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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 10, 2018	2018_508137_0027	003037-18, 005555-18, 005600-18, 008747-18, 011333-18, 011381-18, 013942-18, 017932-18	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

MARIAN MACDONALD (137), VALERIE GOLDRUP (539)

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): September 25-28, October 1-5, 9-12, 15-19 and 22, 2018.

During the course of the inspection, the inspector(s) spoke with Executive Director, Nurse Consultant - Responsive Health Management (RHM), Director of Operations - RHM, Resident Assessment Instrument (RAI) Coordinator, Director of Operations - Caressant Care, Director of Care, Physician, Social Worker, Regional Director - Caressant Care, Director of Clinical Service and Education - Caressant Care, Chief Operating Officer - Caressant Care, Resident Care Coordinator (RCC), Administrative Assistant, Nurse Clerks, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance Worker, Family and residents.

The Inspectors also conducted a tour of the home, observed resident care provision and staff/resident interactions, reviewed residents' clinical records, Risk Management Reports, Complaints Binder, internal investigative records, daily assignment sheets, bathing records staff schedules and education/training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	Légende 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) and an Infoline complaint was received by the Centralized Intake and Triage Team (CIATT), where an identified resident allegedly sustained impaired skin integrity during care provision.

On a specific date, two staff members provided care to an identified resident. A different staff member reported to a Registered Staff Member that the identified resident had impaired skin integrity but the Registered Staff Member was unable to complete a full assessment.

The Executive Director conducted an internal investigation and, while it could not be confirmed that the impaired skin integrity occurred during care provision, no such injury was previously reported and, when interviewed, staff members could not recall if there was prior impaired skin integrity. The Executive Director said the identified staff member did not use proper positioning techniques when care was provided to the resident.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents were bathed, at a minimum twice a week by the method of their choice, including tub baths, showers and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) An anonymous phone call was received by the Ministry of Health and Long-Term Care INFOLINE. The Complainant stated that the home had been short staffed and residents had received their bath.

On a specified date, the Point Click Care (PCC) "Follow-Up Question" report showed only six of 12 scheduled resident baths were documented. Four residents had received a bed bath, one resident had refused and for one resident, it was documented as not applicable. The employee sign-in sheet showed the absence of three staff members, on that date.

B) On a specified date, a Family Member stated that an identified resident had not received a bath recently. The employee sign-in sheet for that date, showed the absence of the staff member who performed baths. A Nurse Clerk stated that the identified staff member who was scheduled to do the baths was off and they were unable to replace them. The 30 day Look Back in PCC, for the identified resident, showed that the resident did not receive a tub bath during a specified time period.

On a specified date, a staff member stated that if a resident refused a bath that they would try to re-approach the resident at least three to four times. They would approach with another PSW. Then they would inform the nurse. They would try to give a bed bath later in the afternoon. The nurse would inform the evening staff to encourage a bed bath or encourage the resident to have a bath.

C) The 30 day Look Back in PCC, related to bathing for another identified resident

showed that the resident had refused their baths on three occasions during a specified time period. On two occasions, the employee sign-in sheet showed the absence of the identified staff member that was scheduled to do the baths and, on one occasion, the employee sign-in sheet showed that the identified staff member that was scheduled to do the baths only worked 4 of the 8 hours.

On a specified date, a staff member stated that this resident enjoyed a tub bath. The 30 day Look Back in PCC showed that the resident did not receive a tub bath during two specified time periods.

On a specified date, the staff member stated that if a resident refused they would try to re-approach the resident at least three to four times. They would approach with another PSW. Then they would inform the nurse. They would try and give a bed bath later in the afternoon. The nurse would inform the evening staff to encourage a bed bath or encourage the resident to have a bath.

D) The 30 day Look Back in PCC, for another resident, showed that the resident had received a bed bath on a specific date. The employee sign-in sheet for that date, showed that the identified staff member that was scheduled to do the baths only worked 4 of the 8 hours.

The plan of care stated that this resident preferred a tub bath.

The 30 day Look Back in PCC, for resident #006, showed that the resident did not receive a tub bath during a specified time period.

E) On a specified date, the "Follow-Up Question" report showed only ten of 13 resident baths were documented. Five residents had received a tub bath, four residents had received a bed bath and, for one resident, it was documented as not applicable.

On a different specified date, the "Follow-Up Question" report showed 16 resident baths documented. Three residents had received a tub bath, ten residents had received a bed bath and three residents had refused.
The Bath List stated that residents were to be given a tub bath unless otherwise indicated.

F) On a specified date, two staff members stated that there was one full-time bath staff member who worked 0900-1700 hours to complete baths. They stated that there were a

lot of baths requiring two person transfers and it was difficult to complete all baths. Some of the baths took 30 to 45 minutes to complete. Previously the home had two bath staff members each day and those shifts overlapped to assist with the heavier baths.

The Nurse Consultant stated it was the role of Resident Care Coordinator and the Director of Care to monitor that baths had been completed. They stated that training had been provided to all direct care staff members on how to use the tub to provide baths. It was the expectation of the home that, even when they worked short, the Registered Staff would ensure that the residents received a tub bath.

The licensee failed to ensure that the identified resident's and other residents received a bath at a minimum, twice a week by the method of their choice, including tub baths.

Issued on this 12th day of December, 2018

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

Original report signed by the inspector.