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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 10, 2014	2014_289550_0001	O-001174-13, O-001175-13	Critical Incident System

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET, OTTAWA, ON, K1N-5C8

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

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA, OTTAWA, ON, K1C-2Z6

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

JOANNE HENRIE (550)

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): January 8 and 9, 2014

During the course of the inspection, the inspector(s) spoke with the Program manager of LTC, Administrator, Director of Care, Registered Nurse, Registered Practical Nurses, Personal Support Workers, Resident #001 and Resident #002

During the course of the inspection, the inspector(s) reviewed two Critical Incident Reports and the resident's health records.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention

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. (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 failed to comply with the O.Reg.79/10, in that the Director was not notified within three business days of a transfer to Hospital due to Resident #001 and #002's injury.

Inspector #550 reviewed a Critical Incident related to a transfer to Hospital following a fall where Resident #001 sustained a fracture. Resident #001 was transferred to the Hospital on a specific date in November 2013. The Hospital contacted the Home on a specific date in November 2013 to inform them the resident was being admitted for a fracture. The Home reported this incident to the Director on a specific date in December 2013, 18 days after becoming aware of a significant change in Resident #001's condition.

Inspector #550 reviewed a Critical Incident related to a transfer to Hospital following a fall where Resident #002 sustained a fracture. Resident #002 was transferred to the Hospital on a specific date in September 2013. The resident's daughter contacted the Home on a specific date in September 2013 to inform them the resident was being admitted for a fracture and was pending surgery. The Home reported this incident to the Director on a specific date in December 2013, 71 days after becoming aware of a significant change in the resident #002's condition. [s. 107. (3.1)]

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Issued on this 10th day of January, 2014

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

Joanne Lennie #550