Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 29, 2021	2021_729615_0017	003150-21	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

Caressant Care on Bonnie Place
15 Bonnie Place St Thomas ON N5R 5T8

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

HELENE DESABRAIS (615)

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): April 26 and 27, 2021.

The following intakes were inspected during this inspection:

Log #005565-21/Critical Incident System (CIS) report #2730-000012-21 related to declaration of an outbreak;
Log #003150-21/CIS report #2730-000009-21 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, the Director of Care and a Personal Support Worker.

The inspector also toured the home, reviewed the resident's clinical records, reviewed the home's CISs and other relevant documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

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):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to immediately inform the Director, in as much detail as is possible in the circumstances, an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care related to a COVID Outbreak declared the day before. A review of the home's CIS report identified that the Public Health Unit was contacted and the outbreak was declared the day before the CIS was submitted. During an interview, the Interim Administrator acknowledged that the outbreak was reported to the Director late, and they expected it to be reported immediately.

Sources: the home's CIS and staff interview. [s. 107. (1) 5.]

2. The licensee has failed to informed the Director, no later than one business day after the occurrence of the incident, that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care 14 days later for a resident's fall, and change in their health conditions. A review of the resident's progress notes indicated that the home contacted the hospital 14 days earlier and confirmed the resident was admitted to the hospital with an injury and change in their health conditions. During an interview, the Interim Administrator acknowledged that the incident was reported late and they expected the incident and change in conditions be reported within one business day to the Director.

Sources: resident's clinical records, the home's CIS and staff interviews. [s. 107. (3) 4.]

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Issued on this 29th day of April, 2021

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

Original report signed by the inspector.