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 # / Registre no	Type of Inspection / Genre d'inspection
Jun 14, 2017	2017_639607_0011	009643-17, 009644-17	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

WINBOURNE PARK
1020 Westney Road North AJAX ON L1T 4K6

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

JULIET MANDERSON-GRAY (607)

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 30, 31 and June 1 and 2, 2017

During the Critical Incident Inspection the following intakes were inspected: Logs # 009643-17,009644-17 and 008982-17.

Summary of Intakes:
1) 009643-17: A Critical Incident Report, regarding an incident that causes injury to a resident for which the resident was taken to hospital.
2) 008982-17: A Critical Incident Report, regarding a fall that resulted in injury to a resident, for which the resident was taken to hospital.
2) 009644-17: A Critical Incident Report, regarding an alleged resident to resident physical abuse that resulted in harm to a resident.

During the course of the inspection, the inspector(s) spoke with the Director of Care, a Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Student Personal Support Worker and a Resident.

During the course of the inspection, the Inspector reviewed Clinical Health Records, observed staff to resident interactions, reviewed Training Records, and home specific policies related to Safe Resident Handling and Fall Prevention and Injury.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **2 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. (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).

Findings/Faits saillants :

1. 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.

Related to Log #008982-17 involving resident #001:

A Critical Incident Report (CIR), was submitted to the Director on an identified date and time in May 2017, for an incident related a fall resulting in an injury sustained to resident #001, resulting in transfer to the hospital, that occurred in April 2017, at an identified time. The CIR indicated that resident #001 was in the hallway when a loud shout was heard by an unidentified Personal Support Worker (PSW). The resident was found on the floor.

A review of the amended CIR with an identified date in May 2017, indicated that and unidentified PSW responded to or discovered the above identified incident, but was not identified in the CIR.

Interview with the DOC, by the Inspector #607, indicated the unidentified PSW's name was not included in the CIR.

The Licensee failed to ensure that the report to the Director included the names of all staff who responded, were present or either discovered the incident, specifically related to resident #001. [s. 107. (4) 2.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The Licensee has failed to ensure staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Related to Log #009643-17 involving resident #001:

A Critical Incident Report (CIR) was submitted to the Director on an identified date and time in May 2017, for an incident that occurred related to a fall resulting in an injury, in May 2017, at an identified time involving resident #001 for which the resident was taken to hospital.

A review of the clinical health records for resident #001, indicated the resident was receiving medications twice daily for three days. Further review of the resident #001's clinical health records failed to locate staff documentation of the resident symptoms, for three identified shifts:

Interview of the RPN #107 and the DOC on an identified date in May, 2017, both indicated to the Inspector, if a resident is receiving a certain medication, the home's expectation is symptoms of infection be recorded every shift, in the home's electronic record system.

This finding is being issued related to resident #003, related to Inspection #2017_639607_0012:

A review of the clinical health records for resident #003, indicated the resident was receiving an identified medication twice daily for 10 days. Further review of the resident #001's clinical health records failed to locate staff documentation of the resident symptoms for two identified shifts:

Interview with RPN #107 and the DOC on May 30, 2017, both indicated to the Inspector, if a resident is receiving a certain medication, the home's expectation is the resident symptoms be recorded every shift, in the home's electronic record until the completion of the medication.

The Licensee failed to ensure staff monitor residents symptoms on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, specifically related to the monitoring of resident #001 and #003's when receiving an identified medication. [s. 229. (5) (a)]

Issued on this 14th day of June, 2017

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

Original report signed by the inspector.