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
Feb 23, 2017	2016_262523_0039	015973-16, 015983-16, 019885-16, 020856-16, 021962-16, 023090-16, 023736-16, 024046-16, 024797-16, 025345-16, 027124-16, 028925-16, 029715-16, 030603-16, 030691-16	Critical Incident System

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

ALI NASSER (523), CAROLEE MILLINER (144)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 26, 27, 28, 31, November 1, 2, 3, 4, 7, 8 and 9, 2016.

This inspection was completed for the following:
Log # 015973-16, CIS # 2603-000004-16, related to a resident fall.
Log # 015983-16, CIS # 2603-000011-16, related to a resident fall.
Log # 019885-16, CIS # 2603-000016-16, related to alleged staff to resident abuse.
Log # 020856-16, CIS # 2603-000021-16 related to resident's suicidal attempt.
Log # 021962-16, CIS # 2603-000024-16, related to alleged resident to resident abuse.
Log # 023090-16, CIS # 2603-000026-16, related to alleged staff to resident abuse.
Log # 023736-16, CIS # 2603-000027-16, related to alleged staff to resident abuse.
Log # 024046-16, CIS # 2603-000028-16, related to alleged resident to resident abuse.
Log # 024797-16, CIS # 2603-000030-16, related to alleged resident to resident abuse.
Log # 025345-16, CIS # 2603-000031-16, related to alleged staff to resident abuse.
Log # 027124-16, CIS # 2603-000032-16, related to alleged staff to resident abuse.
Log # 028925-16, CIS # 2603-000033-16, related to alleged staff to resident abuse.
Log # 030691-16, CIS # 2603-000037-16, related to a resident fall.
Log # 029715-16, CIS # 2603-000034-16, related to a resident fall.
Log # 030603-16, CIS # 2603-000036-16, related to alleged staff to resident abuse.

The following inspections were completed concurrently during this inspection:
Log # 027922-16, Complaint # IL-46787-LO related to wound care.
Log # 020794-16, Complaint # IL-45667-LO related to resident care concerns.
Log # 020460-16, Complaint # IL-45482-LO, related to resident's rights.
Log # 020595-16, Complaint # IL-45589-LO, related to resident's rights.
Log # 019479-16, CIS # 2603-000014-16, related to resident fall.
Log # 020115-16, CIS # 2603-000017-16, complaint related to care concerns.
Log # 031240-16, complaint related to alleged resident to resident abuse and care concerns.
Log # 032582-15, Follow-up to CO # 003 from inspection # 2015_448155_0020 / log # 019819-15 CO # 003 related to the home furnishings maintained in a safe condition and good state of repair.
Log # 027162-16, Follow-up to CO # 001 and # 002 from inspection # 2016_325568_0015 / log # 015931-16 related to responsive behaviours.
Log # 027164-16, Follow-up to CO # 003 from inspection # 2016_325568_0015 / log # 015931-16 related to the home furnishings and equipment kept clean and sanitary.

PLEASE NOTE: A Written Notification and a Voluntary Plan of Correction related to LTCHA, 2007 S.O. 2007, c.8, s.6. (7), identified in concurrent inspection # 2016_538144_0079 (Log # 020460-16, # 020595-16, # 020794-16, # 027922-16) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Resident Care Coordinator(RCC)/Acting Director of Nursing (ADON), Physician, RAI Coordinator, Activity Coordinator, nine Registered staff members, 24 Personal Support Workers and a Hair Dresser.

The inspector(s) also conducted a tour of the home, observed residents and care provided to them, observed resident to resident and staff to resident interactions, reviewed clinical records, relevant meeting minutes and policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 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:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right not to be neglected by the licensee or staff was fully respected and promoted.

A review of a specific Critical Incident System (CIS) report, clinical record review for a specific resident and interview with the pysician indicated that the resident's physician was not contacted after this resident had an incident in the home.
Clinical record review and staff interviews indicated that staff did not call the emergency medical services after an incident with the resident.
The licensee had neglected the resident by not informing the physician to transport the resident to the hospital after their incident in the home. [s. 3. (1) 3.]

2. The licensee has failed to ensure that the resident's rights to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted.

During this inspection it was observed on a certain day that a resident was not afforded privacy while receiving treatment.
A registered staff member said that the home's expectation was that the residents would be afforded privacy while provided care.

During this inspection this non compliance was found to have a severity of minimal harm or potential for actual harm, it was isolated and a previous non compliance was issued in a similar area. [s. 3. (1) 8.]

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 resident's rights to be afforded privacy in treatment and in caring for his or her personal needs, the right to not be treat with neglect and to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs were fully respected and promoted, to be implemented voluntarily.

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Clinical record review for identified residents and staff interviews indicated that different assessments completed for the same period of time were not consistent with each other.

During this inspection this non-compliance was found to have a severity of minimal harm or potential for actual harm, it was isolated and a previous non-compliance was issued in a similar area. [s. 6. (4) (a)]

2. 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.

Clinical record review for a specific resident and staff interviews revealed that the care set out in the plan of care was not provided to the resident.

During this inspection this non-compliance was found to have a severity level of minimal harm/risk or potential for actual harm/risk, the scope was isolated and there was a previous non-compliance in this area.

This non-compliance was previously issued as a Written Notification and a Voluntary Plan of Correction on November 24, 2014, inspection # 2014_202165_0029. [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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the written policy to promote zero tolerance of abuse of residents was complied with.

A) Clinical record review for specific residents and staff interviews indicated that the staff did not comply with the home's policy for reporting of abuse by not informing the on call manager of an alleged incident of resident to resident physical abuse.

B) Clinical record review for a specific resident and staff interviews indicated that an alleged incident of staff to resident abuse was not reported immediately by the home to the Director.

During this inspection this non-compliance was found to have a severity level of minimal harm/risk or potential for actual harm/risk, the scope was isolated and there was a previous non-compliance issued in a similar area. [s. 20. (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 the written policy to promote zero tolerance of abuse of residents was complied with, to be implemented voluntarily.

WN #4: 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).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. 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.

Clinical record review for specific residents and staff interviews indicated that those residents' care plans were not updated and were not based on the assessments of the residents' skin integrity. (523)

2. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of safety risks with respect to the resident.
Clinical record review for a specific resident and staff interviews indicated that resident's plan of care was not based on the assessment of the safety risk with respect to the resident and did not include any safety risk interventions.

During this inspection this non-compliance was found to have a severity level of minimal harm/risk or potential for actual harm/risk, the scope was isolated and there was a previous non-compliance issued in a similar area. [s. 26. (3) 19.]

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 following with respect to the resident's skin condition, including altered skin integrity, and
-interdisciplinary assessment of safety risks with respect to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

At a certain date and time during this inspection hazardous substances were observed to be unattended and accessible to nearby residents.
Two staff members acknowledged that hazardous substances were accessible to residents and stated in interviews that the home's expectation was to keep hazardous substances inaccessible to residents.

During this inspection this non-compliance was found to have a severity level of minimal harm/risk or potential for actual harm/risk, the scope was isolated and there was a previous non-compliance issued in unrelated area. [s. 91.]

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:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
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).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that 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 outcome or current status of the individual or individuals who were involved in the incident.

Clinical record review and staff interviews indicated that the ministry requested specific amendment of a certain Critical Incident System (CIS) report. 27 days after the request for information was made the CIS report was not yet amended to include the requested information.

During this inspection this non-compliance was found to have a severity level of minimal harm, the scope was isolated and there was a previous non-compliance issued in unrelated area [s. 107. (4)]

Issued on this 23rd day of February, 2017

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

Original report signed by the inspector.