Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Aug 30, 2019	2019_785732_0028	010182-19, 010183-19	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 Cobden
12 Wren Drive P.O. Box 430 COBDEN ON K0J 1K0

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

EMILY BROOKS (732)

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): August 26 to 29, 2019

The following logs were inspected during this Critical Incident System inspection:

Log #010182-19 (CIR #2827-000014-19) and log #010183-19 (CIR #2827-000015-19) related to alleged staff to resident neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, the RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

The inspector reviewed resident health care records and investigation records; as well as observed the provision of care and services to residents, and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 care set out in resident #002's plan of care was provided to the resident as specified in the plan.

A Critical Incident Report (CIR) was submitted to the Director describing the alleged neglect of resident #002 on a specified date by PSW #105. The CIR indicated that resident #002 sustained a fall while being transferred by PSW #105 in the bathroom.

Review of resident #002's care plan for a specified date, indicated that for transfers resident #002 required extensive assistance by two staff. Investigation notes provided to Inspector #732 by Administrator #100 indicated that PSW #105 transferred the resident without the assistance of another staff member. In an interview with Inspector #732, Administrator #100 confirmed that PSW #105 transferred resident #002 alone and that the plan of care required resident #002 be transferred by two staff.

Therefore, resident #002 did not receive assistance by two staff members for transfer as indicated in their plan of care, subsequently resulting in a fall. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in resident #001's plan of care was provided to the resident as specified in the plan.

A Critical Incident Report (CIR) was submitted to the Director describing the alleged neglect of resident #001 on a specified date by PSW #105. The CIR indicated that resident #001 was transferred to the toilet at approximately 1500 hours by PSW #105 and that PSW #105 did not tell anyone until 1545 hours, as they were leaving the property.

PSW #101 told Inspector #732 that resident #001 should never be left alone on the toilet. Review of resident #001's care plan indicated that as of a specified date, resident #001 cannot be left unattended on toilet/commode. Review of PSW #105's statement in regard to the incident, indicated that PSW #105 did not remain with resident #001 for the duration of time they were on the toilet and left the property approximately 45 minutes after placing resident #001 on the toilet, with the resident still on the toilet.

In an interview with Administrator #100, they confirmed that PSW #105 did not remain with resident #001 the entire time they were on the toilet and told Inspector #732 that PSW #105 did not comply with resident #001's care plan. Therefore, the licensee failed to ensure that resident #001 was not left unattended on the toilet. [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 care set out in the plan of care is provided to the resident as specified in the plan., to be implemented voluntarily.

Issued on this 30th day of August, 2019

[redacted]

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

Original report signed by the inspector.