Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Nov 21, 2019	2019_781729_0022	015498-19	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

Sara Vista
27 Simcoe Street ELMVALE ON L0L 1P0

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

KIM BYBERG (729), LUCIA KWOK (752)

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): November 4, 5, 6, 7, 13, 14, 2019.

This inspection was completed concurrently with an other inspection - SAOII #2019_830752_0001

The following intake was completed in this critical incident inspection;
Log #015498-19, CI #2710-000006-19 related to an injury resulting in change in resident condition and transfer to hospital.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), and residents.

The inspector also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others collaborated with each other in the assessment of resident #008 so that their assessments were integrated, consistent and complemented each other.

A Critical Incident (CI) that was submitted to the Ministry of Long Term Care (MLTC) stated that resident #008 had a fall and suffered an injury resulting in a transfer to the hospital.

Resident #008 was assessed for being at risk for falls, had multiple diagnoses and needed assistance for all activities of daily living.

Review of resident #008's progress notes in point click care (PCC) stated that on admission they had elevated vital signs, and there was no communication from the staff to the physician for further instruction. Shortly after admission the resident had an unwitnessed fall and sustained injuries as a result of the fall. The resident's vital signs were taken and found to be elevated after they had the fall. The physician was not notified of the fall, the elevated vital signs or the resident's medication history.

The home's policy titled "Fall Prevention and Injury Reduction, Head Injury Routine" with a review date of March 31, 2019 stated that the Physician or Nurse Practitioner were to be notified for further instructions for residents on anticoagulant therapy with a head injury, sedation/analgesic, or emergency transfer to the hospital for assessment.

RN #114 stated that they completed resident #008's post fall assessment and did not document the type of medication the resident was prescribed, nor did they notify the Physician or Nurse Practitioner for further instruction regarding the elevated vital signs or medication history.

The licensee failed to ensure that staff and the Physician collaborated with each other in the assessment of resident #008. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

Issued on this 22nd day of November, 2019

[redacted]

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

Original report signed by the inspector.