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
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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
Jun 3, 2015	2015_190159_0013	H-002613-15	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

NORTHRIDGE
496 POSTRIDGE DRIVE OAKVILLE ON L6H 7A2

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

ASHA SEHGAL (159)

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 28, 29, 2015

During the course of the inspection the inspector reviewed clinical records, interviewed staff and reviewed home's internal investigation report.

During the course of the inspection, the inspector(s) spoke with Director of Care, Registered Nursing staff, Personal Support Workers (PSWs) and residents.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Reporting and Complaints

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. (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):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of an incident within one business day after the occurrence of the Critical Incident which resulted in a significant change in the resident's health condition.

Review of clinical record indicated on a specified date in May 2015 resident #001 had experienced a critical incident that resulted in a significant change in the resident's health condition and for which the resident was taken to hospital. The Critical Incident report submitted to the Director indicated that the resident was admitted to the hospital on life support. The home submitted a critical incident report on a specified date in May 2015 to the Director concerning a critical incident after the licensee had received notification of the resident dying.

Documented progress notes May 2015, identified the home received an update from a hospital nurse that the resident was on life support, unresponsive and unspecified diagnosis.

In May 2015 on a specified date during the interview with the Director of Care, it was confirmed that the critical incident occurred on a specified date in May 2015 and the home did not inform the Director within one business day after the occurrence of the incident when there was a significant change in the resident's condition.

The documentation, critical incident submitted to the Ministry of Health also confirmed this incident occurred in May 2015 and the report was submitted on a specified date in May 2015. [s. 107. (3) 4.]

Issued on this 3rd day of June, 2015

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

Original report signed by the inspector.