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

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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 25, 2013	2013_200148_0001	O-0022405-12, O-002281-12	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

AMANDA NIXON (148)

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): January 8 and 9, 2013 on site.

This inspection reviewed two Critical Incidents.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Caressant Care Corporate Representative, Resident Assessment Instrument Coordinator, Registered nursing staff and Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed resident health records and observed resident care.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee failed to comply with O.Reg, 79/10, s.30(2), in that hourly monitoring of an identified resident, related to risk of falls, was not documented.

The identified resident was known to have a risk of falls. The resident had a fall in September 2012 and two falls in October 2012. The second fall in October 2012 resulted in injury.

The plan of care for the identified resident, related to Risk of Falls included for staff to check every hour to ensure safety. A review of the home's documentation and health care record confirmed that this intervention was not documented. Staff interviews could not confirm if the 1 hour checks for safety were being completed. [s. 30. (2)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee failed to comply with O.Reg. 79/10, s.49(2), in that an identified resident was not assessed using a clinically appropriate assessment instrument after a fall in October 2012.

The identified resident was known to have a risk of falls. The resident had a fall in September 2012 and two falls in October 2012. The second fall in October 2012 resulted in injury.

Interview with the home's Director of Care stated that a Post Fall Investigation and Internal Resident Incident Report are to be completed for each fall.

Registered nursing staff completed progress notes and an Internal Resident Incident Report, however, no Post Fall Investigation was completed for the second fall in October 2012. There was no documentation in the resident health care record to support that an assessment was completed using a clinically appropriate assessment instrument. [s. 49. (2)]

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Issued on this 25th day of January, 2013

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

Amanda Ndji MOHLTC Inspector