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

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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
Oct 25, 2021	2021_593573_0022	011547-21	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 Cobden
12 Wren Drive P.O. Box 430 Cobden ON K0J 1K0

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

ANANDRAJ NATARAJAN (573)

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): October 19, 20 and 21, 2021.

Log #011547-21 related to falls prevention, was inspected during this Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Nursing, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aide and the residents.

During the course of the inspection, the inspector(s) reviewed critical incident report, resident health care records, and other pertinent documents. The inspector (s) observed residents, resident home areas and infection control practices. In addition, inspector(s) observed the provision of care to the resident and observed staff to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used all equipment, supplies, devices, assistive aids, and positioning aids in the home in accordance with manufacturers' instructions.

Inspector observed two residents sitting in their wheelchair with a tab alarm (Personal Monitor) that was attached to the resident's garment with a paper clip. The personal monitor manufacturers' metal clip was replaced with a paper clip. Inspector observed two residents lying in their bed with a bed sensor alarm (Standard Monitor). The standard monitor was not securely mounted and placed on top of the resident's bed side table.

Inspector reviewed both the Personal Monitor and Standard Monitor's manufacturers' instructions for the directions for use. In the safety information/ warning section, the manufacturers' instructions indicated that "never attempt to repair the monitor" and "never use the monitor if it can not be securely mounted". Failing to follow the manufacturers' instructions related to safety information/ warning may result in risk of harm to the residents.

Sources: Direct observations, manufacturer's instructions, and interview with the Director of Nursing. [s. 23.]

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 staff use all equipment, devices, and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

Issued on this 25th day of October, 2021

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

Original report signed by the inspector.