



**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
Direction de l'amélioration de la
performance et de la conformité**

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4^{ième} étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Nov 15, 2013	2013_195166_0042	O-000727- 13	Critical Incident System

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC

1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PORT HOPE)

20 HOPE STREET SOUTH, PORT HOPE, ON, L1A-2M8

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

CAROLINE TOMPKINS (166), MARIA FRANCIS-ALLEN (552)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 13, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care and the Registered Nursing staff

During the course of the inspection, the inspector(s) reviewed the clinical health records of resident #1, the licensee's investigation related to the critical incident and the licensee's policy and procedures related to a specified medical condition.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Medication

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).

(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1.The licensee has a policy that directs staff on how to monitor a specific condition and where to document the results of that monitoring. There is no evidence that any monitoring

Interview with the RN #104, indicated that the R.N. was not aware that the home had a policy in place to related to the monitoring of a specified condition. There is no evidence that monitoring of the resident's specified condition occurred.

Interview with the DOC indicated that the "Form" previously used to monitor the specified condition is no longer used in the home. [s. 8. (1)]



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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 any plan, policy, protocol, procedure, strategy or system that has been put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the 24 hour care plan for Resident #1 provided clear directions to staff related to the resident's health condition and treatments.

RN #101 completed the admission assessment and initiated the 24 hr care plan.

Interview with RN #101 indicated that the resident's substitute decision maker provided information related to the resident's medical history.

Review of resident #1's 24 hour care plan did not identify all the resident's medical conditions and treatments.

There was no clear direction to staff and others in the 24 hour care plan on how to manage, observe and treat the resident's medical condition. [s. 24. (4)]



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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 a 24 hour admission care plan is developed and that care plan identifies a resident's known health condition(s), drugs treatment(s) required, diet orders and provides clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: 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):

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).

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. The licensee failed to notify the Director within one business day of an incident where the resident is taken to hospital.

The clinical records indicate that on an identified date an incident occurred involving Resident #1, who was transferred to the hospital for further treatment.

The Director was not notified of the incident within the time lines as specified by the legislation [s. 107. (3)]

2. The licensee failed name the staff member who was present at the incident.

The name of the staff member who made the medication error was not identified in the critical incident report. [s. 107. (4) 2.]



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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 Director is notified within one business day of a incident that results in the resident's admission to hospital, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131.

Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. Review of physician orders, resident's clinical records and interviews with RN #101, #104 and RPN #100 indicated that Resident #1 was prescribed a specific medication dosage as a medical intervention.

Review of clinical documentation and interview with registered staff indicated that on an identified date the resident was administered the incorrect dosage of medication.
[s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.



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Issued on this 15th day of November, 2013

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

[Handwritten signature] #166
M. Francis-Allen #552.