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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 29, 2018	2018_505103_0030	018393-18, 018624-18, 025085-18, 027304-18	Complaint

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 15-18, 23-26, 2018.

The following intakes were included in this inspection:
Log #018393-18, Log #025085-18, Log #027304-18-complaints related to resident care,
Log #018624-18-complaint related to maintenance services, alleged incompetent resident care, whistle blowing protection and staff training..

During the course of the inspection, the inspector(s) spoke with family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Nurse Practitioner (NP), the Resident Care Coordinator (RCC) and the Administrator.

During the course of the inspection, the inspector conducted a walking tour of the home, reviewed resident health care records, made resident observations related to care and dining, reviewed whistle blowing policy and staff training.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
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 O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident shower has at least two easily accessible grab bars.

On October 17, 2018, the spa room located on the North wing was observed by this inspector. The shower stall located in this room was observed to have only one grab bar located on the left wall of the stall. The back wall of the shower stall had evidence of a previously installed grab bar that was no longer in place.

PSW #100 was interviewed and indicated the shower stall in the North wing was utilized on a regular basis for resident hygiene. They indicated the grab bar from the back wall had been missing for several months. They further indicated residents utilized the grab bars to assist themselves in standing. PSW #100 stated that if a resident was required to stand, they were removed from the shower stall and taken to the area beside the sink where there are grab bars installed.

The Administrator was interviewed in regards to the grab bars in the North spa wing. They indicated they were aware the grab bar from the back wall of the shower stall had been removed several months ago and indicated it had not been replaced because the wall did not have adequate strength to support the re-installation. The Administrator indicated they were trying to address the problem. [s. 14.]

Issued on this 30th day of October, 2018

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

Original report signed by the inspector.