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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Jul 31, 2014	2014_334565_0009	T-604-14	Critical Incident System

Licensee/Titulaire de permis

LABDARA FOUNDATION
5 Resurrection Road, TORONTO, ON, M9A-5G1

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

LABDARA LITHUANIAN NURSING HOME
5 Resurrection Road, TORONTO, ON, M9A-5G1

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

MATTHEW CHIU (565)

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): July 28, 29, 2014.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC).

During the course of the inspection, the inspector(s) reviewed critical incident report #2860-000007-14.

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

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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. (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):
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).

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:

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.

O. Reg. 79/10, s. 107 (4).

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.

O. Reg. 79/10, s. 107 (4).

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. O. Reg. 79/10, s. 107 (4).

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).

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 saillants :

1. The licensee failed to inform the Director immediately, in as much detail as is possible in the circumstances, of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

Record review of the critical incident report #2860-000007-14 and interview with the DOC confirmed that the onset of the respiratory outbreak was on March 20, 2014. The licensee informed the Director of the outbreak on May 2, 2014, 43 days later and not immediately as required. [s. 107. (1) 5.]

2. The licensee failed to make a report in writing to the Director of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act, within 10 days of becoming aware of the incident, or sooner if required by the Director.

Record review and staff interview confirmed that the licensee did not make a report in writing to the Director within 10 days of becoming aware of the onset of the respiratory outbreak on March 20, 2014. The licensee made the written report to the Director on May 2, 2014. [s. 107. (4)]

3. The licensee failed to ensure that the written report includes a description of the individuals involved in the incident, including the names of any residents involved in the incident.

Record review and staff interview confirmed that there were 14 residents involved in the respiratory outbreak. The written report does not include the names of the involved residents. [s. 107. (4)]

4. The licensee failed to ensure that the written report includes whether an inspector has been contacted, and, if so, the date of the contact and the name of the inspector.

Record review and staff interview confirmed that the written report does not include whether an inspector has been contacted, and, if so, the date of the contact and the name of the inspector. [s. 107. (4)]

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Issued on this 31st day of July, 2014

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