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

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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
Feb 3, 2021	2020_780699_0022	005510-20, 007271-20, 008730-20, 024236-20, 025049-20	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

Westside
1145 Albion Road Etobicoke ON M9V 4J7

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

PRAVEENA SITTAMPALAM (699), IANA MOLOGUINA (763)

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): December 15-18, 21-24, 2020.

The following Critical Incident System (CIS) intakes were inspected:

-Log #005510-20, 008730-20 [CIS 2663-000017-20, 2663-000021-20] related to falls;
-log #007271-20 [CIS 2663-000020-20] related to alleged neglect; and
-log #024236-20 and 025049-20 [CIS 2663-000044-20 and 2663-000045-20] related to hypoglycemia requiring transfer to hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), registered nurses (RN), registered practical nurse (RPN), and personal support worker (PSW).

During the course of the inspection, the inspectors conducted observations of staff and resident interactions and provision of care, reviewed resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for a resident.

The resident was found on the floor of the unit's dining room. The dining room door was closed and the lights were off. The home's staff were unsure how the resident got into the dining room on their own as it was expected that the dining room doors were locked by the dietary department and nursing staff after meals were finished. Staff were also expected to check the dining room for any residents present prior to locking the doors. The management team reviewed camera footage of the incident and were unable to determine how the resident got into the dining room. The management team confirmed that staff should have ensured the dining room door was locked after dinner as the dining room was not supervised at that time.

Sources: CIS #2663-000017-20, home's investigation notes, staff interviews (PSW #104, RPN #105, ADOC #107, ED #101). [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

The Ministry of Long-Term care (MLTC) received a CIS report related to a resident experiencing a change in condition which resulted in hospitalization. On an identified date, the resident was confirmed to have an infection. Review of the resident's medication administration record (MAR) indicated the following: assess and document health assessment every shift and document in progress notes. The resident's assessments were not documented in the progress notes for eight shifts, however were checked off as completed in the MAR. Staff confirmed that it was the expectation that each shift document infection monitoring assessment in the progress notes.

Sources: Record review of progress notes, November 2020 MAR, interviews with RN #109, RPN #116, and DOC #112. [s. 6. (9) 1.]

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. (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:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed, within 10 days, of the analysis of an incident and follow-up action, including the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

The MLTC received a CIS report related to a resident experiencing a change in their clinical status which resulted in hospitalization. A review of the CIS indicated that an investigation was initiated for immediate and long-term actions planned to correct the situation and prevent recurrence. The CIS was not amended until twenty days later. The DOC confirmed that the CIS should have been amended with the above information.

Sources: CIS 2663-000044-20, interview with DOC #112. [s. 107. (4) 4.]

Issued on this 4th day of February, 2021

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

Original report signed by the inspector.