Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 28, 29, 2011	2011_067171_0008	Critical Incident

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF LONDON
c/o Dearness Home for Senior Citizens, 710 Southdale Road East, LONDON, ON, N6E-1R8

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

DEARNESS HOME FOR SENIOR CITIZENS
710 SOUTHDALE ROAD EAST, LONDON, ON, N6E-1R8

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

ELISA WILSON (171)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the director of care, registered staff, and health care aides.

During the course of the inspection, the inspector(s) reviewed relevant policies and reviewed the plan of care for an identified resident.

The following Inspection Protocols were used in part or in whole during this inspection:

Critical Incident Response

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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 resident's 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. 2007, c. 8, s. 6 (10).

Findings/Faits sayants :

1. The plan of care is not always reviewed and revised when a resident's care needs change.
The Resident Assessment Protocol documentation from June 24, 2011 regarding Cognitive Loss/Dementia specifically mentions an incident of risk for an identified resident, however the plan of care was not revised to include any interventions or strategies to prevent future incidents. The plan of care summary indicates this specific risk, however the section on interventions was blank when reviewed on July 28, 2011 and this missing information was confirmed by a registered staff person.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits sayants :

1. The regulation requires the licensee to have an emergency plan in place regarding specific situations. The Home has such a policy, however it is not always complied with.

a) The policy has a checklist which is to be completed by the charge nurse or designate, however this checklist was not completed for an identified incident. The documentation was confirmed missing by the director of care on July 28, 2011.

b) The policy also states under "Records" that if a resident is at risk, that person should be identified at risk in their care plan and strategies should be determined to reduce this risk. An identified resident's care plan does indicate a specific risk however that section of the summary care plan had no interventions or strategies listed to reduce the risk. This missing documentation was confirmed by a registered staff person on July 28, 2011.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (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 by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

Findings/Faits sayants :

1. Not all information required regarding a critical incident was reported to the Director in writing. The Home submitted a critical incident report, however the documentation did not include all the details required under the regulations and no further documentation was received regarding this incident as of July 28, 2011.

a) The written report does not include the name of the on-call manager that was notified about the incident. [O.Reg 79/10, s.107 (4) 2.iii]

b) The report indicates the family was notified but does not include the name of such person. [O.Reg 79/10, s.107 (4) 3.iv]

Issued on this 5th day of August, 2011

[redacted]

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

Elisa Wilson