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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Apr 24, 2015	2015_327570_0005	O-001584-15	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 LINDSAY NURSING HOME
240 MARY STREET WEST LINDSAY ON K9V 5K5

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

SAMI JAROUR (570)

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): February 4, 2015

During the course of the inspection, the inspector(s) spoke with identified resident, Director of Nursing (DON), Registered Nurse (RN) and Personal Support Worker (PSW).

Also, the inspector observed identified resident and reviewed clinical records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for Resident #01 set out the planned care for the resident based on the resident's sleep patterns and preferences.

On an identified date, a critical incident (CI)was received identifying that Resident #01 was found on the floor beside bed lying face down. The resident was sent to hospital and returned with a significant change in status.

Review of progress notes and the Safety Plan - Post Fall Investigation on an identified date indicated that Resident #01 sustained a fall when tipped forward while falling asleep in wheelchair.

On an identified date, Staff #103 documented under factors contributing to fall in the Safety Plan - Post Fall Investigation that Resident #01 was up in wheelchair all night instead of resting in bed and the resident was not getting a proper restful sleep.

On February 4, 2015 at 13:10 hrs during an interview, Resident #01 indicated getting up from bed at night and sitting in the wheelchair to ease the pain in both legs.

On the same day, during an interview, Staff #102 indicated that for most of an identified month, Resident #01 has been sleeping in wheelchair at night. When Resident #01 is in bed, the resident will transfer to the wheelchair and tends to fall asleep.

Later that day, the DON indicated that Resident #01 preferred to sleep in wheelchair; staff would put the resident to bed and the resident will try to transfer self to wheelchair; staff encourage the resident to go to bed but the resident does not want to.

Review of Resident #01's plan of care in effect at time of incident (revised on an identified date) indicated no planned care that was based on the resident's sleep patterns and preferences related to resting in wheelchair at night. The plan of care related to falls was not based on the resident's preferences and any associated risk related to self transferring or resting in wheelchair at night.

The DON confirmed that there was no planned care related to the resident's preference to sleep in wheelchair and associated risk of falling related to sleeping in wheelchair at night. [s. 6. (1) (a)]

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 plan of care for Resident #01 set out the planned care for the resident related to the resident's sleep patterns and preferences, to be implemented voluntarily.

Issued on this 15th day of May, 2015

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

Original report signed by the inspector.