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
Mar 23, 2016	2016_461552_0009	032677-15, 035592-15	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

THORNTONVIEW
186 THORNTON ROAD SOUTH OSHAWA ON L1J 5Y2

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

MARIA FRANCIS-ALLEN (552)

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): March 16, 17 & 18, 2016

Log #035592-15 related to complication following a fall and log #032677-15 related to responsive behaviors resulting in injury

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Physiotherapist (PT) and residents.

Also the inspector toured the home, observed staff to resident interaction, resident to resident interaction, reviewed resident's clinical health records and the home's policy related to Falls and Responsive Behaviours.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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).

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:
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).

Findings/Faits saillants :

1. 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.

Regarding log # 035592-15

A Critical Incident Report (CIR) was submitted by the home to the Director on an identified date, indicating that five days earlier, resident #001 was found on the floor. The resident was assessed and complained of discomfort; the resident was engaged in usual activities during the day shift. Later that day, the resident complained of increased discomfort and the next day was unable to move a specific body part. The resident was seen by the physician and sent to the hospital for further examination.

Review of progress notes indicated that on an identified date, the resident's family member called the home to inform them the resident was being admitted to hospital and would be scheduled for surgery.

During an interview with the Acting Director of Care and the Administrator, they both indicated the incident was not reported to the Director as outlined in the legislation.

The home failed to inform the Director within one business day of the incident that resulted in the resident being sent to hospital. [s. 107. (3) 4.]

2. The licensee has failed to ensure that the written report included a description of the individual in the incident including:
(ii.) names of any staff members or other persons who were present at or discovered the incident,

Regarding log # 035592-15

A CIR was submitted by the home on an identified date indicating that five days earlier, resident #001 had fallen and was found by a Personal Support Worker (PSW) sitting on the floor. The CIR did not provide the identity of the staff member.

During an interview with the Acting Director of Care and the Administrator, they acknowledged the name of the staff member who discovered the resident was not included in the CIR as outlined in the legislation. [s. 107. (4) 2.]

Issued on this 23rd day of March, 2016

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

Original report signed by the inspector.