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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 12, 2019	2019_671684_0010	001585-19	Critical Incident System

Licensee/Titulaire de permis

West Parry Sound Health Centre
6 Albert Street PARRY SOUND ON P2A 3A4

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

Lakeland Long Term Care (Eldcap)
6 Albert Street PARRY SOUND ON P2A 3A4

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

SHELLEY MURPHY (684)

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): March 4-8, 2019.

The following intake was inspected during this Critical Incident (CI) Inspection:

-One Log, related to falls prevention.

A Critical Incident Inspection #2019_671684_0009 for Lakeland Long Term Care was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and Residents.

The Inspector also conducted daily tours of the resident care areas, observed provision of care and services, reviewed relevant licensee policies, procedures, programs and resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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	Légende 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. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.
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 of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Inspector #684 reviewed the Critical Incident (CI) report which was submitted to the Director on a specified day in 2019, for an incident which occurred four days earlier. The report was for an incident that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health status. The CI report indicated after the incident the resident showed a change in condition, it also indicated that the resident's health further declined the day before the CI report was submitted to the Director.

Inspector #684 reviewed resident #004's progress notes which indicated that resident #004 had an incident occur on a specified day in 2019, and was sent to the hospital, as they were exhibiting a change in condition. The progress notes further indicated on another specified day in 2019, that resident #004 showed further change in condition and the nurse manager was made aware of this by the hospital.

Inspector #684 reviewed the home's policy "Reporting Process for Critical Incidents", 4.20 ADO-O.P. which was last reviewed October2018. The policy stated: "A member of the Senior Leadership team will ensure that the Director is informed of the following incidents at LLTC no later than one business day after the occurrence of the incident, followed by a report required under 107 (4) of the Ministry of Health and Long Term Care (MOHLTC) Act:
An incident that causes an injury to a resident for which the resident is take to a hospital and that results in significant change in the resident's health condition".

Inspector #684 interviewed the DOC who stated that not submitting the Critical Incident (CI) before the date that it was submitted in 2019, was an error on their part, as initially the hospital informed them that they thought resident #004 had one diagnosis and then discovered the change in condition was related to a different diagnosis. The DOC went on to state that "Yes" the incident was reported late. [s. 107. (3)]

Issued on this 12th day of March, 2019

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

Original report signed by the inspector.