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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 22, 2014	2014_178102_0048	O-000619-14	Complaint

Licensee/Titulaire de permis

BELCREST NURSING HOMES LIMITED
250 Bridge Street West, BELLEVILLE, ON, K8P-5N3

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

BELCREST NURSING HOMES LIMITED
250 Bridge Street West, BELLEVILLE, ON, K8P-5N3

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

WENDY BERRY (102)

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): October 22, 2014

This complaint inspection is related to a malfunction of a component of the resident-staff communication and response system which occurred in June 2014. The system was restored to full function within 5 days of the occurrence.

During the course of the inspection, the inspector(s) spoke with the Environmental Services Manager, the Administrative Assistant, several staff.

During the course of the inspection, the inspector(s) obtained and reviewed records related to the call system malfunction and subsequent repair; observed the system components and checked operation in one area of the home.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Safe and Secure Home

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an environmental hazard that affected the provision of care or the safety, security or well- being of one or more residents for a period greater than 6 hours.

Pagers carried by nursing staff, which are a major component of the resident staff communication and response system, malfunctioned on June 21, 2014 at 22:48 pm. In response to an Infoline complaint related to the system malfunction, a telephone discussion was initiated by an MOH<C Intake Inspector on June 26, 2014. During the discussion, the Director of Care identified that a Critical Incident Report (CIR) had not been submitted.

On June 26, 2014 CIR # 2901-000018-14 related to the above incident, was submitted to the MOH<C. On June 27, 2014 the CIR was amended to report that the resident-staff communication and response system was repaired and was fully operational. [s. 107. (3) 2.]

Issued on this 22nd day of October, 2014

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