Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
August 5 and 6, 2010	2010_147_2942_04Aug161241	Critical Incident – H-00415

Licensee/Titulaire
Holland Christian Homes Inc.
7900 McLaughlin Road South
Brampton, ON
L6Y 5A7

Long-Term Care Home/Foyer de soins de longue durée
Grace Manor
45 Kingknoll Drive
Brampton, ON
L6Y 5P2

Name of Inspector/Nom de l'inspecteur

Laleh Newell

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with:

Director of Care, Assistant Director of Care, Administrator, 2N RPN and the resident.

During the course of the inspection, the inspector:

- Interviewed Sandra, RPN and resident
- Clinical chart and progress notes reviewed
- Policy and Procedure related to abuse and neglect reviewed
- Internal investigation and Internal incident report reviewed
- The personnel files of the staff who were involved in the incident reviewed.

The following Inspection Protocols were used in part or in whole during this inspection:

- Critical Incident Response Inspection Protocol
- Prevention of Abuse and Neglect Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with The Long-Term Care Homes Program Manual Standards and Criteria.
M1.18 - The facility's policies, procedures, and work routines shall be followed in the provision of care and services. Staff shall be re-instructed when required.

Findings:

1. An identified resident was found on the floor in the resident's room on May 19, 2010 and incontinent of stool for approximately five hours before staff became aware. Documentation in the resident's progress notes indicate staff did respond to the resident, however did not follow home's policy and procedures related to completing an incident report and notifying the manager on call.

Inspector ID #:	147

WN #2: The Licensee has failed to comply with The Long-Term Care Homes Program Manual Standards and Criteria.

A1.31 - All concerns and complaints received shall be documented, including a list of the issues, date expressed, date and follow up action taken, final resolution if any, and date feedback was provided to the complainant.

Findings:

1. The incident related to an identified resident's fall which occurred on May 19, 2010 was not reported to the Ministry of Health and Long Term Care (MOHLTC) until June 30, 2010. Documentation indicates the home became aware of the incident on June 2, 2010 as the resident reported the incident to the staff.

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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 be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Nov 26/10.
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).