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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2017	2017_448155_0021	024276-17	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 HARRISTON
24 LOUISE STREET P.O. BOX 520 HARRISTON ON N0G 1Z0

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

SHARON PERRY (155), NUZHAT UDDIN (532), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 30, 31, November 1 and 2, 2017.

The following intakes were completed within this RQI:
- Log 001159-17 / complaint IL-48855-LO and log 000467-17 / Critical Incident 2595-000001-17 related to alleged resident to resident abuse and resident charges for accommodation;
- Log 032258-16 / Critical Incident 2595-000017-16, log 023181-16 / Critical Incident 2595-000009-16 and log 024710-16 / Critical Incident 2595-000010-16 related to a falls resulting in residents being sent to hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, RAI Coordinator, Resident Care Coordinator, Registered Dietitian, Physiotherapist, Registered Nurse, three Registered Practical Nurses, ten Personal Support Workers, Resident Council representative, Family Council representative, residents and families.

The inspectors also toured the home, observed medication administration, medication storage; reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, posting of required information; observed the provision of resident care, resident and staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Responsive Behaviours

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	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. (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 the plan of care was provided to the resident as specified in the plan.

Review of a Critical Incident report stated that an identified resident had a fall. The doctor and family were notified.

Review of progress notes for an identified date, stated the following:
At an identified time, the identified resident had a fall. The fall was unwitnessed. Upon assessment it noted that the identified resident was complaining of pain and they were sent to the hospital.
Another progress note stated that it was reported by the staff that the identified resident was found lying on the floor. It further stated that a fall prevention device was missing.

The plan of care for the identified resident was reviewed and it stated that the resident was at risk of falls. The plan of care identified that the resident used three fall prevention devices.

Review of the post fall assessment identified that the fall was unwitnessed and a fall prevention device was not in place at the time of the fall.

In an interview with an identified Personal Support Worker they shared that the identified resident did use fall prevention devices.

During an interview with the Resident Care Coordinator (RCC) they reviewed the post fall assessment and the progress note documentation that stated that a fall prevention device was not in place. The RCC stated that as per the post fall assessment the falls prevention device was not in place. The RCC acknowledged that the care set out in the plan of care was not provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

This area of non-compliance was determined to have a severity of actual harm / risk (level 3), the scope was isolated (level 1) and there was a previous related area of non-compliance issued in the last three years (level 3). [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 16th day of November, 2017

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

Original report signed by the inspector.