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**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 13, 2017 | 2017_395613_0001 | 033451-16, 034033-16, 000018-17, 000032-17, 000530-17, 000657-17 | Critical Incident System |

### Licensee/Titulaire de permis

RIVERSIDE HEALTH CARE FACILITIES, INC.
110 VICTORIA AVENUE FORT FRANCES ON P9A 2B7

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

RAINYCREST
550 OSBORNE STREET FORT FRANCES ON P9A 3T2

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

LISA MOORE (613)

## 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 9-13, 2017**

**The following intakes were completed during this inspection:**
**Two Critical incident reports submitted by the home related to resident to resident abuse;**
**Two Critical incident reports submitted by the home related to concerns of resident to resident abuse;**
**Two Critical incident reports submitted by the home related to resident falls that resulted in injuries.**

**During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Administrative Assistant (AA), Psychogeriatric Lead, and Outreach PSW from the Canadian Mental Health Association**

**The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.**

**A concurrent Complaint Inspection #2017_395613_0002 was also completed during this inspection.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**
**Minimizing of Restraining**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**

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

**7 WN(s)**
**5 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out, the planned care for the resident.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director in December 2016, which identified resident #006 had been found on the floor, leaning against the bed rail on their bed in December 2016. The CI report revealed that resident #006 sustained a minor injury. A review of the comments written on the Ministry of Health and Long-Term Care (MOHLTC) Incident report, from when RN #115 had telephoned the Long-Term Care Home Emergency pager in December 2016, identified that the "resident fell out of bed and because the bed had not been in the lowest position, resident sustained an injury. Staff had neglected to lower the bed as it should have been".

A review of the resident's electronic progress notes on Gold Care identified that the resident was found on the floor, leaning against the bed rail on their bed. It was documented that resident #006's bed was not in the lowest position, the bed was mid-way between the highest and the lowest position.

On January 12, 2017, the Inspector interviewed PSW #109, who confirmed that staff were expected to ensure that residents' beds were in the lowest position when they put them into their beds.

A review of the resident's care plan at the time of the incident did not identify an intervention to maintain the bed in the lowest position when resident #006 was in it. The care plan had been updated after the incident to include this intervention in December 2016.

On January 11, 2017, the Inspector interviewed the Administrator (ADM), Director of Care (DOC) and Assistant Director of Care (ADOC). The ADM and DOC stated that it was their expectation that all residents' beds should be placed in the lowest position when residents were in their beds to ensure safety. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director in January 2017, which identified abuse between resident #003 and resident #004. Resident #004 sustained injuries as a result of the incident.

A review of resident #003's care plan identified that specific monitoring staffing had been initiated in December 2016, for specific times daily.

During interviews with PSW #111 and RPN #103, they informed the Inspector that the unit had been short staffed during a specific day shift in January 2017. When the abuse incident had occurred between resident #003 and #004, they identified that there had been no specific monitoring for resident #003.

On January 12, 2017, the Inspector interviewed the ADM, who verified that the unit had been short staffed and resident #003 did not have the specific monitoring at the time and as a result the abuse to resident #004 had occurred in January 2017. The ADM stated the staff assigned to monitor resident #003 was not available to come in for their scheduled shift and a replacement staff member did not come to work until a later specific time on that date. The incident of abuse between resident #003 and resident #004 had occurred prior to the replacement staff member arriving to work in January 2017. There was no specific monitoring of resident #003, as per their care plan in January 2017, when the incident had occurred.

No further action will be taken in regards to this non-compliance as there is currently an outstanding order for s. 6 (7) in Resident Quality Inspection #2016_463616_0026. [s. 6.

(7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for resident #006 that set out, the planned care for resident #006 and that the care set out in the plan of care is provided to resident #003 as specified in the plan, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**

**Specifically failed to comply with the following:**

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and their bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director in December 2016, which identified resident #006 was found on the floor, leaning against the bed rail on their bed in December 2016. The CI report revealed that resident #006 sustained a minor injury. A review of the comments written on the MOHLTC Incident report, from when RN #115 had telephoned the LTC Home Emergency pager in

December 2016, identified that, "resident fell out of bed and because the bed had not been in the lowest position, resident sustained an injury. Staff had neglected to lower the bed as it should have been".

On January 9, 10 and 11, 2017, Inspector #613 observed resident #006 in their bed with their bed rails in the guard position.

The Inspector reviewed the resident's health care record and the plan of care, which did not identify the use of the bed rails. As well, there was no documentation found to support that the resident had been assessed in regards to the bed rail use or that their bed system had been evaluated.

On January 12, 2017, the Inspector interviewed RPN #112 and RPN #113, both were unaware who was responsible for completing resident assessments for the use of bed rails or the bed system evaluations.

A review of the home's policy titled, "Bed Entrapment Prevention Program" last revised on September 21, 2015, indicated that the registered staff were responsible for the assessment, care planning and monitoring of bed entrapment prevention. Upon admission, re-admission and with any significant change in condition each resident was to be assessed for potential risk for entrapment on the bed (Refer to Bed Rail Assessment Form);
-the mattress condition and fit to the bed frame was to be assessed (Refer to Potential Zones for Entrapment);
-the bed rail was to be assessed for reliability for latching and for stability.

On January 11, 2017, Inspector #613 interviewed the Director of Care (DOC), who stated resident #006 used the bed rails for repositioning themselves in their bed. The DOC informed the Inspector, that a certain object had been changed on resident #006's bed, after their fall in December 2016. The Inspector requested the original resident assessment and bed system evaluation and the bed system evaluation that had been conducted after the certain object had been changed on resident #006's bed.

On the same date, the Inspector interviewed the ADM, DOC and Assistant Director of Care (ADOC). The DOC stated they had looked for resident #006's assessment forms and bed system evaluations and could not locate them. The DOC confirmed that resident #006 had not been assessed nor had their bed system been evaluated in accordance with evidence-based practices to minimize risk to the resident.

On January 12, 2017, the Inspector interviewed PSW #109, who stated resident #006 did have bed rails, but the resident was unable to use the bed rails to reposition them self while in bed. PSW #109 confirmed the care plan did not identify the use of the bed rails for the resident.

No further action will be taken in regards to this non-compliance as there is currently an outstanding order for r. 15 (1) in Resident Quality Inspection #2016_463616_0026. [s. 15. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, resident #006 is assessed and their bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.***

---

**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to protect residents from abuse by anyone and has failed to ensure that residents were not neglected by the licensee or staff.

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director in January 2017, which identified abuse between resident #003 and resident #004. Resident #004 sustained injuries as a result of the incident.

A review of resident #003's health care record, revealed that resident #003 had ten incidents of abuse towards other residents that were documented in the electronic progress notes on Gold Care during a six month period prior to the abuse incident that had occurred in January 2016. The progress notes identified that resident #003 had been provided with specific monitoring since December 2016 as resident #003 was not responding to the interventions as outlined in their care plan.

A review of resident #003's care plan, revealed under the aggression, anger/agitation nursing focus, as interventions dated December 2016, indicated that there were multiple interventions in place to manage the resident's behaviours.

During observations on January 10, 11 and 12, 2017, the Inspector noted that a specific intervention had not been properly implemented. RPN #103 verified to the Inspector that the intervention had not been implemented.

During interviews with PSW #101, PSW #110, PSW #111 and RPN #103, they all reported to Inspector #613 that they were aware of resident #003's responsive behaviours and verified that the resident had a history of displaying specific responsive behaviours towards other residents. All staff identified that they were aware of the interventions in the resident's care plan. PSW #111 and RPN #103 informed the Inspector that the unit had been short staffed during a specific shift in January 2017, when the abuse incident had occurred between resident #003 and #004, and identified that there had been no specific monitoring as per their plan of care.

On January 11, 2017, the Inspector interviewed the Director of Care (DOC), who confirmed staff and management were aware of resident #003's past abusive history and had tried to manage the abusive responsive behaviours with different interventions, but they had been unsuccessful. The DOC stated specific monitoring was implemented in December 2016, for specific times daily, to assist with monitoring and minimizing resident #003's specific responsive behaviours.

On January 12, 2017, the Inspector interviewed the Psychogeriatric Resource Lead (PRL) #108 and the Outreach PSW #107 from the Canadian Mental Health Association, who stated they had extensive involvement with resident #003, with three previous past

referrals. Regular case reviews for resident #003 had been done every 1-2 months to determine the effectiveness of the interventions in place. PRL#108 stated that some of the recommended interventions were not implemented consistently by the direct care staff. The PRL stated the day of the incident in January 2017, there had been no specific monitoring of resident #003 and a specific intervention had not been implemented. The PRL stated that other residents would be more protected if staff had consistently used the recommended interventions to reduce the level of risk to others. The PRL stated staff were very aware of resident #003's responsive behaviours and the risks they imposed to the other residents, as well other non-pharmacological interventions that had been recommended, had not been implemented.

A review of the home's policy titled, "Responsive Behaviours" with no revision date, identified that the home was committed to ensuring the needs of residents with responsive behaviours were met. The policy identified that effective strategies for individual residents would be integrated into their care plan to prevent or minimize risk of altercations and potentially harmful interactions.

A review of the home's policy titled, "Zero Tolerance of Abuse and Neglect" ORG-III-PAT-10, with an effective date of November 3, 2016, indicated that the home was committed to providing an environment of zero tolerance of abuse or neglect of residents by any person.

On January 12, 2017, the Inspector interviewed the ADM, who verified that the unit had been short staffed and resident #003 did not have the required specific monitoring at the time and as a result the abuse occurred in January 2017. The ADM confirmed abuse had occurred to resident #004 and that they had not protected resident #004 from abuse. [s. 19. (1)]

2. Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director in January 2017, alleging resident to resident abuse that had occurred in December 2016. The home had contacted the Director via the LTC Home Emergency Pager in December 2016. The CI report revealed that resident #001 abused resident #002 in December 2016 by touching them inappropriately. Resident #002 had rang their call bell to notify staff of the incident.

A review of the home's investigation notes revealed that resident #001 was found in resident #002's room. Resident #001 admitted that they had abused resident #002 and they stated that they knew it was wrong and it would not happen again.

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A review of the home's policy titled, "Zero Tolerance of Abuse and Neglect" ORG-III-PAT-10, with an effective date of November 3, 2016, indicated that the home was committed to providing an environment of zero tolerance of abuse or neglect of residents by any person.

During an interview with PSW #102 on January 10, 2017, they stated that before the incident had occurred with resident #002 in December 2016, they had observed resident #001 in the room of another resident, resident #007. Resident #007 had appeared angry but would not inform the PSW why they were angry. PSW #102 also stated that approximately one month or two weeks prior to the incident with resident #002, that resident #001 appeared to have more confusion.

A review of the electronic progress notes on Gold Care, dated in December 2016, identified documentation that resident #001 was spoken to by a staff member about entering other residents rooms and to make sure that the other residents wanted them in their room prior to entering. No other documentation about the resident entering other resident rooms or increased confusion was in the progress notes on Gold Care.

During interviews with PSW #102 and RN #100, both stated they were shocked when they had been informed that the incident had occurred, as resident #001 had no previous history of abuse towards other residents and resident #001 had never made inappropriate comments to other residents.

On January 11, 2017, Inspector #613 interviewed the Administrator (ADM), Director of Care (DOC) and Assistant Director of Care (ADOC). The ADM confirmed they had not protected resident #002 from abuse.

No further action will be taken in regards to this non-compliance as there is currently an outstanding order for s. 19 (1) in Resident Quality Inspection #2016_463616_0026. [s. 19. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.***

---

**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints**

**Specifically failed to comply with the following:**

**s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to immediately forward a received written compliant concerning the care of a resident to the Director.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted in January 2017, identifying that the home had received a complaint letter from a family member of resident #004 in January 2017, who had requested a written report about the abuse incident that had occurred in January 2017, involving resident #004 and resident #003.

A review of the home's policy titled, "Managing Complaints Policy" Document #P-VI-3, with no revision date, identified that the Administrator would report to the Ministry of Health and Long Term Care (MOHLTC) all written complaints received by the home. A review of policy titled, "Managing Complaints Administrative Procedure" with no revision date, identified a procedure to ensure that all written complaints to the home about a resident's care or about the operation of the home was sent immediately to the Ministry of Health and Long Term Care. The policy identified the email address, phone number and fax number of the MOHLTC.

On January 11, 2017, the Inspector interviewed the ADM, who confirmed that they had not forwarded the written complaint to the Director immediately, but had forwarded the written letter, two business days after receiving. [s. 22. (1)]

2. Inspector #613 reviewed a Critical Incident Report (CI) that was submitted in January 2017, identifying that the home had received a complaint letter from a family member of resident #007 in January 2017, alleging possible resident to resident abuse.

On January 11, 2017, the Inspector interviewed the ADM, who confirmed that they had not forwarded the written complaint to the Director immediately, but had forwarded the written letter, three business days after receiving. [s. 22. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to immediately forward a received written compliant concerning the care of a resident to the Director, to be implemented voluntarily.***

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director in January 2017, alleging resident to resident abuse that had occurred in December 2016. The home had contacted the Director via the LTC Home Emergency Pager in December 2016. The CI report revealed that resident #001 abused resident #002 in December 2016, by touching them inappropriately. Resident #002 had rang their call bell to notify staff of the incident.

A review of the home's investigation notes revealed that resident #001 was found in resident #002's room. Resident #001 admitted that they had abused resident #002 and they stated that they knew it was wrong and it would not happen again. A review of resident #001's progress notes and an email, in the investigation file, identified that the police force had not been notified until a specific date and time in December 2016, 19 and a half hours after the abuse had occurred.

A review of the home's policy titled, "Zero Tolerance of Abuse and Neglect Registered Staff Procedure" ORG-III-PAT-10.5 with an effective date of November 3, 2016, identified that registered staff were to notify police if necessary of alleged /suspected/unwitnessed or witnessed incidents that may constitute a criminal offense (Appendix E).

On January 11, 2017, the Inspector interviewed the ADM, who stated they had thought that the police had been notified immediately of the incident. The Inspector showed the ADM the documentation which identified the police were notified of the abuse in December 2016. The ADM stated they would check their emails and provide documentation to the Inspector. The ADM did not provide further documentation to the Inspector that identified the police had been contacted immediately by the home. [s. 98.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.***

---

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**

**Specifically failed to comply with the following:**

**s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:**
**2. A description of the individuals involved in the incident, including,**
**i. names of all 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. 104 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to inform the Director of the names of any residents involved in the incident, within 10 days of becoming aware of the incident, or sooner if required by the Director.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director in November 2016, which identified that an unknown resident #008 had a fall in November 2016. The CI report identified that resident, #008, had not sustained any injury in November 2016, as a result of the fall. Then on another date in November 2016, it was determined that resident had sustained an injury as a result of the fall that had occurred in November 2016. The Director had requested the licensee to amend the CI report.

On January 10, 2017, the Inspector met with the ADM, who had submitted the CI report to the Director in November 2016. The ADM verified that they had not identified the name of the resident involved in the incident.

An amendment from the licensee was not provided to the Director as of January 10, 2017. [s. 104. (1) 2. i.]

---

**WN #7: 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:**
**1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.**
**O. Reg. 79/10, s. 107 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure they informed the Director of an incident under subsection (1), (3) or (3.1) within 10 days of becoming aware of the incident, or sooner if required by the Director to make a report in writing to the Director setting out the immediate actions that had been taken to prevent recurrence.

Inspector #613 reviewed a Critical Incident Reports (CI) that was submitted to the Director in November 2016, which identified that an unknown resident #008 had a fall in November 2016. The CI report identified that resident #008 had not sustained any injury in November 2016, as a result of the fall. Then in November 2016, it was determined that resident had sustained an injury and was transferred to the hospital, where they were diagnosed with an injury as a result of the fall that had occurred in November 2016. The Director had requested the licensee to amend the CI report.

In December 2016, the Director had requested the licensee to amend the CI report for the following;

-the date the resident returned to the home, following their hospital transfer
-resident's falls risk score

An amendment from the licensee was not provided to the Director as of January 9, 2017.
[s. 107. (4) 1.]

---

**Issued on this 26th day of April, 2017**

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

**Original report signed by the inspector.**