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

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	2013_215123_0016	H-000309-13	Critical Incident System

Licensee/Titulaire de permis

DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7

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

ERIN MILLS LODGE NURSING HOME
2132 DUNDAS STREET WEST, MISSISSAUGA, ON, L5K-2K7

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

MELODY GRAY (123)

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): July 30, 31, August 1, 21, 22, 23, 27, 28, 29, 30 and September 18, 2013

Concurrent inspection #2013_215123_0017/H-001930-12,H-00105-13,H-000368-13,H-000602-13
PLEASE NOTE: One non-compliance was identified related to the Licensee's failure to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee of a long-term care home is required to have, institute or otherwise put in place is complied with. This non-compliance [O.Reg.79/10,s.8 (1)]was issued in Inspection #2013_215123_0017,conducted concurrently, and is contained in the report of that inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Staff, Personal Support Workers(PSW) and residents.

During the course of the inspection, the inspector(s) reviewed the home's records including policies and procedures, reviewed residents' records including care plans, observed resident care and observed available equipment and supplies in the home.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. While being transported by staff, an identified resident(#007) fell from the wheelchair when their shoes got caught on the floor. The resident suffered injury as a result of the fall and was taken to the hospital. The home's records related to the incident were reviewed and it was noted that the resident's wheelchair foot pedals were not on the wheelchair during the transport. The home's staff education records, investigation records and policies and procedures including: Minimal Lift Policy and Procedures #HS-04-02-06; Falls Prevention Assessment and Management #RCM04-04-01 and Wheelchair Safety #HS-04-02-05 were reviewed and it was noted that: Both foot rests must be down, the resident's feet on the foot rests, hands away from wheels, and elbows tucked in, while the chair is being pushed. The resident's record including the care plan was reviewed and it indicated that the staff were to ensure that the wheelchair foot pedals were to be attached and that the resident's feet were to be secured on the pedal for locomotion on the unit. The Director of Care(DOC)was interviewed and reported that the staff did not follow the resident's plan of care or the home's policies and procedures related to wheelchair safety during transport of the resident in the wheelchair. [s. 6. (7)]

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 :

1. The licensee failed to inform the Director no later than one business day after the occurrence of the incident of an injury in respect of which a person is taken to hospital. The record of resident (#007)was reviewed. The resident was taken to the hospital as a result of injuries they sustained from a fall while being transported by staff in their wheelchair and the occurrence was not reported to the Director until five days later. The Administrator was interviewed and reported that the incident happened over a long-weekend. The Director of Care (DOC) was away from the home and did not immediately complete the report upon their return. [s. 107. (3)]

Issued on this 26th day of February, 2014

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