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
Aug 24, 2017	2017_605213_0017	009047-17	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 WOODSTOCK NURSING HOME
81 FYFE AVENUE WOODSTOCK ON N4S 8Y2

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

RHONDA KUKOLY (213), ALI NASSER (523)

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): August 3, 4, 2017

This complaint inspection was completed related to concerns regarding medications and care.

This inspection was completed concurrently while in the home July 31, Aug 1, 2, 3, 4, 2017, completing:
Complaint Inspection #2017_605213_0016, Log #017641-17, related to staffing concerns.
Follow-Up Inspection #2017_605213_0015, Log #016031-17, #016042-17 and follow up to an Immediate Order, all related to medication management.

Findings in this inspection related to O. Reg 79/10 s. 131(2) and s. 135 regarding medication administration and medication incidents have been issued in Follow-Up Inspection #2017_605213_0015, as further evidence to support Compliance Order #001 and #003.

During the course of the inspection, the inspector(s) spoke with the Director of Care, a Resident Care Coordinator, two Personal Support Workers, a resident and a family member.

The Inspectors also made observations and reviewed health records, internal investigation records, incident reports and other relevant documentation.

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

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	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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of the health record for a resident was completed. On an identified date, the resident had a fall when using an assistive device.

A fall Incident Report completed in Risk Management in Point Click Care, showed that the resident was found on the ground in front with the assistive device.

The plan of care for the resident showed an intervention to disable the assistive device in specific circumstances to prevent falls. This intervention was created approximately nine months prior to the fall.

In an interview with the Director of Nursing (DON), they said that the plan of care for the resident directed staff to disable the assistive device in specific circumstances to prevent falls. The staff on that occasion did not disable the device, resulting in a fall. The DON acknowledged that staff did not provide the care as it was set out in the plan of care for resident.

The severity of this non-compliance was minimal harm and the scope was isolated. The home does have a history of non-compliance in this subsection of the legislation, it was issued as a Voluntary Plan of Correction during a Follow-Up Inspection #2017_605213_0007 in May 2017 and as a Voluntary Plan of Correction during a Resident Quality Inspection #2017_605213_0007 in August 2016. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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Issued on this 25th day of August, 2017

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

Original report signed by the inspector.