Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 6, 2020	2020_605213_0008	000016-20, 002196-20	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 Woodstock Nursing Home
81 Fyfe Avenue WOODSTOCK ON N4S 8Y2

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

RHONDA KUKOLY (213), MELANIE NORTHEY (563)

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): March 2, 3 and 4, 2020.

This inspection was completed related to:
log #000016-20, critical incident #2636-000001-20 regarding an unexpected death,
log #002196-20, critical incident #2636-000003-20 regarding a fall.

It was completed while concurrently completing Follow up Inspection #2020_605213_0007, related to infection prevention and control.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Associate Director of Care, the Caressant Care Chief Operating Officer, the Caressant Care Director of Professional Practice, the Caressant Care Regional Director, the the OMNI Lead Education/On-site Representative, two Resident Care Coordinators, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents.

The Inspectors also made multiple observations, reviewed health records, training records, policies and procedures, evaluations, communications and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control

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	Légende 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).

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 :

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.

A Critical Incident System Report was reported to the Ministry of Long-Term Care by the home related to a resident who fell and suffered a significant injury.

A resident was observed on three separate dates and a specific intervention related to falls was not in use for a resident. A Personal Support Worker (PSW) stated they were familiar with the resident and that the resident no longer used that intervention.

The current care plan in Point Click Care documented a focus statement related to resident moderate fall risk. It stated the resident would forget to call for help and to mitigate the risk of injury from falls, there was an intervention to be in place that was also to be encouraged, as resident often refused.

A registered staff member stated the resident would often refuse the intervention and it was no longer used.

A Resident Care Coordinator (RCC) stated the intervention was still used by the resident. The RCC verified the intervention was identified as a fall strategy to mitigate risk of injuries related to falls and should have been in use.

The licensee has failed to ensure that the care set out in the plan of care related to a specific intervention for a resident was provided to the resident as specified in the plan.

[s. 6. (7)]

2. The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A Critical Incident System Report was reported to the Ministry of Long-Term Care by the home related to a resident who fell and suffered a significant injury.

A resident was observed on three separate dates and a specific intervention was not in use for a resident. A Personal Support Worker (PSW) stated they were familiar with the resident and that the resident no longer used that intervention. A registered staff member also verified the resident no longer used the intervention.

The Assistant Director of Care (ADOC) stated the resident no longer used the intervention. The ADOC stated the physiotherapist would decide if the intervention was required. The Physiotherapy progress note stated the intervention was not to be used due to the injury from the fall and specified the level of transfer to be completed for the resident.

The current care plan in Point Click Care documented a focus statement related to the use of the specific intervention. The care plan also had conflicting information related to the resident’s level of transfer. The Resident Care Coordinator (RCC) verified the intervention was removed after the resident’s fall with injury and the care plan was not updated to reflect the change.

The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary. [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 the care set out in the plan of care provided to residents as specified in the plan and that residents are reassessed and the plan of care reviewed and revised when residents' care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 11th day of March, 2020

[redacted]

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

Original report signed by the inspector.