



**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
Direction de l'amélioration de la
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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
Mar 6, 2015	2015_347197_0008	O-001325-14	Critical Incident System

Licensee/Titulaire de permis

CROWN RIDGE HEALTH CARE SERVICES INC
106 CROWN STREET TRENTON ON K8V 6R3

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

WESTGATE LODGE NURSING HOME
37 WILKIE STREET BELLEVILLE ON K8P 4E4

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 4, 2015

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Assistant Director of Care, a Registered Nurse, a Registered Practical Nurse and a Personal Support Worker.

The inspector also made resident observations and reviewed a resident's health care record, a critical incident report and the home's Falls Prevention and Management Program.

**The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention**

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	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. The licensee has failed to comply with O. Reg. 79/10, s. 107(3)4 in that an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to hospital, was not reported to the Director within one business day after the occurrence.

"significant change" means a major change in the resident's health condition that,

- will not resolve itself without further intervention,
- impacts on more than one aspect of the resident's health condition, and
- requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

On a specified date, Resident #1 sustained a fall.

The next day, Resident #1 was assessed as having an increase in pain, was unable to weight bear and was then sent to hospital for further assessment. The progress notes indicate that the hospital called that same day and stated that Resident #1 was being admitted with a fracture.

The Critical Incident Report was first submitted to the Ministry of Health and Long-Term Care 4 business days after the incident occurred. [s. 107. (3)]

Issued on this 6th day of March, 2015

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

Original report signed by the inspector.