



**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  
Direction de l'amélioration de la  
performance et de la conformité**

London Service Area Office  
130 Dufferin Avenue 4th floor  
LONDON ON N6A 5R2  
Telephone: (519) 873-1200  
Facsimile: (519) 873-1300

Bureau régional de services de  
London  
130 avenue Dufferin 4ème étage  
LONDON ON N6A 5R2  
Téléphone: (519) 873-1200  
Télécopieur: (519) 873-1300

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Apr 24, 2015	2015_416515_0011	006612-15	Complaint

**Licensee/Titulaire de permis**

BLUEWATER REST HOME INC.  
37792 Zurich-Hensall Rd RR #3 ZURICH ON N0M 2T0

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

BLUE WATER REST HOME  
LOT 21, HWY 84 R. R. #3 ZURICH ON N0M 2T0

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

RAE MARTIN (515)

**Inspection Summary/Résumé de l'inspection**



**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**

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): April 22 and 23, 2015.**

**This inspection was completed as a result of a fall sustained by a resident and was done concurrently with L-002027-15 - Resident Quality Inspection (RQI).**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, Director of Care, two Registered Staff, a Personal Support Worker and a Resident.**

**The following Inspection Protocols were used during this inspection:**

**Falls Prevention**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,**

**(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and**

**(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).**

**Findings/Faits saillants :**

An identified Resident had a fall, sustained an injury and was subsequently hospitalized.

A review of the resident's clinical health record revealed documentation in progress notes indicating that it was determined not to submit a Critical Incident report as there were no fractures and no change in condition related to the fall.

An interview with a Registered Staff member and a Personal Support Worker confirmed the resident's condition had changed on return from hospital.

A review of the Plan of Care revealed the Care Plan was updated on return from hospital to include additional interventions related to falls prevention.

An interview with the Chief Executive Officer and the Director of Care confirmed that a Critical Incident report should have been submitted and the expectation that the home's staff report critical incidents in accordance with the legislation. [s. 107. (3.1) (b)]



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

***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 where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, and where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4), to be implemented voluntarily.***

---

Issued on this 24th day of April, 2015

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

**Original report signed by the inspector.**