Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

Division des foyers de soins de longue durée
Inspection de 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
Dec 9, 2016	2016_538144_0079	020460-16, 020595-16, 020794-16, 027922-16	Complaint

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

Long-Term Care Home/Foyer de soins de longue durée

CARESSANT CARE FERGUS NURSING HOME
450 QUEEN STREET EAST FERGUS ON N1M 2Y7

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

CAROLEE MILLINER (144)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 31, November 1 and 2, 2016.

The complaint inspection was related to skin and wound care, resident rights, duty to protect and infection prevention and control.
The following infoline reports were reviewed with this inspection:
IL-45482-LO, IL-45589-LO, IL-45667-LO and IL-46787-LO.

During the course of the inspection, the inspector(s) spoke with one resident, the Administrator, Acting Director of Nursing (ADON), one Registered Nurse (RN), one Registered Practical Nurse (RPN), two Personal Support Workers (PSW's) and one Nurse Aide (NA).

During the course of the inspection, the Inspector reviewed one resident clinical record and one letter titled "Direction To Act Against Medical Advice."

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Personal Support Services
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity.

Review of the clinical record for resident #001 revealed the resident was receiving treatment for a specific health concern.
The resident's clinical record included frequent progress notes related to their medical condition and treatment outcome.

Resident #001 advised the Inspector that they were told by the previous Director of Nursing #107 and Acting Director of Nursing (ADON) #101 that they would not be provided with a specific service in the home if they did not comply with a certain request from the home.

Resident #001 advised the Inspector they continued to receive the particular service until ADON #101 removed them from the service.

Resident #001 and PSW's #105 and #106 confirmed the resident received a specific service unsupervised in their room for a few months until a couple days prior to this inspection.
The resident's clinical record confirmed ADON #101 spoke with the resident three months prior to this inspection regarding their medical condition and told the resident they could no long attend an identified service in the home.

When interviewed, Administrator #100 agreed that the home was not respectful of the resident' #001's s rights and did not recognize the resident's dignity. [s. 3. (1) 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 the resident's right to be treated with courtesy and respect was fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the resident's skin condition, including altered skin integrity.

Review of the clinical record for resident #001 revealed that specific treatment interventions had been initiated for a particular medical condition.

Further review of resident #001's clinical record revealed that various treatment interventions initiated over time were not included in the resident's written plan of care during the last three plan of care reviews.

The Administrator #100 and ADON #101 agreed that the resident's plan of care when reviewed on the identified dates, should have also been based on an interdisciplinary assessment of the resident's current treatment. . [s. 26. (3) 15.]

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 is based on, at a minimum, interdisciplinary assessment of the resident's skin condition, including altered skin integrity, to be implemented voluntarily.

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Issued on this 16th day of December, 2016

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

Original report signed by the inspector.