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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Oct 5, 2015	2015_264609_0051	023182-15	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 ON BONNIE PLACE
15 Bonnie Place St Thomas ON N5R 5T8

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

CHAD CAMPS (609)

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): September 23, 2015

This inspection is being completed as a result of complaint submitted to the Ministry of Health and Long Term Care related to falls.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, two Behavioural Supports Ontario (BSO) staff, two Residents and two Personal Support Workers (PSW).

The inspector(s) also reviewed clinical records, incident reports, policies and procedures and plans of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that any procedure put in place by the home was complied with.

A review of the home's policy titled "Head Injury Routine" effective date August 2015 instructed staff to perform a head injury routine monitoring protocol as well as complete a resident incident report and a post fall investigation on all unwitnessed falls.

For the purposes of this report a fall is defined as "any unintentional change in position where the resident ends up on the floor, ground, or other lower level" taken from Resident Assessment Instrument-Minimum Data Set (RAI-MDS 2.0).

A review of clinical records revealed that on a specified day an identified resident had an unwitnessed fall. Clinical records revealed no head injury routine was performed, no resident incident report and no post fall investigation was completed.

A review of clinical records revealed that on a specified day another identified resident had an unwitnessed fall. Clinical records revealed no head injury routine was performed.

A review of the clinical records revealed that on a specified day a third identified resident had a fall that was unwitnessed and no head injury routine was performed as per the home's policy.

An interview with the DOC confirmed that it was the expectation that all unwitnessed falls were to have a head injury routine performed as well as complete a resident incident report and a post fall investigation. In the case of the three cited falls this did not occur and should have. [s. 8. (1) (a),s. 8. (1) (b)]

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 any procedure put in place by the home is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The Licensee has failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours.

A review of clinical records for an identified resident revealed family concerns related to ineffective fall interventions.

An interview with BSO staff revealed that an identified resident was known to interfere with the fall interventions of their roommate. BSO staff confirmed that this behaviour had been long-standing and had occurred more than once.

A review of clinical records for the identified resident revealed no identification or interventions related to the resident's known responsive behaviour.

During an interview, the RAI-Coordinator confirmed that the identified resident did not have the specific responsive behaviours identified on their plan of care and strategies were not developed or implemented despite the home's expectation to do so. [s. 53. (4) (b)]

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 strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours,, to be implemented voluntarily.

Issued on this 6th day of October, 2015

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

Original report signed by the inspector.