On June 8, 2016 inspectors #623 and #570 noted the hallway on a specific unit was extremely cold. Inspector #570 met with the Environmental Services Manager (ESM) who checked the temperature in the hallway of that specific unit and the following was

noted:
- hallway temperature in close proximity to an identified was 19.6 degrees Celsius;
- hallway temperature in close proximity to another identified room was 17.1 degrees Celsius;
- room temperature in an identified room was 19.1 degrees Celsius.

Review of the home's Temperature Daily Log (completed by laundry staff at 0600 and 1400 hours) and Air/Humidex Temperature Daily Log (completed by nursing staff during the day and night shifts) for a four month period failed to demonstrate that the temperature within the home is being maintained at 22 degrees Celsius; the logs indicated multiple entries of temperature below 22 degrees Celsius ranging from 19 to 21 degrees Celsius.

Interview with the ESM indicated that he is aware of the drop in temperatures below 22 degrees Celsius. The ESM indicated the drop in temperature is due to an ongoing issue with windows left open by staff or residents.

Interview with the Administrator confirmed that the temperatures drops on occasions below 22 degrees Celsius and that the home is not maintained at the required temperature. [s. 21.]

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (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 resulted in a physical injury or pain to the resident or caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Regarding log #012974-16

A Critical Incident Report (CIR) was submitted by the home on an identified date indicating that3 days earlier, resident #041 was sitting in the room of a co-resident - staff attempted to redirect resident #041 who became angry and exhibited physical responsive behaviors towards two staff members. Resident #041 then self propelled to the dining room and sat in the doorway. When resident #042 attempted to enter the dining room, resident #041 was physically abusive towards resident #042 which caused the resident to fall to the floor.

Review of clinical health records indicated resident #042 was assessed and there were no apparent injuries but, the resident indicated having some discomfort.. Documentation further indicated an attempt had been made to call the family but the staff was unable to reach them. There is no further documented evidence to support that any other attempts were made to contact the family about the incident.

The staff member who completed the CIR is no longer at the home.
During an interview with the DOC, she acknowledged there is no documented evidence to support the resident 's family had been immediately notified of the incident of abuse. [s. 97. (1) (a)]

2. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Regarding log #021128-15

A CIR was submitted by the home on an identified date indicating that four days earlier, hours it was reported to the RN that while a co- resident was walking in front of resident #041, he/she demonstrated physical abuse towards the co- resident. Resident #041

then approached another co resident and attempted to inappropriately sexually touch the co-resident but was stopped by a staff member.

Review of the investigation indicated resident #041's SDM was notified of the incident but the SDMs of the co-residents were not notified of the incident.
During an interview with the DOC, she acknowledged that the residents family should have been informed of the incident. [s. 97. (1) (b)]

Issued on this 14th day of June, 2016

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

Original report signed by the inspector.