



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 prévue le Loi de 2007 les foyers de soins de longue

**Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité**

**Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133**

**Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133**

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 23, 24, 27, 2012	2012_099188_0030	Critical Incident

Licensee/Titulaire de permis

**LADY DUNN HEALTH CENTRE
17 Government Road, Box 179, Wawa, ON, P0S-1K0**

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

**LADY DUNN HEALTH CENTRE
17 Government Road, P.O. Box 179, Wawa, ON, P0S-1K0**

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Director of Patient Care Services, Registered Nursing Staff, the Assistant to the Director of Patient Care Services and Personal Support Workers.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff and resident interactions and reviewed health care records.

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 subsections:

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.**
- 2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.**
- 3. A missing or unaccounted for controlled substance.**
- 4. An injury in respect of which a person is taken to hospital.**
- 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 reviewed critical incident report. Inspector noted that a resident sustained an injury for which they were transferred to hospital. Inspector noted this incident was reported outside of the one business day reporting time frame. The licensee failed to ensure that the Director is informed no later than one business day after an injury in respect of which a person is taken to hospital. [O. Reg. 79/10, s.107(3)(4)]

Issued on this 27th day of August, 2012



**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
prévus le Loi de 2007 les
foyers de soins de longue**

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

A handwritten signature in black ink, appearing to read "M. [unclear]". The signature is written in a cursive style.