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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 17, 2019	2019_626501_0008	012902-17, 022533-17, 026656-17, 027007-17, 027301-17, 028107-17, 018483-18, 030342-18, 031463-18	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

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): March 27, 28, 29, April 1, 2, 3, 4, 5, 9, 10, 11, 2019.

This inspection was inspected concurrently with inspection #2019_626501_0009.

The following follow up intake was inspected:

Intake #031463-18 related to compliance order #001 from inspection #2018_687607_0005

The following critical incident system (CIS) intakes were inspected related to falls prevention and management:
Log #027301-17
Log #027007-17
Log #026656-17
Log #028107-17
Log #018483-18
Log #030342-18
Log #022533-17

The following CIS intake related to the prevention of abuse and neglect and responsive behaviours was inspected:
Log #012902-19

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), registered nurse (RN), registered practical nurses (RPN), personal support workers (PSW), and physiotherapist (PT).

During the course of the inspection, the inspector reviewed health care records, the licensee's monitoring systems as required for the compliance order, relevant policies and procedures and video surveillance footage.

The following Inspection Protocols were used during this inspection:

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6.	CO #001	2018_687607_0005	501

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	Légende 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. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care on an identified date, which stated that resident #022 had a fall on an identified date which had occurred seven days previously. The resident had been found with an injury and had been taken to the hospital.

A review of resident #022's progress notes indicated they returned from the hospital on an identified date with an identified treatment to an identified body part. A day later, it was documented in the progress notes that the resident had identified symptoms. Referrals were made to identified team members. Later on the same day, the resident was noted to have further identified symptoms. Medical records documentation a few day later indicated that the resident had a possible injury to an identified area of the body. According to further documentation, the resident continued to decline and passed away on an identified date.

An interview with DOC #102 indicated the reason the home had not informed the Director no later than one business after the resident had a significant change in health status was because they were unaware of the meaning of significant change. The home reported the incident on an identified date, after finding about there was an injury. The DOC acknowledged they should have informed the Director, the day after the resident's return from hospital when further symptoms appeared.

The licensee failed to ensure the Director was informed of resident #022's fall no later than one business day after the occurrence that caused injury for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition. [s. 107. (3) 4.]

Issued on this 23rd day of April, 2019

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

Original report signed by the inspector.