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
Oct 10, Nov 20, 2012	2012_171155_0011	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 ARTHUR NURSING HOME
215 ELIZA STREET, P.O. BOX 700, ARTHUR, ON, N0G-1A0

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

SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Registered Dietitian, (1) Registered Nurse, (2) Personal Support Workers, and (4) Residents.

During the course of the inspection, the inspector(s) toured the resident living areas of the home, observed care provided to residents, and reviewed resident clinical records.

The log number for this inspection is L-001383-12.

The following Inspection Protocols were used during this inspection:

Personal Support Services

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.) 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. A resident's plan of care indicates that they are at risk for falls. Interventions as per plan of care indicate that the resident is to have their call bell within reach at all times and pinned to their clothing when in bed. On October 10, 2012 the resident was lying in bed and their call bell was not within reach and not pinned to their clothing. Staff confirmed that the call bell was not within reach nor pinned to clothing. [LTCHA, 2007, S.O. 2007, c.8, s.6.(7)]
2. A resident has been has been assessed by the physician and treatment prescribed for a medical condition. The plan of care does not provide any directions to staff and others who provide direct care to the resident with regards to this medical condition. This was confirmed by staff. [LTCHA, 2007, S.O. 2007, c.8, s.6.(1)(c)]
3. A resident's plan of care indicates that they are at a risk for falls and that they have a chair alarm. During observations no chair alarm was noted to be in place. Staff confirmed that the resident does not have a chair alarm as indicated in their plan of care. [LTCHA, 2007, S.O. 2007, c.8, s.6.(7)]
4. A resident's plan of care indicates that they need extensive assistance with toileting. There is no direction on the plan of care as to when the staff are to toilet them. In point of care it indicates that they are toileted as per plan of care. Staff interviewed indicate they just take them every couple of hours. [LTCHA, 2007, S.O. 2007, c.8, s.6.(1)(c)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and 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 20th day of November, 2012

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