Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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 23, 2022	2022_931821_0008	017147-21	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Hillside Manor
Highway 8, 5066 Perth East Line 34, R.R. #5 Stratford ON N5A 6S6

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

PETER HANNABERG (721821)

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 16-18, and 21, 2022.

The following Critical Incident intakes were completed within this inspection:

Related to Falls Prevention and Management:

Critical Incident Log #017147-21.

IPAC checklist version A2 was also completed at the time of the Critical Incident inspection. Inspector Yuliya Fedotova (632) was also present during the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care/Falls Program Lead, the Infection Control Manager, a Registered Nurse, two Personal Support Workers, one Housekeeper, and a resident.

The Inspector also conducted observations throughout the home related to Infection Prevention and Control practices, staff-to-resident interactions, and a resident's room. The Inspector also reviewed records including: resident care plans, progress notes, clinical assessments, medication administration records, and relevant policies of the home.

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

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 the care set out in a resident's care plan was provided as specified in the plan.

A resident had a fall resulting in an injury and transfer to hospital. As part of the resident's fall prevention strategies, keeping the call bell within reach was included in their care plan. During an observation of the resident in their room, the call bell was not within reach of the resident.

After a discussion with Personal Support Worker (PSW) #102, the call bell was moved within reach of the resident. The Assistant Director of Care (ADOC)/Falls Lead#103 stated that the call bell should have been within reach of the resident. There was no harm/risk of harm to the resident at the time of the observation.

Sources: The resident's care plan; direct observation; and interviews with PSW#102 and the ADOC/Falls Lead#103. [s. 6. (7)]

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Issued on this 23rd day of March, 2022

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

Original report signed by the inspector.