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
Oct 29, 2018	2018_505103_0028	008668-18, 008680-18, 009488-18, 009497-18, 009725-18, 010685-18, 025319-18, 026994-18	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 Marmora
58 Bursthall Street P.O. Box 429 MARMORA ON K0K 2M0

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

DARLENE MURPHY (103)

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): October 15-18, 23-26, 2018.

The following intakes were included in this inspection:
Log #008668-18 (CIS #2718-000020-18), Log #008680-18 (CIS #2718-000021-18), Log #009725-18 (CIS #2718-000027-18), Log #010685-18 (CIS #2718-000028-18), Log #025319-18 (CIS #2718-000039-18) and Log #026994-18 (CIS #2718-000042-18)- incidents of resident to resident abuse,
Log #009488-18 (CIS #2718-000026-18) and Log #009497-18 (CIS #2718-000025-18)- incidents of alleged staff to resident abuse.

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

During the course of the inspection, the inspector conducted a walking tour of the resident care areas, reviewed resident health care records, and made resident observations.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
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 care was provided to resident #001 as outlined in the plan of care.

On an identified date, PSW #108 requested help with resident #001 who had been toileted. When PSW #112 entered the bathroom to assist, resident #001 was found on the toilet in an awkward position and was unable to stand.

Resident #001's plan of care was reviewed and at the time of this incident, indicated the resident required a sit to stand lift and two staff for all transfers.

The Administrator was interviewed in regards to this incident and indicated PSW #107 had failed to utilize the sit to stand lift and the two staff that were required for all of resident #001's transfers. The Administrator indicated that PSW #112 had been able to confirm that there had been no sit to stand lift in the room at the time of the incident and that they had to retrieve one in order to get the resident safely off of the toilet. The resident did not sustain any injuries as a result of the incident. [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 resident #001 is transferred as specified in the plan of care, to be implemented voluntarily.

Issued on this 30th day of October, 2018

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

Original report signed by the inspector.