Ontario

Ministry of Health and Long-Term Care

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

Ministére 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
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 27, 30, 31, Aug 2, 7, 2012	2012_030150_0016	Critical Incident

Licensee/Titulaire de permis

NORTH RENFREW LONG-TERM CARE SERVICES INC.
47 Ridge Rd, DEEP RIVER, ON, K0J-1P0

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

NORTH RENFREW LONG-TERM CARE SERVICES INC.
47 RIDGE ROAD, P.O. BOX 1988, DEEP RIVER, ON, K0J-1P0

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

CAROLE BARIL (150)

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 Administrator, Director of Care, Resident Assessment Instrument (RAI) Coordinator, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW)

During the course of the inspection, the inspector(s) reviewed the home's infection control related policies and procedure, the fall prevention program, infection control committee minutes, training program for staff, infection symptoms tracking sheet, observed the location of the hand sanitizer and supplies, interviewed the staff above and observed resident care.

During the course of this inspection, the inspector conducted two critical incident inspections, log# O-002735-11, log# O-000079-12.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Infection Prevention and Control

Findings of Non-Compliance were found during this inspection.

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NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (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 loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.

2. An unexpected or sudden death, including a death resulting from an accident or suicide.

3. A resident who is missing for three hours or more.

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

The licensee has failed to comply with O.Reg 79/10, s.107 (1) 5, in that the licensee did not immediately inform the Director of an outbreak.

The gastroenteritis outbreak was declared in December 28, 2011. The Director was notified of the outbreak on January 11, 2012, 15 days after its onset.

Issued on this 7th day of August, 2012

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