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

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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
Nov 22, 2013	2013_200148_0048	O-000190-13	Complaint

Licensee/Titulaire de permis

ROYAL CANADIAN LEGION DISTRICT 'D' CARE CENTRES
59 Lawson Rd, TORONTO, ON, M1C-2J1

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

TONY STACEY CENTRE FOR VETERANS' CARE
59 Lawson Road, TORONTO, ON, M1C-2J1

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 19, 2013, on site.

During the course of the inspection, the inspector(s) spoke with Administrator, registered and non-registered nursing staff members.

During the course of the inspection, the inspector(s) reviewed the resident health care record, including plan of care and flow sheets.

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

Personal Support Services

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. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s.38 (b), whereby the licensee failed to ensure that a resident or the resident's substitute decision maker is notified when the resident requires new personal belongings.

The substitute decision maker (SDM) of Resident #1 informed the inspector that the resident had been missing dentures for several days prior to the SDM being notified of the missing personal belongings. A review of the resident's health care record confirmed that the resident's dentures were missing and that the SDM was not notified of the missing dentures until several days after the staff of the home identified them as missing. [s. 38. (b)]

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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s.107 (1) 2., whereby the licensee did not ensure that the Director is immediately informed of an unexpected or sudden death.

In accordance with O.Reg. 79/10, s.107 (1) and (4), a licensee shall ensure that the Director is immediately informed, in as much detail as is possible of an unexpected or sudden death. The licensee is also required to provide a written report to the Director, as described by subsection 4, within 10 days of becoming aware of the incident.

On a specified date, the health status of Resident #1 deteriorated leading to the absence of vital signs. A review of the health care record and interviews with staff demonstrate that the death of Resident #1 was unexpected.

The Administrator of the home confirmed that the Director was not immediately informed by the licensee of the sudden death, described above, nor has a written report made to the Director, as of November 19, 2013, as required by O.Reg. 79/10, s.107(4). [s. 107. (1)]

Issued on this 22nd day of November, 2013

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

Amanda Nix RD LTCH Inspector