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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2018	2018_626501_0018	011570-17, 013628-17, 027772-17, 029644-17, 007622-18	Critical Incident System

Licensee/Titulaire de permis

Providence St. Joseph's and St. Michael's Healthcare
3276 St. Clair Avenue East TORONTO ON M1L 1W1

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

Providence Healthcare
3276 St. Clair Avenue East SCARBOROUGH ON M1L 1W1

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

SUSAN SEMEREDY (501)

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): October 16, 17 and 18, 2018.

This Critical Incident System (CIS) inspection was initiated in order to increase the sample size for non-compliance found in complaint inspection 2018_626501_0017. The inspections were conducted concurrently.

The following CIS intakes were inspected during this inspection:
Log #027772-17, CIS#C554-000059-17 related to falls prevention and management, and
Log #007622-18, CIS#C554-000021-18 related to falls prevention and management and critical incident reporting.

PLEASE NOTE: A written notification and voluntary plan of correction related to O.Reg 79/10 s. 49(2) was identified in this inspection and has been issued in complaint inspection report 2018_626501_0017.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Care Manager (RCM), Clinical Informatics Specialist, registered nurses (RNs), registered practical nurses (RPNs), and resident assistants (RAs).

During the course of the inspection the inspector observed the delivery of resident care and services, observed staff to resident interactions, and reviewed resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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. (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:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that where an incident occurred that caused an injury to a resident for which the resident was taken to a hospital and which resulted in a significant change in the resident's health status, a report was made in writing to the Director setting out the outcome or current status of the individual or individuals who were involved in the incident.

The home submitted CIS report #C554-000021-18 to the Ministry of Health and Long-Term Care on an identified date. According to the report, resident #003 had a fall, was sent to the hospital and was diagnosed with an identified medical condition and was awaiting an identified procedure.

During an interview with Resident Care Manager (RCM) #116, they acknowledged the report failed to set out the outcome or current status of the individual or individuals who were involved in the incident. [s. 107. (4) 3. v.]

Issued on this 24th day of October, 2018

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

Original report signed by the inspector.