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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 8, 2016	2016_320612_0023	026788-16	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE TIMMINS
15 Hollinger Lane Box 817 Schumacher ON P0N 1G0

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

SARAH CHARETTE (612), LINDSAY DYRDA (575), RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 19-23, and 26-30, 2016.

During the course of the inspection, the Inspectors reviewed eight Critical Incident (CI) reports submitted by the home to the Director related to residents' who fell, two CIs reports related to staff to resident abuse, one CI report related to misuse/ misappropriation of a residents' money, one CI report related to a complaint received by the home related to improper care of a resident, one CI report related to a resident sustaining an injury of unknown cause and one complaint related to the care of a resident after a fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Program Manager, Social Services Worker, Registered Dietitian (RD), Maintenance Manager, Support Services Manager, Physiotherapy Assistant, Behavioural Support Services (BSO) staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents and their family members.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to residents interactions, reviewed residents’ health care records, staffing schedules, staff training records, policies, procedures, programs, and staff personnel files.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **3 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following right of residents was fully respected and promoted: 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

During the inspection, Inspector #612 was approached by the DOC stating that resident #020 was requesting to speak with an inspector to report an incident of physical abuse by staff.

Inspector #612 interviewed resident #020 who identified specific staff members, who had approached them to assist them with an activity of daily living. The resident stated that the staff members were hurting them, and caused them pain. The resident stated that

they had told the staff members to stop because they were hurting them but they did not stop.

The home submitted a CI report in regards to the incident. The incident was investigated by the DOC of the home.

Inspector #612 interviewed PSW #144. They stated that they were trying to assist resident #020 with RPN #142 and PSW #143. They reported that they started assisting the resident and that the resident was verbally and physically responsive at that point; however, they continued to provide care to the resident. PSW #144 stated that resident #020 had stated that they were experiencing pain; however, they had to assist the resident as after 2100 hours there was only two staff left on the unit after that time. They reported that the resident was physically responsive with RPN #142; therefore, at that time the staff left the resident alone.

The Inspector reviewed resident #020's care plan which stated that when the resident was exhibiting responsive behaviours, verbal or physical, staff were to stop what they were doing, ensure the resident's safety, and return at a later time to provide care.

The Inspector interviewed the DOC who stated that the staff members did eventually leave resident #020 as they were displaying verbally and physically responsive behaviours; however, the staff members wanted to ensure that the resident was safe before doing so. [s. 3. (1) 4.]

2. Inspector #612 reviewed a complaint submitted to the Director in regards to resident #016 who had fallen and was left alone for a period of time awaiting transfer to the hospital for further assessment. The Home had submitted a CI report, related to a complaint they received regarding the same incident.

Inspector #612 reviewed another CI report, submitted by the home which described that resident #016 was found on the floor by PSW #141. The resident reported that they had fallen, and as a result, had sustained multiple injuries. The resident was assessed by the physician who recommended they be sent for further assessment to rule out additional injuries.

The Inspector interviewed resident #016 and their family member. The resident reported that after the fall, they had been assessed by registered staff and the physician. They reported that they were left alone in their room after the fall to wait for the paramedics to

arrive in order to transfer them to the hospital for further assessment. They reported that they were scared and shaking; however, they were unsure how long they were left alone, only that it felt like a very long time. The resident's family member stated that they arrived just after the paramedics and that the paramedic had told them that the resident was all alone in their room when they had arrived.

The Inspector interviewed RN #106 who confirmed that they had assessed resident #016 post fall and that the physician had assessed the resident as well. They stated that there was a period of time, they did not recall exactly how long, that the resident was unattended, while they left to call the paramedics, the resident's family member, and prepare the paper work to transfer the resident.

The Inspector interviewed the DOC who stated that they had met with the resident's family member after the fall and had investigated why no staff remained with the resident while awaiting the arrival of the ambulance to transfer the resident to the hospital. They confirmed that no staff had remained with the resident post fall and since the incident they had sent out a memo to advise the registered staff that they were to remain present with a resident at all times while waiting for paramedics for an emergency transfer. [s. 3. (1) 4.]

3. The licensee has failed to ensure that every resident had the right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

During the initial tour of the home on September 19, 2016, at 1245 hours, on a specific unit, Inspector #638 observed that the electronic medication administration record (eMAR) was left unlocked and unattended by RPN #126 in the dining area during the lunch dining service. Residents and their family members were located within in the area of the eMAR and resident personal health information (PHI) was accessible to anyone.

In an interview with the Inspector, RPN #126 stated that it was expected that the eMAR should have been locked when it was left unattended or not in use.

Inspector #638 interviewed the DOC who indicated that it was the home's expectation that PHI was kept confidential and that the eMAR was locked when left unattended in order to protect the residents' PHI. [s. 3. (1) 11. iv.]

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 the following right of resident #016 and #020 is fully respected and promoted: 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: 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:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. 2007, c. 8, s. 6 (7).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

During stage one of the inspection, resident #003 was observed with an assistive device, in a specific position.

On September 26, 2016, Inspector #638 observed resident #003, with an assistive device, in the same position. Further observations made on September 27, 2016, indicated that resident #022 and #024 had an assistive device, in the same position.

Inspector #638 conducted a record review of the plan of care for resident #003, which indicated that resident #003 required the use of the assistive device; however, no mention specifying the use of the specific position. A concurrent review of the care plan of resident #022 and #024 indicated the use of the assistive device; however, there was no intervention specifying the use of the specific position.

In an interview with Inspector #638, PSW #113 stated that residents who had the assistive device utilized the specific position as a common practice. In a concurrent interview, PSW #113 stated that there was no documentation within the residents' plan of care directing staff to utilize the assistive device in the specific position.

Inspector #638 conducted an interview with RPN #118 and they stated that no formal assessments were completed to determine if the specific position of the assistive device was considered a restraint and that it could be considered a restraint should the intervention prevent a resident from attempting a certain action.

In an interview with Inspector #638, the DOC stated that no preliminary assessments had been completed for residents who had the assistive devices in the specific position, which would have determined the resident's needs and whether the specific position of the device would be restraining to the resident. [s. 6. (2)]

2. Observations made by Inspector #638 throughout the inspection indicated that on September 20, 26, 27, 28 and 29, 2016, resident #003 was observed without a certain item of clothing.

Inspector #638 conducted a record review of resident #003's plan of care which did not

indicate whether or not the resident was to be wearing the item of clothing at any point in time.

In an interview with Inspector #638, RPN #138 stated that resident #003 would not keep that item on and as a result staff no longer attempt to apply the item of clothing. In a concurrent interview RPN #138 stated that the plan of care had not been updated in order to reflect the resident's needs and preferences.

Inspector #638 interviewed the DOC who indicated that it was the home's expectation that the plan of care was based on an assessment of the resident and their needs and preferences and that for resident #003 the plan of care should have been updated to portray the resident's needs and preferences accordingly. [s. 6. (2)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A review of the Minimum Data Set (MDS) assessment, as a result of a stage one trigger indicated that resident #003 had a worsening pressure ulcer from the previous MDS.

A record review of resident #003's physician order related to the dressing change provided specific directions to the registered staff. In a concurrent record review of the treatment administration record (TAR) for resident #003 did not match the physician order.

Inspector #638 observed resident #003's dressing change to the wound on their left foot on September 22, 2016, by RN #105. During the observation RN #105 completed the dressing change as per the physician order.

In an interview with Inspector #638, RN #105 stated that the registered staff were to reference the TAR when providing wound care treatment. Upon review of the TAR and physician order for resident #005, RN #105 stated that the physician order and TAR were not consistent and did not complement one another and should have in order for the registered staff to provide the appropriate treatment.

During an interview with Inspector #638, the Nursing Care Coordinator (NCC) stated that the physician order and TAR for the treatment of resident #003's wound were not

consistent and did not give clear direction to staff. In a concurrent interview, the NCC stated that it was the home's expectation that the plan of care was consistent and complemented each other.

No further action will be taken in regards to this non-compliance as there is currently an outstanding compliance order (CO) and Directors Referral (DR) for s. 6. (4) (b) in Follow Up Report #2016_391603_0018. [s. 6. (4) (b)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During stage one of the inspection, it was identified that resident #004 had an unplanned weight loss in excess of regulatory limits according to a record review. Over a one month period the resident lost 9.4 per cent weight. Over a two month period, the resident gained 10.9 per cent.

Inspector #575 reviewed the resident's plan of care which indicated that the resident received a supplement twice a day and required assistance at meals.

The Inspector observed a meal service and noted that PSW #109 had assisted resident #004 with their meal; however, the resident did not drink their fluids. The resident was not observed to be offered assistance to consume the supplement at any time during the observation.

The Inspector asked PSW #109 if the fluid in the cup was the supplement. The PSW indicated that they were not sure, proceeded to smell the beverage and stated that it must be. The PSW stated that they did not normally provide care for this resident. RPN #100 confirmed that the beverage was the supplement. RPN #100 indicated that PSWs were responsible for documenting the amount of the supplement consumed by the resident at meal time.

After the lunch service, the Inspector reviewed the documentation which indicated that the resident had consumed 75-100 per cent of the supplement at lunch; however, this did not occur as the glass with the supplement remained full during the Inspectors observations and no staff assisted the resident to drink it. [s. 6. (7)]

5. During stage one of the inspection, a family member of resident #004 indicated to Inspector #575 that on a specific date when they arrived at the home, resident #004 did

not have their assistive devices in place. The family member of resident #004 stated that part-time staff were not aware of the plan of care. The family member explained that the resident ate better without their assistive device; therefore, the resident did not require the use of their assistive device at meals; however, staff were required to assist the resident to apply their assistive device after meals.

Inspector #575 reviewed the resident's plan of care. The care plan indicated that staff were to apply the resident's assistive device in the morning and remove them at bedtime, or when the resident was resting in bed. Under nutritional status, the care plan indicated a specific intervention related to the assistive device.

On September 27, 2016, the Inspector interviewed PSW #123 who indicated that they primarily assisted the resident during meal time. The PSW stated that they were aware of the specific intervention listed in the residents plan of care related to the assistive device. The PSW indicated to the Inspector that the specific intervention listed in the resident's plan of care related to the assistive device was not followed during the meal service on September 27, 2016, as another staff member was providing the care to the resident prior to entering the dining room. [s. 6. (7)]

6. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During stage one of the inspection, resident #002 was observed with an assistive device.

On September 28, 2016, Inspector #575 reviewed the resident's plan of care. Under the focus for dressing, the care plan indicated that staff were to apply an assistive device in the morning, and remove at bedtime.

On September 28, 2016, Inspector #575 observed the resident in their room at 1539 hours; the resident did not have the assistive device applied.

The Inspector interviewed PSW #125 who indicated that they were not aware if the resident was required to wear the assistive device; however, they showed the Inspector the assistive device which appeared to be broken.

The Inspector interviewed Physiotherapy Assistants #135 and #136 who indicated that the resident's assistive device had been broken for approximately one month.

The Inspector interviewed the DOC regarding the resident's assistive device. The DOC stated that they became aware approximately a week and a half ago that the resident's assistive device required repair. The DOC stated that they were in the process of determining if the assistive device could be repaired. The DOC indicated that the resident's Substitute Decision Maker (SDM) was aware and indicated that they might not have documented their conversation with the SDM.

The Inspector reviewed the plan of care with the DOC. The DOC indicated that the resident's plan of care should have been updated to reflect the current status of the assistive device. [s. 6. (10) (b)]

7. During stage one of the inspection, it was identified that resident #007 was hospitalized for a period of time.

On September 29, 2016, Inspector #575 reviewed resident #007's plan of care. The care plan indicated an intervention with a specific timeline identified by the resident’s family. Under the physician order tab on Point Click Care (PCC), a nursing measure indicated a different timeline for the same intervention which was entered six months after the intervention in the care plan.

The Inspector also noted a different intervention entered in the care plan on a specific date, which after review of the resident's health care record was noted to be resolved two days later; however, the care plan did not reflect that.

On September 29, 2016, during an interview with the Inspector, RPN #100 stated that the staff were to follow the intervention identified in the physician order tab in the timeline identified there.

On September 30, 2016, Inspector #575 reviewed the plan of care with RN #106 who confirmed that the care plan was not updated to reflect the timeline identified in the physician order tab and the care plan was not updated to reflect that the different intervention which was resolved two days later. [s. 6. (10) (b)]

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 the care set out in the plan of care is provided to resident #004 as specified in the plan and that resident #002 and #007 are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or the care set out in their plan was no longer necessary, to be implemented voluntarily.

WN #3: 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:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

During stage one of the inspection, it was identified that resident #005 had an unplanned weight loss at a rate in excess of regulatory limits according to a record review. Over a one month period, resident #005 lost 16.8 per cent body weight.

During an interview with Inspector #575, RPN #124 stated that residents' weights were completed at the beginning of each month and were documented on Point Click Care (PCC) under the weights and vitals tab.

Inspector #575 reviewed the resident's health care record. The Inspector noted that the resident’s last recorded weight was at the beginning of August 2016. The resident was absent from the home for a period of time at the beginning of September 2016. Documentation under the weight task during the period of time the resident was absent from the home indicated that the resident was, "not available" for the monthly weight. The resident's care plan indicated that staff were to assess for weight loss.

The Inspector reviewed the home's policy titled, "Weight Change Program", version November 2013, which indicated that residents' were weighed on admission, monthly, or more frequently as required. Weights were to be completed during the first bath day within the first seven days of each month. The Inspector noted that although the resident was in hospital during this time, they had five baths since returning to the home and no weight had been obtained.

During an interview with RPN #124, they confirmed that resident #005 did not have a weight recorded for September 2016. [s. 8. (1) (b)]

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 the home's policy titled, "Weight Change Program," version November 2013, is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non residential areas were kept closed and locked when they were not supervised by staff.

During the initial tour of the home on September 19, 2016, Inspector #638 observed the housekeeping door on a particular home area was not locked and the residents could have accessed the housekeeping room which contained chemicals and cleaning supplies.

In an interview with Inspector #638, RPN #100 and PSW #117 stated that all non residential areas were to be closed and locked when not in use or being monitored and that the housekeeping room was supposed to have been locked to prevent residents from entering the non residential area.

Inspector #638 interviewed the DOC who indicated that all non residential home areas were to have been kept closed and locked when not supervised by staff for resident safety. [s. 9. (1) 2.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had their personal items, including personal aids labelled within 48 hours of admission and of acquiring, in the case of new items.

During the initial tour of the home on September 19, 2016, Inspector #638 observed that in the tub room on a specific unit there was a pair of used and unlabelled nail clippers as well as a personal hygiene loofa. Further observations made on a particular unit indicated that in the tub room there were used and unlabelled hairbrush, nail clippers and TENA soothing cream. Another unit had four used nail clippers which were unlabelled in the tub room.

Inspector #638 interviewed PSW #137, who stated that all resident personal items were supposed to be labelled so that their personal hygiene products would not be used on more than one resident. In an interview with Inspector #638, RPN #100 stated that all personal items should be labelled in order to determine whom the items belonged to.

In an interview with the Inspector #638, the DOC stated that it was the home's expectation that all personal items were labelled. [s. 37. (1) (a)]

WN #6: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) 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:
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.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report to the Director included the long-term actions planned to correct the situation and prevent recurrence.

Inspector #612 reviewed a CI report submitted to the Director by the home, related to a fall by resident #019, which resulted in a transfer to hospital. The resident was suspected to have sustained an injury; however, it was determined that the resident had not. The CI report was submitted the same day as the fall, and no further amendments were made with updates in regards to the long-term actions planned to correct the situation and prevent recurrence within the 10 day period.

The Inspector reviewed the home's policy titled, "Mandatory and Critical Incident Reports (ON)", policy #RC-11-01-06, last reviewed April 2016, which stated that the mandatory/critical written report to the Director should have contained the long-term actions planned to correct the situation and prevent recurrence.

On September 29, 2016, Inspector #612 interviewed the DOC who confirmed that they had not updated the report to the Director with the long-term actions planned to correct the situation and prevent recurrence within the 10 day time frame. [s. 107. (4) 4.]

Issued on this 14th day of December, 2016

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

Original report signed by the inspector.