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
Apr 15, 2013	2013_200148_0014	O-002446-12	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 COBDEN
12 WREN DRIVE, P.O. BOX 430, COBDEN, ON, K0J-1K0

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 8, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Registered and non-registered nursing staff and residents.

During the course of the inspection, the inspector(s) reviewed resident health records and observed resident care and services. In addition, the inspector reviewed the home's Abuse & Neglect Policy along with the documented investigation conducted by the home related to the critical incident.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. (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).

Findings/Faits saillants :

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1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (1)a, in that the licensee did not ensure that the written plan of care for Resident #002, set out the planned care for the resident.

Resident #002 has a diagnosis of dementia. The resident was involved with a resident to resident abuse on a specified date. The current plan of care indicates that an identified intervention was provided to the resident. Staff interviews on April 8, 2013, confirmed that the resident was provided the identified intervention, sometime after the abuse incident, for the purposes of distraction and coping. Staff member #101, who is involved with the homes BSO Team, stated that the identified intervention was quite useful to distract the resident.

Staff confirmed, that on a later date, the identified intervention was removed from the resident and was no longer in place.

On April 8, 2013, the written plan of care set out the provision and use of an intervention that was not the planned care for Resident #002. [s. 6. (1) (a)]

Issued on this 15th day of April, 2013

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

Amanda Nix RD LTCH Inspector