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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 2, 2014	2014_339579_0011	S-000176-13,S-000333-13	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

BIRCHWOOD TERRACE
237 Lakeview Drive, R. R. #1, KENORA, ON, P9N-4J7

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

JANET MCNABB (579)

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): June 17, 18 and 19th, 2014

Logs S-000372-13,S-000472-13,S-000474-13 were also inspected

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered staff, personal support workers (PSW), residents and the ward clerk.

During the course of the inspection, the inspector(s) walked through resident home areas, observed staff to resident interactions, reviewed health records, various policies and procedures, and the maintenance service logs.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Minimizing of Restraining

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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. Inspector reviewed a Critical Incident System (CIS) report submitted in 2013, related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. This CI was submitted late as having been reported more than 10 days after the incident had been confirmed.
The licensee failed to make a report in writing to the Director of any of the incidents described in r. 107 (1), (3) or (3.1), within 10 days of becoming aware of the incident, that includes:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. [s. 107. (4) 1.]

2. Inspector reviewed 4 other CI's from 2013, that also were submitted related to an injury that resulted in a transfer to hospital involving 4 different resident incidences. An amendment had been requested through CIS for an update on treatment proposals or resident's health status for each separate CI; and an additional CI required an update from the licensee on equipment repair.
All of the information requested to be submitted from the licensee to the CIS was not received.
The licensee failed to ensure a report in writing included actions taken in response to the incident, including:
i. what care was given or action taken as a result of the incident, and by whom,
v. the outcome or current status of the individual or individuals who were involved in the incident. r. 107. (4) 3. [s. 107. (4) 3.]

Issued on this 2nd day of July, 2014

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