Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 28, 2021	2021_831211_0007	025610-20	Critical Incident System

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 Bourget
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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

JOELLE TAILLEFER (211)

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): February 25, 26, 2021 and March 3, 4, 2021.

The purpose of this inspection was to conduct a critical incident inspection Log # 025610-20 relating to a fall that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurses (RNs), Physiotherapist, Behavioural Supports Ontario PSW (BSO/PSW), Personal Support Workers (PSWs), Physiotherapist Assistant, Resident Services Attendants (RSA), a Cook, Physiotherapist Assistant, Housekeeping Staff and a resident.

In addition, the inspector reviewed the residents' health care records, the Post Fall Investigations, the Post Head Injury Assessment forms, the policies and procedures related to Head Injury Routine, Safety Plan-Resident, and Personal Assistive Service Devises (PASD), Directive #3 for Long-Term Homes under the Long-Term Care Homes Act, 2007 issued on August 28, 2020, under "Re-Admissions" related to hospital transfers to long-term care homes, The Guidance Document: Identifying Beds in Long-Term Care Homes that Must be Vacant or should be used only as Isolation Beds" Version 1, dated January 12, 2021 and the residents list.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 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	Légende 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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for a resident that sets out clear directions to staff and others who provide direct care to the resident related to their mobility.

The resident's health care records indicated that the resident sustained an injury after a fall. The resident's progress notes written by the physiotherapist recommended the use of a wheelchair for mobility.

The resident's pictogram on the wall above the resident's bed illustrated that the resident required a walker and one person assist at all times.

Interviews with a Registered Nursing Staff, stated that the resident was unable to walk and the resident's pictogram should illustrated a picture of a wheelchair, not a walker.

The licensee has failed to ensure that the resident's pictogram sets out clear directions to staff and others who provided direct care to the resident related to the resident's mobility.

Sources: Review of the resident's pictogram and the progress notes. Interview with a Registered Nursing Staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure when a resident was reassessed and the plan of care reviewed and revised, the resident's mobility was changed.

The resident's health care records indicated that the resident sustained an injury after a fall. The resident's progress notes written by the physiotherapist recommended the use of a wheelchair for the resident's mobility.

Review of the resident's current nursing care plan, indicated that the resident's mobility was to use a walker as an assistive device and to walk to and from the dining rooms.

Interviews with a Registered Nursing Staff, stated that the resident's care plan related to mobility was not updated. The resident was presently using a wheelchair, not a walker.

The licensee has failed to ensure that the resident's care plan was reviewed and revised when the resident's mobility equipment was changed from a walker to a wheelchair.

Sources: A resident's care plans and progress notes. Interview with a Registered Nursing Staff. [s. 6. (10) (b)]

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 residents that sets out clear directions to staff and others who provide direct care to the resident, and to ensure that a resident is reassessed and the plan of care reviewed and revised at any other time when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control practice program when the staff didn't assist residents with their hand hygiene before a meal.

Inspector #211 observed during lunch time on two different days that the staff didn't assist residents with hand hygiene before their meal. Interviews with three PSWs stated that residents' hands were not sanitized prior to their meal.

Sources: Inspector #211's observation. Interviews with three PSWs. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control practice program by assisting residents with their hand hygiene before meal, to be implemented voluntarily.

Issued on this 29th day of April, 2021

[redacted]

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

Original report signed by the inspector.