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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Oct 6, 2014	2014_353589_0009	T-722-13	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

WESTSIDE
1145 Albion Road, Rexdale, ON, M9V-4J7

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

JOANNE ZAHUR (589)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 14, 15, 18, 2014.

This inspection was completed during Resident Quality Inspection (RQI), T-115-14.

During the course of the inspection, the inspector(s) spoke with the complainant, personal support worker (PSW), registered nursing staff (RN/RPN), registered practical nurses (RPN), nurse manager (NM), assistant director of care (ADOC), director of care (DOC).

During the course of the inspection, the inspector(s) reviewed health records, the home's policy on Handling of Concerns/Complaints/Compliments, the home's policy on Admissions, Transfers, Discharges and Death and the home's internal investigation notes.

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

Findings of Non-Compliance were found during this inspection.

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. 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 failed to ensure that the following policy: Admissions, Transfers, Discharges and Death, Procedure Upon Death of Resident, Index LTC-A-120 (September 2001), procedures #7 and #10 was complied with. The above mentioned policy states the following:
-procedure #7, when family is notified, the RN/RPN/Physician will discuss viewing of the body, funeral arrangements and religious preferences if not previously identified. Special requests will be documented on the progress notes and,
-procedure #10, family members will be accompanied to the room upon arrival. All members of the Care Team will offer privacy, support and comfort to the family.

A review of the health record and staff interviews reveal that resident #001's spouse was not called on an identified date, and informed that the resident's condition had further deteriorated and that she/he had died at approximately at an identified time. When resident #001's spouse arrived at the home a few hours later, she/he was not greeted by any member of the Care Team and upon entering her/his room, the spouse found the privacy curtains drawn around the bed. The spouse assumed care was being provided but when did not hear any voices, he/she pulled the curtain back to discover resident #001 was deceased.

An interview with the DOC confirmed that there was a breakdown of communication between two identified staff which resulted in the failure to notify family of resident #001's death and specifically, failure to comply with the above mentioned policies procedures # 7 and 10. [s. 8. (1)]

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Issued on this 6th day of October, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Galur (589)