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
Jan 30, 2015	2015_258519_0008	008767-14	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 FERGUS NURSING HOME
450 QUEEN STREET EAST FERGUS ON N1M 2Y7

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

SHERRI GROULX (519)

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 29, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Registered Nurse, a Restorative Care Worker, a Personal Support Worker, and a Resident.
The inspector reviewed clinical records, investigative reports, and Policies and Procedures. The environment of the home and staff interactions with Residents was observed.

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.
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A Resident became agitated with a Personal Support Worker (PSW) after the PSW had come into the room without knocking and startled the Resident. The Resident started to yell at the PSW.

The following morning the PSW returned to the room and spoke to the Resident in a disrespectful manner.

Upon interview with the Resident's spouse it was stated that the comment made by the PSW was disrespectful to them.

Upon interview with the Director of Care it was confirmed that the comment made by the PSW was inappropriate and disrespectful to both Residents. [s. 3. (1) 1.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A Resident sustained a fall in their room after confronting a Personal Support Worker (PSW) who had entered the room unexpectedly.

The PSW witnessed the Resident fall but did not report it.

Upon interview with the Resident's spouse it was confirmed that the fall was not reported as no follow up assessment was done.

Upon review of the home's Policy titled, "Safety Plan - Resident", dated September 2013, it states under "Post Fall Management" that upon discovery of a fall a Code Care is to be called by the staff member who discovers the incident. At a Code Care the interdisciplinary team will:
a) Initiate Head Injury Routine and assess the resident's level of consciousness and any potential injury associated with the fall as required.
b) Notify the attending physician and ensure immediate treatment after the fall as indicated.
c) Complete an internal incident report, post fall investigation and detailed progress note.
d) Investigate the contributing factors associated with the fall including location, time, and related activity.
e) Review Safety Plan interventions and modify the plan of care as indicated.
f) Communicate to all shifts that the resident has fallen and is at risk to fall.
g) Monitor the resident for 48 hours after a fall if the resident is taking anticoagulants such as Heparin, Coumadin, or Aspirin.

Upon interview with the Director of Care it was confirmed that it is the home's expectation that every fall is to be reported so an assessment of the Resident can be done. [s. 49. (2)]

Issued on this 30th day of January, 2015

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

Original report signed by the inspector.