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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
April 11, 2011	2011_021505_0001	Complaint and CIS (log # O-000706 & O-000719)

Licensee/Titulaire
Community Lifecare Inc.
1955 Valley Farm Road, 3rd Floor
Pickering, ON
L1V 1X6

Long-Term Care Home/Foyer de soins de longue durée
Community Nursing Home Pickering,
1955 Valley Farm Road,
Pickering, ON
L1V 3R6

Name of Inspector(s)/Nom de l'inspecteur(s)
Lynda Brown (#111)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint and CIS inspection for a deceased resident.
During the course of the inspection, the inspector(s) spoke with: The Clinical Director of Care.
During the course of the inspection, the inspector(s): reviewed the resident's health record and the homes staff interviews.
The following Inspection Protocols were used in part or in whole during this inspection: Critical Incident and Complaints.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
2 CO: CO # 001, 002

NON- COMPLIANCE / (Non-respectés)	
Definitions/Définitions **WN** – Written Notifications/Avis écrit **VPC** – Voluntary Plan of Correction/Plan de redressement volontaire **DR** – Director Referral/Régisseur envoyé **CO** – Compliance Order/Ordres de conformité **WAO** – Work and Activity Order/Ordres: travaux et activités	
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8,
s.6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
s.6(10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the residents care needs change or care set out in the plan is no longer necessary; or
care set out in the plan has not been effective

Findings:
An identified resident had a change in condition resulting in injury and the plan of care was not reviewed or revised.
An identified resident had a change in condition resulting in injury and did not receive the care set out in the plan of care based on the preferences of that resident.

Inspector ID #:	111

Additional Required Actions:
CO # 001 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #2: LTCHA, 2007 S.O. 2007, c.8, s.23(1) Every licensee of a long-term care home shall ensure that,
(a)every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i)abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulation.

Findings:
An identified resident sustained an injury of unknown cause and was not investigated immediately.

Inspector ID #:	111

Additional Required Actions:
CO # 002 was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #3: O.Reg. 79/10, 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. An injury in respect of which a person is taken to hospital (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required b the Director, make a report in writing to the Director setting out the following with respect to the incident:	
Findings: An identified resident sustained an injury resulting in transfer to hospital and the Ministry was not notified within one business day after the occurrence of the incident and a report was not received by the Ministry within 10 days.	
Inspector ID #:	111

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**		**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Linda Brown
Title:	**Date:**	**Date of Report:** (if different from date(s) of inspection). Apr. 26, 2011

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Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public	
Name of Inspector:	Lynda Brown	**Inspector ID #**	111
Log #:	O-000706 & O-000719		
Inspection Report #:	2011_021505_0001		
Type of Inspection:	Complaint & Critical Incident		
Date of Inspection:	April 11, 2011		
Licensee:	Community Lifecare Inc. 1955 Valley Farm Road, 3rd Floor Pickering, ON L1V 1X6		
LTC Home:	Community Nursing Home Pickering, 1955 Valley Farm Road, Pickering, ON L1V 3R6		
Name of Administrator:	Metzie Lacroix (Acting)		

To Community Lifecare Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA, 2007 S.O. 2007, c.8,
s.6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
s.6(10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the residents care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective

Order: The licensee shall ensure that when a residents care needs change, they receive the care as set out in the plan of care and based on the residents assessed needs. When the care set out in the plan of care is no longer necessary or has not been effective, that the resident is reassessed and the plan is reviewed and revised.

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Grounds: An identified resident had a change in condition resulting in injury and the plan of care was not reviewed or revised.	
This order must be complied with by:	Immediate

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)
Pursuant to: LTCHA, 2007 S.O. 2007, c.8, s.23(1) Every licensee of a long-term care home shall ensure that, (a)every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i)abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulation.			
Order: The licensee shall ensure that every alleged, suspected or witnessed incident of a resident resulting in injury of unknown cause is investigated immediately.			
Grounds: An identified resident sustained an injury of unknown cause and was not investigated immediately.			
This order must be complied with by:	Immediate.		

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007.*

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk

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Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 26 day of April , 2010.	
Signature of Inspector:	Lynda Brown
Name of Inspector:	Lynda Brown (#111)
Service Area Office:	Ottawa Service Area Office