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

Division des foyers de soins de longue durée
Inspection de sions 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
May 12, 2016	2016_330573_0012	012709-16	Critical Incident System

Licensee/Titulaire de permis

GEM HEALTH CARE GROUP LIMITED
470 RAGLAN STREET NORTH RENFREW ON K7V 1P5

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

GROVES PARK LODGE
470 RAGLAN STREET NORTH RENFREW ON K7V 1P5

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

ANANDRAJ NATARAJAN (573)

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): May 10 and 11, 2016.

During the course of the inspection, the inspector conducted critical incident inspections for log #021906-15, 036400-15, 010268-16 and 012709-16 related to a falls incident with an injury, resulted in a significant change in residents health status.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Clinical supervisor, RAI Coordinator, Registered physiotherapist, Registered nurse (RN), Registered practical nurse (RPN), Personal supports workers (PSW) and Physiotherapy assistants (PTA). In addition, the inspector also observed resident care and resident rooms.

During the course of the inspection, the inspector reviewed Critical Incident (CI) reports, reviewed identified resident health records (including clinical assessments, care plans, progress notes, medication administration records, flow sheets, hospital discharge summaries) and the home’s Falls Prevention & Management Program in place at the time of inspection.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
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	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. (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):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was not immediately informed of an unexpected death of resident #002, resulting from a fall accident.

Related to Log # 012709-16

The Critical Incident Report (CIR) #2646-000002-16 indicated that resident #002 had an unwitnessed fall on a specified date. Further the CIR report indicates that resident #002 deceased approximately four hours later, after the fall accident.

Inspector #573 reviewed resident #002's Death Certificate, For immediate cause of death it indicates "fall due to fragility of old age".

The Director was informed three (3) days after the occurrence of the resident #002's fall accident which resulted in unexpected death. [s. 107. (1)]

2. The licensee has failed to ensure that the Director was not informed within three business days after the occurrence of an incident that caused an injury, for which the resident was taken to hospital resulting in a significant change in resident's health condition.

Related to Log #010268-16

The Critical Incident Report (CIR) #2646-000001-16 indicated that on a specified date resident #001 had an unwitnessed fall and was transferred hospital for an assessment. Resident #001 was diagnosed with a fracture that would require surgical repair.

Inspector #573 spoke with Director of Care who indicated that resident #001 underwent surgery on a specific date and returned to facility five days post-surgery.

Inspector #573 spoke with home's RAI Coordinator who indicated that resident #001's fall resulted in significant change in the resident's health status.

On a specified date the Director was informed of the significant change in the resident # 001's health status due to the fall, which is six (6) business days after the occurrence of the incident.[s. 107. (3.1)]

Issued on this 12th day of May, 2016

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

Original report signed by the inspector.