Ontario

Ministry of Health and Long-Term Care

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

Ministére 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
Oct 17, 18, 19, 21, Nov 29, Dec 7, 2011; Jan 5, 2012	2011_053122_0019	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

BIRCHWOOD TERRACE
237 Lakeview Drive, R. R. #1, KENORA, ON, P9N-4J7

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

ROSE-MARIE FARWELL (122)

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, the Education Coordinator, Registered Staff and Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed related critical incident report, reviewed the resident's health care record, observed the provision of care and services to the resident named in the critical incident, reviewed policies and procedures related to falls prevention.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. On July 29, 2011 the MOHLTC received notification through the critical incident reporting system that a resident had fallen and sustained an injury which required transfer to hospital.

On October 19, 2011, the Inspector reviewed the resident's health care record and noted that the resident was assessed in hospital and returned to the home with a tentative diagnosis of a fractured humerous. The Inspector was unable to locate a post falls assessment on the resident's health care record.

On October 19, 2011, the Inspector requested the assistance of the DOC and the Administrator in locating the resident's post falls assessment. After consulting with the Education Coordinator, the Administrator reported that a post falls assessment utilizing a clinically appropriate assessment tool specifically designed for falls had not been completed for the resident because the assessment tool had not yet been implemented at the time of the resident's fall on July 28, 2011.

The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [LTCHA 2007, O. Reg. 79/10, s. 49 (2)].

Issued on this 5th day of January, 2012

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