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

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 performance et de la conformité

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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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
Jan 2, 2014	2013_226192_0029	L-001009-13	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

CAMBRIDGE COUNTRY MANOR
3680 SPEEDSVILLE ROAD, R R 31, CAMBRIDGE, ON, N3H-4R6

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

DEBORA SAVILLE (192)

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): December 20, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care, Resident Assessment Instrument (RAI) Coordinator, Maintenance Supervisor, Personal Support Workers, family and residents.

During the course of the inspection, the inspector(s) toured the home, and observed utility rooms.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

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Findings of Non-Compliance were found during this inspection.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On December 20, 2013 while conducting a tour of the home it was observed that a resident who was being transferred in the mechanical lift, was left exposed to those passing by in the corridor . The resident was observed from the corridor to have been left suspended from the lift, positioned over the bed and left unattended while staff worked in the room.

On December 20, 2013 at 0950, upon entrance to the home a resident was observed to be walking down the corridor in the presence of two staff. One staff member was guiding the resident while speaking directly to the second staff member. The resident almost walked into the desk before the staff member diverted her attention from her peer to intervene and guide the resident safely around the desk. The staff members attention then returned to her peer.

On December 20, 2013 while conducting a second tour of the home two staff were observed to be attempting to stand a resident who was demonstrating resistive behaviours. Other staff and residents were noted to be observing the interaction between staff and resident. No attempt was made to provide privacy for the resident.

Residents of the home were not treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity on December 20, 2013. [s. 3. (1) 1.]

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 ensuring that every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures are developed and implemented for, (d) addressing incidents of lingering offensive odours.

On December 20, 2013 offensive odours were noted upon entrance to the home at 0950. Tour of the home was conducted and offensive odours remained present at the entrance of the home at 1015 and 1045 hours.

Interview with family confirmed that offensive odours are almost always present when entering the home.

Interview with staff of the home confirmed that offensive odours are at times present at the entrance to the home. [s. 87. (2) (d)]

Issued on this 2nd day of January, 2014

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

Debora Saville (192)