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 22, 2014	2014_287548_0002	O-OOO373-13	Critical Incident System

Licensee/Titulaire de permis

COUNTY OF RENFREW
9 INTERNATIONAL DRIVE, PEMBROKE, ON, K8A-6W5

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

BONNECHERE MANOR
470 ALBERT STREET, RENFREW, ON, K7V-4L5

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

RUZICA SUBOTIC-HOWELL (548)

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): In early January 2014

The inspection was conducted as a result of one critical incident report.

During the course of the inspection, the inspector(s) spoke with the Resident, Administrator, Director of Care, Resident Care Coordinators, Registered Nurse,Registered Practical Nurse,Health Care Aide and Personal Support Workers (PSWs).

During the course of the inspection, the inspector(s) observed Resident, resident/staff interactions, reviewed resident health care records and home policy: Bonnechere Manor Standard Operating Procedure, Title: Falls Prevention Program, SOP N-19-005 Date: February 2010 Revision Date: March 19 2012.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
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 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 :

1. As indicated by the resident health care record and Critical Incident Report. On a certain day in April 2013 registered staff were called to Resident room to assess Resident who had fallen. Resident sustained injury from the fall.Resident voiced complaint of some discomfort at that time. Physician notified of incident and chest x-ray ordered. Resident transported to hospital for assessment on a certain day in May 2013 and returned back to the home the following day.

The Director was informed of the incident described above through the Critical Incident System several days later. The Director was not informed within one business day of an injury that resulted in transfer to hospital.

It is noted, that O.Reg 79/10, s.107(3) was amended as of September 15, 2013. This finding relates to an incident that occurred prior to September 15, 2013 and therefore the previous s.107 (3) was applied. [s. 107. (3.1)] [s. 107. (3.1)]

Issued on this 23rd day of January, 2014

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