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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 5, 2013	2013_220111_0011	O-000270-13	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

LYNDA BROWN (111)

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): June 12 & 13, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator and the Director of Care (DOC)

During the course of the inspection, the inspector(s) reviewed a deceased resident health care record and reviewed the home Falls Prevention Policy

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

Findings of Non-Compliance were found during this inspection.

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

Review of progress notes for deceased Resident #1 indicated the resident had sustained two falls within nine days. Both falls occurred at approximately the same time and from the resident's bed. The second fall resulted in an injury requiring transfer to hospital, and the resident subsequently passed away.

Review of Resident#1 plan of care indicated the resident was independent with transfers and mobility, able to weight bear, and used a four wheeled walker for mobility. The resident had a potential for falls related to history of falls and impaired mobility. The interventions included: resident to wear proper, non-slip footwear, checked every hour to ensure safety, call bell within easy reach at all times, re-enforce need to call for assistance, evaluate effectiveness/side effects of psychotropic drugs with physician (for possible adjustment in dosage/ elimination of medication).There were no interventions to reduce the risk of falls related to the recent falls.

There licensee failed to reassess the resident and ensure the plan of care was reviewed and revised after the resident sustained two falls at the bedside. [s. 6. (10) (b)]

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 at risk for falls are reassessed and the plan of care is reviewed and revised when the residents care needs change or the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

Review of progress notes for deceased Resident #1 indicated the resident had sustained two falls within nine days. Both falls occurred at approximately the same time and from the resident's bed. The second fall resulted in an injury requiring transfer to hospital, and the resident subsequently passed away.

Review of the post fall assessments "Safety Plan-Post fall Investigation" for Resident#1 indicated there were no post fall assessments completed for the two falls that occurred.

The licensee failed to ensure that when a resident has fallen, the resident is assessed and a post fall assessment is conducted using a clinically appropriate assessment instrument specifically designed for falls. [s. 49. (2)]

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Issued on this 15th day of July, 2013

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