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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 24, 2016	2016_288549_0023	013433-16	Resident Quality Inspection

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 COBDEN
12 WREN DRIVE P.O. BOX 430 COBDEN ON K0J 1K0

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

RENA BOWEN (549), KATHLEEN SMID (161)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 17, 18, 19, 22, 23, 2016

Log # 004252-16 which is related to plan of care was inspected concurrently.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the home's Skin Care Leader, the home's Resident Assessment Instrument (RAI) Coordinator, the Director of Care (DOC) and the Administrator.

The inspectors toured the home, reviewed resident health care records, the resident's mobility equipment cleaning schedule, the resident and family general meeting minutes, observed resident care being provided , medication administration pass and infection prevention and control practices.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 is provided to the resident as specified in the plan.

Resident #021 was admitted to the home on a specified date in December 2014. The Minimum Data Set (MDS) assessment dated a specified date in December 2015 indicated that Resident #021 has short and long term memory problems and cognitive skills for daily decision-making is moderately impaired - decisions poor; cues or supervision required. The MDS also indicates that the transfers between surfaces-to and from: bed, chair, wheelchair and standing position is extensive assistance with two person's physical assist.

The home submitted critical incident report on a specified date in February 2016 indicating that resident #021 was being transferred alone by PSW #106 from the wheelchair to the toilet when the resident let go of the grab bar and fell backwards onto the floor. The resident did not sustain any injuries from the fall.

Inspector #549 reviewed resident #021 progress notes dated a specified date in October 2015 which indicated that the resident was assessed by the home's physiotherapist on a specified date in October 2015 and was found to be a two person transfer for all transfers.

The written plan of care dated a specific date in December 2015 was the written plan of care in effect at the time of the February 2016 incident.

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The December 2015 written plan of care was reviewed by Inspector #549. The written plan of care indicated that resident #021 required extensive assistance by two staff for transfers.

The Administrator indicated during an interview on August 23, 2016 that the written plan of care in place at the time of the incident in February 2016 indicated that resident #021 was a two person extensive assist for all transfers and that the transfer logo in the resident's room at the time also indicated that the resident was a two person assist for transfers

In summary the licensee failed to ensure that resident #021 was transferred from the wheelchair to the toilet on a specified date in February 2016 by two staff providing

extensive assistance as set out in the written plan of care dated a specified date in December 2015 which resulted in the resident falling backwards. [Log# 004252-16] [s. 6. (7)]

Issued on this 24th day of August, 2016

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

Original report signed by the inspector.