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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Public Copy/Copie du public

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_610633_0019	014037-18	Critical Incident System

Licensee/Titulaire de permis

Retirement Home Specialists Incorporated
120 Conception Bay Highway Suite 110, Villa Nova Plaza Conception Bay South ON A1W 3A6

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

Morriston Park Nursing Home
7363 Calfass Road, R.R. #2 PUSLINCH ON N0B 2J0

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

SHERRI COOK (633)

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 17-19, 2018.

The following intake was completed during this inspection:

Log # 014037-18/ 2727-000006-18 related to plan of care.

Inspector Amanda Owen #738 was present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care, a Registered Nurse (RN), a Health Care Aide (HCA), Personal Support Workers (PSWs) and residents.

In addition the inspector(s) observed resident care and reviewed the plans of care for the identified residents and the home's relevant documentation.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention

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 that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident (CI) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) stated that a resident fell and sustained an injury. The CI also stated that the care plan for the resident was not followed at the time of this incident.

The plan of care for the resident stated that the resident was not to be left unattended during a specific care.

A Health Care Aide (HCA), Registered Nurse (RN) and the Assistant Director of Care (ADOC) all said that resident interventions for care were documented in their care plan, kardex and on signage above their bed and in their bathroom. The ADOC acknowledged that the care plan for the resident was not followed by a PSW at the time of this incident and the resident sustained an injury as a result.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan of care. [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 that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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Issued on this 29th day of October, 2018

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

Original report signed by the inspector.