



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 le Loi de 2007 les foyers de soins de longue

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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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Jul 26, Aug 4, 5, 2011; 2011_046166_0019; Critical Incident

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Resident, the Resident Care Coordinator(RCC), the Director of Care(DOC) and a Registered Nurse(RN).

During the course of the inspection, the inspector(s) observed the resident, reviewed the resident's health care records and the licensee's policies related to "Pain Assessment" and "Notification of Responsible Party".

The following Inspection Protocols were used in part or in whole during this inspection:

Pain

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions

WN - Written Notification
VPC - Voluntary Plan of Correction
DR - Director Referral
CO - Compliance Order
WAO - Work and Activity Order

Définitions

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.)

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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 subsections:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

**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
(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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits sayants :

1. An identified resident complained of pain after sustaining an injury. Documentation in the resident's file confirm that the resident was complaining of progressive discomfort. There is no clinical evidence that the resident's pain complaints were assessed to determine if other interventions were required to address and manage the resident's discomfort.[s.6.(2)]
2. There is no evidence in any clinical documentation or staff communication records of interdisciplinary assessments in relation to the resident's status.[s.6.(4)(a)]
3. The resident's Substitute Decision Maker(SDM) was not notified of the incident and the resident's change in condition until two days after the incident. The Home failed to provide the resident's SDM with the opportunity of participating in the resident's plan of care following the injury.[s.6.(5)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following subsections:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits sayants :

1. The licensee has a clinical assessment tool for pain. There is no documentation in the resident's health records that identifies this assessment tool was implemented to assess the resident post injury. Interview with the RCC, the DOC and a RN confirmed that the resident was not assessed for pain using a clinically appropriate assessment instrument specifically designed for this purpose.[s.52.(2)]



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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 all residents who display symptoms of pain both verbally and non verbally are immediately assessed for pain using a clinically appropriate assessment instrument specifically designed for that purpose., to be implemented voluntarily.

Issued on this 9th day of August, 2011

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

A handwritten signature in black ink, appearing to read "James Thompson", written over a white background within a rectangular box.