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 prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 20, 24, 25, 26, 30, 31, Feb 22, Mar 5, 2012	2012_081113_0006	Critical Incident

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

JANE CARRUTHERS (113), NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Staff, the Environmental Service Manager, and an identified Resident.

During the course of the inspection, the inspector(s) inspected the bed, reviewed maintenance requisition books, the Preventative Maintenance Program, the Health and Safety Program, health records and the Falls Policy.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 15. Accommodation services
Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. On January 11, 2012, an identified resident leaned on the bed rail to reach for the pull cord to turn off the over the bed light. The bolt securing the bed rail was not tight. It did not secure the bed rail and when it was leaned on, it caused the bed rail to separate from the bed and the identified Resident to fall to the floor. (section 15. (2) (c))

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 furnishings are maintained in a safe condition and in a good state of repair. This plan is, 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 subsections:

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. An identified Resident did not receive the required care as indicated in the care plan.

2. Plan of care for the identified resident indicates the following: "Resident is a medium risk for falls as evidence by FRAT assessment score, impaired mobility, balance, gait - Bed is kept at lowest level and in locked position".
3. On January 16th, 2012, the resident was found on the floor after sliding off the bed. The bed was not in the locked position.
4. Post falls documentation completed by registered staff indicated interventions initiated to prevent recurrence is the application of a bed alarm and chair alarm.
5. LTC Inspector observed no chair alarm in place on the resident's wheelchair on January 11 and 12, 2012.
6. There was no documentation regarding the chair and bed alarm. Plan of care was updated by registered staff after LTC Inspector reviewed with registered staff.
7. The Plan of Care for the identified resident indicates the following: "call bell/light cord is within reach". The resident confirmed that the light cord was not within reach on January 11,2012 causing the resident to reach over the loose bed rail and fall out of bed.

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. This plan is, to be implemented voluntarily.

Issued on this 5th day of March, 2012

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

Jane Carruthers