Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 5, 11, 18, 19, May 4, 7, 8, 10, 13, 2012	2012_071159_0007	Critical Incident

Licensee/Titulaire de permis

DELCARE LTC INC.
4800 DUFFERIN STREET, TORONTO, ON, M3H-5S9

Long-Term Care Home/Foyer de soins de longue durée

CAWTHRA GARDENS LIMITED PARTNERSHIP
590 Lolita Gardens, MISSISSAUGA, ON, L5A-4N8

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

ASHA SEHGAL (159)

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 Administrator, Director of Care, registered staff, personal support workers, and residents.
H-002597-11

During the course of the inspection, the inspector(s) reviewed resident records and plan of care for identified resident, reviewed policies and procedures related to falls prevention and restraints program.

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

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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.) 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 subsections:

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 failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan of care [s.6(7)]

The care set out in the plan of care was not provided to the resident as specified in the plan of care in relation to fall prevention and application of physical device for risk for falls.
The plan of care for specified resident indicated to have resident use of an external physical device when in wheel chair for prevention of injury to self or to others characterized by high risk for falls. A review of critical incident report of 2011, the multidisciplinary progress notes, and interview with Registered Practical Nurses confirmed that the resident was left on a side chair at the nurses station and staff did not transfer resident to a wheel chair and apply a external physical device.
The Progress notes in resident's record and interview with the Director of Care confirmed resident was assessed as being a high risk for falls related to unsteady gait, generalized weakness and cognitive impairment. The resident had an attending physian's order for use of a external physical device when in the wheel chair. Interview with the Director of Care and the Registered Nursing staff confirmed that staff should have transferred resident to a wheel chair as there was no provision in the plan of care for resident to use a side chair.

The care set out in the plan of care for the resident was not provided as specified in the plan of care in relation to monitoring of resident.
The plan of care for the resident indicated resident is to be monitored and staff to check every 15 minutes and document in the observation monitoring record for safety. Interview with the personal support service worker (PSW) and the review of Observation record confirmed that the resident was monitored every half and hour and not every 15 minutes. The observation monitoring record was found incomplete.

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 with ensuring that the care set out in the plan of care is provided to the resident as specified in the plan of care, to be implemented voluntarily.

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Issued on this 15th day of May, 2012

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

Rebecca Qie for Asha Sehgal