Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
August 25, 2010	2010-137-2636-25Aug103546	Critical Incident2636-000025-10 L-00339

Licensee/Titulaire
Caressant Care Nursing and Retirement Homes Ltd.
264 Norwich Ave.
Woodstock, ON N4S 3V9

Long-Term Care Home/Foyer de soins de longue durée
Caressant Care Woodstock
81 Fyfe Ave.
Woodstock, ON N4S 8Y2

Name of Inspector(s)/Nom de l'inspecteur(s)
Marian C. Mac Donald - # 137

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: Administrator, Director of Care, Corporate Consultant, RPN, PSW's and resident.

During the course of the inspection, the inspector: reviewed the resident's records and the Home's Resident Mobility Assessment policy.

There were no Inspection Protocols used in part or in whole during this inspection:

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

[2] WN
[2] VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with : LTCHA, 2007, S.O 2007, c.8, 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.

Findings: For the resident identified in the CIS report, the plan of care, related to transferring, indicates resident requires extensive assistance X2 staff for transferring, using the sit/stand electronic lift. The resident was manually assisted by one staff at the time of the Critical Incident. During the inspection, resident was manually assisted X 2 staff into his wheelchair. The electronic lift was not used.
Related to toileting, the plan of care indicates resident requires extensive assistance and cannot be left unattended on toilet. For the resident identified in the CIS report, he was left unattended at the time of the incident.

Inspector ID #:	137

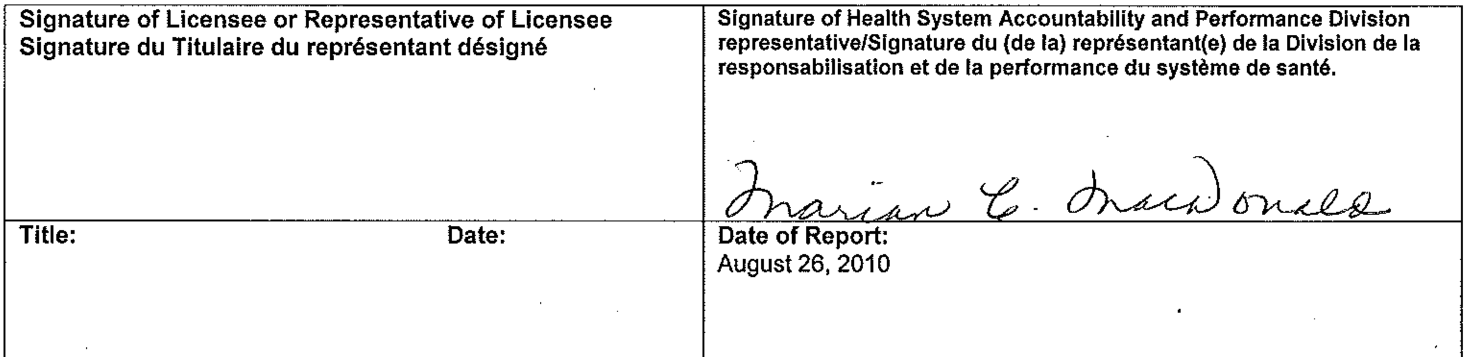
Additional Required Actions:
VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance, related to plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with: O. Reg. 79/10, s.36
Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Findings:
For the resident identified in the CIS report, the plan of care indicates resident requires extensive assistance X2 staff for transferring using sit/stand electronic lift. The resident was manually assisted by one staff at the time of the Critical Incident.
During the inspection, PSW confirmed that the resident was manually assisted X2 staff, into his wheelchair. The electronic lift was not used.

Inspector ID #:	137

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, related to transferring and positioning techniques, to be implemented voluntarily.



Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**		**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title:	**Date:**	**Date of Report:** August 26, 2010