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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 17, 2018	2018_589641_0001	028292-17, 028295-17	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 MARMORA
58 BURSTHALL STREET P.O. BOX 429 MARMORA ON K0K 2M0

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

CATHI KERR (641)

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 4 and 5, 2018.

This inspection was conducted in reference to two critical incidents, Log # 028292-17 related to a resident falling sustaining an injury, and Log #028295-17 related to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Registered staff, Personal Support Workers (PSW) and residents. As well, the Inspector observed resident care, reviewed resident heath care records and the falls prevention program.

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

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the outcome or current status of resident #001 who was involved in an incident for which a critical incident was submitted to the Director.

The following finding is related to log #028292-17.

A critical incident which was submitted to the Director on a specified date, and amended four days later, indicated that resident #001 had a fall on a specified date that resulted in an injury. Three weeks later the resident was pronounced deceased. The Institutional Patient Death Record indicated that the death was an accidental death and The Medical Certificate of Death identified the fall as contributing to the cause of death.

During an interview with Inspector #641 on January 4, 2018, the Director of Care (DOC) #100 indicated that resident #001 had experienced a fall resulting in an injury and that the resident had passed away three weeks later. DOC #100 specified that the home had notified the coroner when resident #001 passed since the resident's health had declined since the fall. The DOC indicated that she had not seen the exact cause of death on the death certificate itself. The DOC identified that resident #001 had been up and about prior to the fall and that the resident's health declined after this incident.

Inspector #641 reviewed the resident's health care records. The last progress note for resident #001 indicated that after pronouncing the resident deceased, the registered staff notified the physician who indicated that the resident's death was a coroner's case.

The licensee had failed to ensure that the Director was updated when resident #001 health declined and subsequently passed away. [s. 107. (4) 3.]

Issued on this 17th day of January, 2018

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

Original report signed by the inspector.