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
Sep 3, 2014	2014_283544_0023	S-000101, 149, 164, 322-14	Critical Incident System

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST
21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2

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

BELVEDERE HEIGHTS
21 BELVEDERE AVENUE, PARRY SOUND, ON, P2A-2A2

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

FRANCA MCMILLAN (544)

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 19, 20, 2014 in relation to:

Log # S-000101-14
Log # S-000164-14
Log # S-000149-14
Log # S-000322-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Associate Director of Care, Registered Staff, Personal Support Workers (PSWs), Residents and Families.

During the course of the inspection, the inspector(s) observed the delivery of care and services to the Resident, staff to Resident interactions, reviewed policies and procedures for the Falls Prevention and Management Program, staff education regarding the Falls Prevention and Management Program, reporting regarding Critical Incidents, Resident health care records including progress notes, residents plans of care, and post falls assessments that were conducted for the residents involved in the critical incidents.

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

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. (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. Inspector # 544 reviewed the following Critical Incident Reports:

(A) CI M503-000006-14 Resident # 002
(B) CI M503-000009-14 Resident # 003
(C) CI M503-000007-14 Resident # 004

(A) Resident # 002 sustained a fall which resulted in a transfer to hospital and was admitted to hospital after suffering a fracture.

The critical incident was not reported to the Director within one business day after the occurrence of the incident.

(B) Resident # 003 sustained a fall. Resident # 003 was transferred to the hospital for X-rays which revealed a fracture and other injuries.
Resident # 003 had another fall at the home and was assessed by the physician at the home. It was decided that no further intervention was required at this time.
The physician re-assessed Resident # 003 due to some issues that Resident # 003 was experiencing. The physician ordered an X-ray which identified a fracture.

The licensee did not inform the Director of both injuries in which a Resident was taken to hospital and had a significant change in their condition within one business day.

(C) Resident # 004 sustained a fall. Staff observed that the Resident was experiencing pain.
Resident # 004 was accompanied to the hospital and had X-rays taken. Resident # 004 had sustained a fracture.

All above information was confirmed by Staff # 102

The licensee failed to ensure that the Director is informed within one business day after the occurrence of an injury that results in a significant change in the Resident's health condition and for which the resident is taken to a hospital. [s. 107. (3)]

Issued on this 8th day of September, 2014

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