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
May 26, 2021	2021_729615_0020	008092-20, 010066-20, 011329-20, 015355-20, 016572-20, 000532-21, 001412-21, 001850-21, 002185-21, 003985-21	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

Westside
1145 Albion Road Etobicoke ON M9V 4J7

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

HELENE DESABRAIS (615), ALI NASSER (523)

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): May 10, 11, 12, 13, 14, 17, 18, 19 and 20, 2021.

The following intakes were inspected during this inspection:

Log #008092-20/Critical Incident System (CIS) report #2663-000021-20;
Log #010066-20/CIS #2663-000025-20;
Log #011329-20/CIS #2663-000026-20;
Log #015355-20/CIS #2663-000032-20;
Log #000532-21/CIS #2663-000002-21, and;
Log #001412-21/CIS #2663-000005-21, related to falls prevention;
Log #016572-20/CIS #2663-000034-20;
Log #001850-21/CIS #2663-000007-21, and;
Log #003985-21/CIS #2663-000014-21, related to prevention of abuse, neglect and retaliation;
Log #002185-21/CIS #2663-000008-21, related to medication.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Registered Nurse-Infection Prevention and Control Lead, a Registered Nurse, a Registered Practical Nurse-Behavioural Support Ontario, three Registered Practical Nurses and five Personal Support Workers.

The inspectors also toured the home daily, observed Infection Prevention and Control practices, residents and the care provided to them, staff to residents interactions, reviewed residents' clinical records and other relevant documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **1 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. 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 plan interventions were provided to the resident as specified in the plan.

A Critical Incident System (CIS) report submitted, on a specific date, showed that a Personal Support Worker (PSW) failed to apply the resident's specific care plan interventions when providing care to the resident which caused injury to the resident and was transferred to hospital. In an interview, the Administrator indicated that the resident had specific interventions in place and that the care was not provided to the resident as specified in the plan of care.

Sources: resident’s plan of care and clinical records, CIS report and staff interviews. [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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 26th day of May, 2021

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

Original report signed by the inspector.