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
Feb 26, 2014	2014_103193_0001	T-165, 177-14	Critical Incident System

Licensee/Titulaire de permis

WOODS PARK CARE CENTRE INC.
110 LILLIAN CRESCENT, BARRIE, ON, L4N-5H7

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

WOODS PARK CARE CENTRE
110 LILLIAN CRESCENT, BARRIE, ON, L4N-5H7

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

MONICA NOURI (193)

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 27, 2014.

During the course of the inspection, the inspector(s) spoke with the director of care.

During the course of the inspection, the inspector(s) reviewed applicable Critical Incident reports.

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

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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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees.
O. Reg. 79/10, s. 107 (1).

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:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

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:
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. This non-compliance is related to r. 107. (1). Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. [s. 107. (1)]

2. The licensee failed to ensure that the Director is immediately informed, in as much detail as possible, in the circumstances of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

Two Critical Incidents reports were submitted by the licensee on January 8, 2014.
Critical Incident report #2821-000002-14, was submitted to report a respiratory outbreak declared by Public Health as started on December 9, 2013 and declared over on December 27, 2013.
Critical Incident report #2821-000003-14, was submitted to report an enteric outbreak declared by Public Health as started on December 23, 2013 and declared over on January 3, 2014.
The two above mentioned incidents were not reported immediately as required; they were submitted 30 days and respectively 16 day later.
Interview with the home's director of care confirmed the late reporting of both Critical Incident reports. [s. 107. (1)] [s. 107. (1)]

3. The licensee failed to ensure that, within 10 days of becoming aware of an outbreak of a reportable or communicable disease, makes a report in writing to the Director.

Two Critical Incidents reports, #2821-000002-14 and #2821-000003-14, were submitted by the licensee on January 8, 2014 in relation to an enteric and a respiratory outbreak.
The license became aware of the respiratory outbreak on December 9, 2013, and of the enteric outbreak on December 23, 2013.
Staff interview confirmed both reports were not submitted within 10 days as required; they were submitted 30 days and respectively 16 day later. [s. 107. (4) 1.]

4. The licensee failed to ensure that the written reports include whether an inspector was contacted and, if so, the date of the contact and the name of the inspector.

Record review indicated and staff interview confirmed the Critical Incidents reports #2821-000002-14 and #2821-000003-14, submitted on January 8, 2014, related to the enteric and respiratory outbreaks, did not include whether an inspector has been contacted, and, if so, the date of the contact and the name of the inspector. [s. 107. (4) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is immediately informed, in as much detail as possible, in the circumstances of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act, to be implemented voluntarily.

Issued on this 26th day of February, 2014

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

Monica Nouri