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
Oct 9, 2013	2013_178102_0017	000227-13	Critical Incident System

Licensee/Titulaire de permis

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 (PORT HOPE)
20 HOPE STREET SOUTH, PORT HOPE, ON, L1A-2M8

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

WENDY BERRY (102)

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 03, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care; registered and non registered Nursing staff.

During the course of the inspection, the inspector(s) reviewed documentation and a resident's records related to 3 critical incidents. Looked at door security systems.

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

Responsive Behaviours

Safe and Secure Home

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) 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

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1. Critical incident (CI) report # 2639-000003-13 identifies that a named resident had an "elopement off facility premises". CI date and time is identified as Friday "8-Mar-2013 12:00". The CI was reported to the Ministry of Health(Director)on Monday March 11, 2013.
Documentation printed from the residents' electronic file; chart # 1203047, identifies that the elopement described in CI report # 2639 000003-13, occurred on March 06, 2013. The incident note was recorded at 10:16 am in the record titled "Brief individual report on incidents and progress notes-by unit".
The CI was not reported within one business day after the occurrence date of March 06, 2013.

CI report # 2639-000004-13 identifies that a named resident had an elopement "on street just off home property". Actions taken included "Code yellow called, resident returned to home". CI date and time is identified as "March 13, 2013 09:35". The CI was reported to the Ministry of Health (Director) on March 13, 2013.
Documentation printed from the residents' electronic file; chart # 1203047 identifies that the elopement described in CI report # 2639-000004-13 occurred on March 11, 2013 at 12:00 hours. The incident note was recorded at 13:39 in the record titled "Brief individual report on incidents and progress notes-by unit".
The CI was not reported within one business day after the occurrence date of March 11, 2013. [s. 107. (3)]

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 critical incident reports contain accurate information and that the reports are made and/or submitted as required by legislation, to be implemented voluntarily.

Issued on this 9th day of October, 2013

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