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

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
Jun 6, 2014	2014_339579_0008	S-000520-13,S-000039-14	Critical Incident System

Licensee/Titulaire de permis

SMOOTH ROCK FALLS HOSPITAL
107 KELLY ROAD, P.O. BOX 219, SMOOTH ROCK FALLS, ON, P0L-2B0

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

SMOOTH ROCK FALLS HOSPITAL
107 KELLY ROAD, P.O. BOX 219, SMOOTH ROCK FALLS, ON, P0L-2B0

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

JANET MCNABB (579)

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): May 28 and 29, 2014

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Registered Staff, Personal Support Workers and the Activity Coordinator.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas, reviewed various policies and health records, interviewed staff and observed staff to resident interactions.

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:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. Inspector reviewed a Critical Incident (CI) report pertaining to a Disease Outbreak incident in the home that occurred in 2013. The inspector identified that required pieces of information were not submitted to the Director at any time: a description of the individuals involved in the incident, including, names of residents involved in the incident.
The licensee did not ensure that an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
(4)2 A description of the individuals involved in the incident, including,
(i) names of any residents involved in the incident. [s. 107. (4) 2.]

2. Inspector reviewed a Critical Incident (CI) report pertaining to a Disease Outbreak incident in the home that occurred in 2013. The inspector identified that required pieces of information were not submitted to the Director at any time: actions taken in response to the incident, including, the outcome or current status of the individual or individuals who were involved in the incident.
The licensee did not ensure that an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
(4)3 Actions taken in response to the incident, including,
v. the outcome or current status of the individual or individuals who were involved in the incident. [s. 107. (4) 3.]

Issued on this 6th day of June, 2014

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