



**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
Direction de l'amélioration de la
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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
Mar 22, 2013	2013_090172_0009	L-000159-13	Complaint

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

JOAN WOODLEY (172)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 21, 2013

**During the course of the inspection, the inspector(s) spoke with the
Administrator, the Medical Adviser, the Public Health Officer for the Home, and
the Home's Infection Prevention and Control Coordinator.**

**During the course of the inspection, the inspector(s) made observations and
reviewed documentation related to the outbreak such as line listings, fact sheet,
and critical incident.**

**The following Inspection Protocols were used during this inspection:
Infection Prevention and Control**



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Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 107. Reports re critical incidents



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Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

- 1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding. O. Reg. 79/10, s. 107 (1).**
 - 2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).**
 - 3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).**
 - 4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).**
 - 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).**
 - 6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).**
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Findings/Faits saillants :

1. The Licensee has failed to ensure that the Director is immediately notified of an outbreak .

The Critical Incident was first submitted to the Ministry of Health and Long Term Care on March 4, 2013 when the outbreak had been declared on Feb. 22, 2013.

Interview with the Administrator confirmed these dates. [s. 107. (1)]



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Issued on this 22nd day of March, 2013

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

Joan L. Shredley RA