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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 23, 2013	2013_128138_0002	O-002371-12	Critical Incident System

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

Long-Term Care Home/Foyer de soins de longue durée

PARISIEN MANOR NURSING HOME
439 SECOND STREET EAST, CORNWALL, ON, K6H-1Z2

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

PAULA MACDONALD (138)

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 10 and 14, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, RAI Coordinator, and personal support workers.

During the course of the inspection, the inspector(s) reviewed Critical Incident Report, resident health record, internal investigation documents, employee records, and the home's falls prevention policy.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

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 failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) in that licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care.

A Critical Incident Report was submitted to MOHLTC stating that the resident fell when s/he was left unattended on the toilet on a day in November 2012 and that the resident was subsequently transferred to hospital for assessment. The Critical Incident Report further stated that the resident was not to be left unattended while on the toilet and that a staff was disciplined for not following resident's care plan.

A review of the resident's care plan confirmed that the resident required staff to stay with him/her while being toileted as it was determined that s/he was not safe on his/her own. The RAI Coordinator confirmed that this care plan for the resident was in place at the time of the resident's fall.

The staff member involved in the incident confirmed that the resident was left unattended while s/he was being toileted and that the resident fell while s/he was unattended. Interview statements signed by the staff member indicated that s/he was unaware that the resident was not to be left alone while on the toilet but s/he did confirm that the resident's care plan was made available by the home and is accessible by staff. [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 regarding prevention of falls is provided to the resident as specified in the plan, to be implemented voluntarily.

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Issued on this 23rd day of January, 2013

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

Paula MacDonald RD