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 # / Registre no	Type of Inspection / Genre d'inspection
Sep 2, 2016	2016_285126_0018	007177-16, 006119-16, 024285-16	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

ÉLISABETH-BRUYÈRE RESIDENCE
75 BRUYERE STREET OTTAWA ON K1N 5C8

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

LINDA HARKINS (126)

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): August 11 and 12, 2016

During this inspection, three Critical Incidents were inspected; two related to allegation of abuse and one related to an incident that caused an injury to a resident which the resident was taken to the hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care/ Clinical Manager, the Charge Nurse, Registered Practical Nurses (RPN), Personal support Workers (PSW) and two residents.

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

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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Log # 024285-16
The licensee failed to inform the Director no later one business day after the occurrence of an incident that caused an injury to a resident # 001, that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

On a specify date in June 2016, a resident transferred independently without waiting for the assistance of the nursing staff. Resident # 001 fell and sustained an injury. Resident # 001 returned to the home on specific date in July 2016 with significant changes in her health condition.

On August 12, 2016, Inspector # 126 held a discussion with the new Director of Care (DOC)/Clinical Manager(CM). The new DOC/CM indicated that she started the position at the end of May 2016. She indicated that she was aware that resident # 001sustained an injury that resulted in a significant changes in his/her health condition. The new DOC/CM indicated that she was not aware of legislative requirements of notifying the Long Term Care Home(LTCH) Director [107.(3)(4)]. On August 4, 2016, the previous CM was on site providing support to the new DOC/CM and indicated to her that a critical incident report was to be submitted for the above incident.

The LTCH Director was not notified of the incident of June 2016 until August 4th, 2016 when the Critical Incident was submitted. [s. 107. (3)]

Issued on this 2nd day of September, 2016

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

Original report signed by the inspector.