



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4ième étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Table with 4 columns: Report Date(s) / Date(s) du Rapport, Inspection No / No de l'inspection, Log # / Registre no, Type of Inspection / Genre d'inspection. Row 1: Apr 3, 2014, 2014\_195166\_0005, O-000691-13, Critical Incident System

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PORT PERRY)
15941 Simcoe Street, Port Perry, ON, L9L-1N5

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

CAROLINE TOMPKINS (166)

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): February 10, 11, 2014

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Nurses, Registered Practical Nurses, Quality Coordinator, Director of Care, Administrator.

During the course of the inspection, the inspector(s) reviewed the documentation records for Resident #6.

The following Inspection Protocols were used during this inspection:



**Critical Incident Response  
Personal Support Services**

**Findings of Non-Compliance were found during this inspection.**

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**



Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).

(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

---

**Findings/Faits saillants :**

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change.

On an identified date, Resident #6 sustained an injury during a health crisis.

A physical assessment of the resident's status was completed immediately post incident.

Clinical records indicate the resident continued to complain of pain. Analgesic was administered several times (6) in a two day period with moderate to minimum effect. The resident was transferred to the hospital for further assessment.

There is no evidence that Resident #6 was reassessed when analgesic was administered to the resident and when the resident continued to complain of pain.[s.

6. (10) (b)]

***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 the licensee shall ensure that residents are reassessed and the plan of care reviewed when residents' needs change, to be implemented voluntarily.***

---

**WN #2: 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 :**

The licensee failed to inform the Director no later than one business day after the occurrence of the incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

A critical incident was received reporting Resident #6 sustained an injury during a health crisis. The resident continued to complain of pain and was transferred to the hospital for further assessment, 2 days post incident.

The Director was not notified of the incident within the legislated time frame[s. 107. (3)]

---



Ministry of Health and  
Long-Term Care

Ministère de la Santé et des  
Soins de longue durée

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

Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée

Issued on this 3rd day of April, 2014

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

Caroline Tompkins  
#166