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 13, 14, Dec 30, 2011; Jan 5, 2012	2011_070141_0035	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

WEST OAK VILLAGE
2370 THIRD LINE, OAKVILLE, ON, L6M-4E2

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

SHARLEE MCNALLY (141)

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, Director of Care, Assistant Director of Care, registered staff, Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed resident records, home's investigation notes, home's policies and procedures for Falls Interventions Risk Management and Head Injury Routine.

Reference Log H-001884-11/H-001893-11

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

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. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The plan of care for an identified resident did not set out clear direction to staff and others who provide direct care to the resident. The resident had a fall causing transfer to hospital for treatment in 2011. The resident was identified in the Resident Assessment Protocol as an immediate risk for falls. The resident was using both a bed and chair alarm for safety. The use of the chair alarm was confirmed by staff. The written plan of care does not identify the use of a chair alarm as a strategy for the immediate risk of falls.
The resident's plan of care did not identify the "falling star" logo as a strategy related to the immediate risk of falls. The home policy and procedure Fall Interventions Risk Management (LTC-N-70) states that residents identified at an immediate risk for falls will be identified under a "falling star" logo, which will be included as a prevention strategy in the resident's plan of care. The Director of Care confirmed that this strategy should be included in the resident's written plan of care. s.6(1)(c)
2. The plan of care for an identified resident did not set out clear direction to staff and others who provide care to the resident. The resident was identified in the Resident Assessment Protocol as an immediate risk for falls. The resident's plan of care did not identify the "falling star" logo as a strategy related to the immediate risk of falls. The home policy and procedure Fall Interventions Risk Management (LTC-N-70) states that residents identified at an immediate risk for falls will be identified under a "falling star" logo, which will be included as a prevention strategy in the resident's plan of care. The Director of Care confirmed that this strategy should be included in the resident's written plan of care. s.6(1)(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 resident's written plans of care set out clear direction to staff and others who provide direct care to the resident,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the policy for Head Injury Routine (LTC-D-70), as a component of the Fall Intervention and Protocols policy (LTC-N-70), was complied with for an identified resident. The resident had multiple falls in 2011 that involved hitting their head. The resident was placed on Head Injury Routine (HIR) for each occurrence. The policy for "Head Injury Routine" (LTC-D-70) states that resident shall be assessed every 30 minutes for 2 hours, then every hour for 6 hours, then every 4 hours for 8 hours and every 8 hours for 56 hours after each fall if there has been a fall involving sudden impact or blow to the head. Assessments for this resident were not completed by registered staff consistently when on Head Injury Routine for each identified time period, including periods when the resident was sleeping. s.8(1)(b)

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following subsections:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee did not ensure that all devices in the home were kept in good repair. An identified resident was placed on a wireless bed alarm for safety. The resident was found on the crash mat beside their bed. The bed alarm failed to sound when the resident left the bed. The home's investigation found that the magnetic bracket for the bed alarm was improperly positioned causing the alarm to fail. Staff confirmed that the home identified while installing the wireless alarms that if the alarm bracket was not placed in the upright position the alarm would not activate if the resident moved. Education on the use of the monitor had been completed and a guideline had been sent to all home areas instructing staff on the proper positioning of the bracket to ensure would function. During this inspection the memo could not be located as confirmed by staff. s.90.(2)(b)

Issued on this 11th day of January, 2012

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