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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2018	2018_589641_0004	027415-17, 028090-17, 029468-17	Critical Incident System

Licensee/Titulaire de permis

Crown Ridge Health Care Services Inc.
106 Crown Street TRENTON ON K8V 6R3

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

Westgate Lodge Nursing Home
37 Wilkie Street BELLEVILLE ON K8P 4E4

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

CATHI KERR (641)

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): January 31, February 1 and 2, 2018.

The following logs were inspected during this inspection:
Log #027415-17, Log #028090-17 and Log #029468-17.

During the course of the inspection, the inspector(s) spoke with the Administrator (Admin), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.
During the course of the inspection, the inspector reviewed resident care and services, staff to resident interactions, reviewed resident health care records, Critical Incident System reports (CIS) and relevant licensee investigation notes and policies and procedures related to falls prevention.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (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 has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

A critical incident was submitted to the Director on a specified date, indicating that resident #003 fell five days earlier and sustained an injury.

On February 2, 2018, the Inspector reviewed with the Assistant Director of Care (ADOC) the critical incident that had been submitted to the Director related to resident #003's fall on a specified date. The ADOC acknowledged that the critical incident had been submitted three business days after the incident had occurred. The ADOC reviewed the resident's progress notes with the Inspector, which indicated that there had been a progress note the day after the incident occurred, stating that resident #003 would likely require more treatment at the hospital.

During an interview with the Inspector on February 2, 2018, the Administrator (Admin) indicated that she had been aware that resident #003 had a significant injury, but had waited for further information from the hospital about the status of the resident before submitting the critical incident to the Director.

The licensee failed to ensure that the Director was informed no later than one business day after resident #003 fell, sustaining a significant injury. Log #028090-17 [s. 107. (3)]

Issued on this 13th day of February, 2018

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

Original report signed by the inspector.