Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 24, 2017	2017_262630_0031	009954-17	Resident Quality Inspection

Licensee/Titulaire de permis

STEEVES & ROZEMA ENTERPRISES LIMITED
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

Long-Term Care Home/Foyer de soins de longue durée

WESTMOUNT GARDENS LONG TERM CARE HOME
590 Longworth Road LONDON ON N6K 4X9

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

AMIE GIBBS-WARD (630), MARIAN MACDONALD (137)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 30 and 31, November 1, 2 and 3, 2017.

The following concurrent inspections were conducted during the Resident Quality Inspection (RQI):

Follow-up to inspection 2016_508137_0017 including the following orders: Follow-up Log #030732-16/CO#001 related to locks on bathroom doors; Follow-up Log #030732-16/CO#002 related to the resident-staff communication

system;

**Follow-up to inspection 2016_508137_0018 including the following orders:
Follow-up Log #030713-16/CO#001 related to prevention of neglect;
Follow-up Log #030713-16/CO#002 related to the skin and wound care program;**

Complaint Log #033330-16/IL-48171-LO related to personal support services;

**Critical Incident Log #031743-16 for Critical Incident System (CIS) report 2878-000044-16 related to falls prevention;
Critical Incident Log #029008-16 for Critical Incident System (CIS) report 2878-000045-16 related to prevention of abuse and neglect;
Critical Incident Log #029595-16 for Critical Incident System (CIS) report 2878-000046-16 related to prevention of abuse and neglect;
Critical Incident Log #032203-16 for Critical Incident System (CIS) report 2878-000047-16 related to prevention of abuse and neglect;
Critical Incident Log #032657-16 for Critical Incident System (CIS) report 2878-000048-16 related to prevention of abuse and neglect;
Critical Incident Log #033291-16 for Critical Incident System (CIS) report 2878-000052-16 related to prevention of abuse and neglect;
Critical Incident Log #000019-17 for Critical Incident System (CIS) report 2878-000055-16 related to missing medication;
Critical Incident Log #007717-17 for Critical Incident System (CIS) report 2878-000012-17 related to missing medication.**

During the course of the inspection, the inspector(s) spoke with the Administrator, the Vice President of Long-Term Care for Steeves and Rozema Group, the Manager of Resident Care (MRC), the Assistant Manager of Resident Care (AMRC), a Resident Assessment Instrument (RAI) Coordinator, a Resident Care Coordinator, the Manager of Life Enrichment, the Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Wound Care Lead, the internal Behavioural Supports Ontario (BSO) Team, Maintenance Services, Environmental Services, a Residents' Council member, family members and over twenty residents.

The inspectors also observed resident rooms and common areas, observed general maintenance and cleanliness of the home, observed medication storage areas, observed medication administration, observed residents and the care

provided to them, reviewed health care records and plans of care for identified residents, reviewed various policies and procedures of the home and reviewed various meeting minutes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **6 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_508137_0018	137
O.Reg 79/10 s. 48. (1)	CO #002	2016_508137_0018	137
O.Reg 79/10 s. 9. (1)	CO #001	2016_508137_0017	137

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	Legendé 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. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was properly calibrated so that the level of sound was audible to staff in every area accessible by residents, including all dining rooms, tub/shower rooms and resident bedrooms/bathrooms, when doors were closed.

On September 29, 2016, during Resident Quality Inspection #2016_508137_0017, Compliance Order (CO) #002 was issued and the licensee was ordered to take action to achieve compliance by ensuring that the home was equipped with a resident-staff communication and response system that, in the case of a system that used sound to alert staff, was properly calibrated so that the level of sound was audible to staff in every area accessible by residents, including all dining rooms, tub/shower rooms and resident bedrooms/bathrooms when doors were closed. This order was to be complied with by October 28, 2016.

During multiple interviews with identified staff it was reported that the resident-staff communication and response system was not audible in the dining rooms, resident bedrooms, bathrooms and tub/shower rooms, if the doors were closed. It was also reported that the call signal from the resident-staff communication and response system was to go to the registered staff pager, if not responded to after five minutes.

Multiple observations by the inspector found that the resident-staff communication and response system was not audible in identified resident care areas throughout the home. During these observations the inspector also found that the signal did not go to the registered staff pager within an identified time period.

During an interview the Administrator said the inaudibility of the resident-staff communication and response system and the delayed time period for the signal to go to the registered staff pagers was not acceptable, posing a potential risk to residents. The Administrator said interventions were going to be put in place to mitigate risk to residents related to the resident-staff communication and response system. The Administrator said it was not acceptable that the resident-staff communication and response system was not properly calibrated so that the level of sound was audible to staff in every area accessible by residents, including all dining rooms, tub/shower rooms and resident bedrooms/bathrooms, when doors were closed.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was widespread during the course of this inspection, as it affected all five neighbourhoods (100 per cent). There was a compliance history of this legislation being issued in the home on April 13, 2015, in Resident Quality Inspection (RQI) #2015_303563_0015 as a Voluntary Plan of Correction (VPC) and on September 29, 2016, in RQI #2016_508137_0017 as a Compliance Order (CO) with a compliance due date of October 28, 2016. [s. 17. (1) (g)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) which identified an incident of alleged resident to resident abuse between two identified residents.

During multiple interviews with identified staff it was reported that there had been an incident of alleged abuse that had occurred between the two identified residents. The staff reported that one of the identified residents had a history of specific behaviours. The staff reported that it was the expectation in the home that alleged incidents of

resident to resident abuse would be reported by staff to management based on the home's policy on the prevention of abuse and neglect.

The clinical record for one of the identified residents showed multiple documented incidents of specific responsive behaviours that were directed towards other residents. The clinical record did not include documented evidence that these incidents had been reported by staff to the management in the home.

The home's policy titled "08-05 Resident Abuse and Neglect" with last revision date May 19, 2015, which was in place in the home at the time of the CIS stated:
- "Team members shall notify the Administrator and/or Manager Resident Care/Registered Nurse/Registered Practical Nurse immediately upon observation or receiving knowledge of a suspected/reported incident of Resident abuse or neglect. The Administrator must be notified immediately if they are not the first person to whom abuse is reported. Immediate reporting mean the same day."
- "Notification of the MOHLTC Compliance Inspector - the Inspector will be notified by the Administration immediately (same day) upon determining that there are reasonable grounds to suspect a situation has occurred which is outlined in Long Term Care Homes Act 24 (1) Mandatory Reporting. Notification will be done the same day by completion of a Critical Incident Report. If the Critical Incident report is not completed that day then you need to call the after-hours pager."

During an interview the Manager of Resident Care (MRC) said that although they were familiar with the CIS report that had been reported to the MOHLTC, this incident had been investigated and followed through by a former Administrator. The MRC acknowledged that based on a review of the documentation by the former Administrator, the staff did not report the incident immediately and the former Administrator did not report the incident to the MOHLTC as per the home's policy. Based on a review the clinical record for the identified resident, the MRC acknowledged that there were multiple incidents of potential resident to resident abuse that had not been reported by staff to the management in the home. The MRC said it was the expectation in the home that staff would comply with the prevention of abuse and neglect policy and all potential incident of resident to resident abuse would be reported and investigated.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home did not have a history of non-compliance in this subsection of the legislation. [s. 20. (1)]

2. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents clearly set out what constituted abuse and neglect.

During interviews with identified staff it was reported that they received education on inappropriate behaviours as part of their training on prevention of abuse and neglect. When asked how they would identify if a behaviour from one resident towards another resident was potentially abuse, they expressed that they were not really clear. They said that if a resident was having a specific type of responsive behaviours towards other residents then it was the expectation that staff would respond, document and report.

During an interview the MRC was asked what they considered abuse in the home and they said that they would refer to their prevention of abuse policy as this included the definition of abuse.

A review of the home's written policy to promote zero tolerance of abuse and neglect of residents titled "Admin 08-05A Abuse Definitions" with "Last Revision Date May 14, 2017" showed that this included specific definitions of each type of abuse.

During a follow-up interview the MRC said that they spoke with the Staff Educator for the corporation regarding the definitions of abuse included in the policy. The MRC acknowledged that the definition of a specific type of abuse included in the home's written policy did not clearly set out what constituted abuse and neglect as it was not consistent with the definition of abuse as identified in the regulations. The MRC said it was the expectation in the home at the definition included in the prevention of abuse and neglect policy would meet the requirements of the legislation.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home did not have a history of non-compliance in this subsection of the legislation. [s. 20. (2)]

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 by ensuring that the written policy to promote zero tolerance of abuse and neglect of residents is complied with and by ensuring that it clearly sets out what constitutes abuse and neglect, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations and failed to identify and implement interventions.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) which identified an incident of alleged resident to resident abuse between two identified residents.

During multiple interviews with identified staff it was reported that there had been an incident of alleged abuse that had occurred between the two identified residents. The staff reported that one of the identified residents had a history of specific behaviours.

The staff reported that it was the expectation in the home that alleged incidents of resident to resident abuse would be reported by staff to management based on the home's policy on the prevention of abuse and neglect. Staff reported that they would know about the interventions that were in place for residents regarding responsive behaviours by referring to the resident's plan of care. During these interviews it was also reported that this identified resident had been followed by the home's internal Behavioural Supports Ontario (BSO) team, but there was no documented evidence that the residents specific responsive behaviours had been assessed or included in the resident's plan of care until after the CIS had occurred.

The clinical record for one of the identified residents showed multiple documented incidents of specific responsive behaviours that were directed towards other residents. The clinical record did not include documented evidence that these responsive behaviours had been assessed or addressed in the plan of care until after the CIS had occurred.

During an interview the Manager of Resident Care (MRC) said that although they were familiar with the CIS report that had been reported to the MOHLTC this incident had been investigated and followed through by a former Administrator. Based on a review the clinical record for the identified resident, the MRC acknowledged that there were multiple incidents of potential resident to resident abuse that had not been reported by staff to the management in the home. The MRC acknowledged that the plan of care for this identified resident had not been revised to include the identification of triggers and the interventions for these specific responsive behaviours.

Based on these interviews and clinical record review the licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between this identified resident and other residents in the home. This resident had several documented incidents with other residents related to specific responsive behaviours, and there was insufficient evidence to demonstrate that these had been assessed, potential triggers identified and interventions implemented until after the CIS incident occurred. The clinical record also showed that after the resident had been assessed by external resources the plan of care had not been updated to reflect the triggers and interventions for an identified time period after the incident.

The severity was determined to be a level three as there was actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on May 15, 2017, in Critical Incident

System (CIS) Inspection #2017_262630_0012 as a Voluntary Plan of Correction (VPC). [s. 54.]

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 by ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and identifying and implementing interventions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances were kept inaccessible to residents at all times.

A) Observations during the Resident Quality Inspection (RQI) found that at an identified time the door to the hair salon was open and an identified resident was seated in the salon, with no one in attendance. The salon was located in a public area, near the café, in close proximity to the elevators, which were readily accessible to residents, visitors and staff. Hazardous substances, such as chemicals and a hot curling iron were accessible to residents. The inspector brought the observation to the attention of the Manager Resident Care (MRC) who stayed with the resident.

B) Observations found that at an identified time specific equipment was found in the doorway entrance to a resident care area. A resident was observed in the area at the time. The inspector also observed the door to a specific room was propped open with a door stop and shelves of chemicals were visible. There were several containers of multiple cleaners and disinfectants observed in the room. This room was accessible to residents and there was no one in attendance.

During an interview with an identified staff member it was acknowledged that the door to the room was left unlocked and open and there was no staff in attendance of the room at the time.

During an interview with the Administrator it was acknowledged that the door to the room was left unlocked and open and there was no staff in attendance of the room at the time. The Administrator said the door to that specific room was to be locked at all times when unattended and hazardous chemicals were to be kept inaccessible to residents at all times, to mitigate potential risk to residents.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home did not have a history of non-compliance in this subsection of the legislation. [s. 91.]

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 by ensuring all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

During an interview with the Administrator and Manager of Resident Care (MRC) it was reported that the annual evaluation of the medication management system for the home was completed using the Institute for Safe Medication Practices (ISMP) Canada.

During an interview the MRC said that they completed the evaluation with the Pharmacist and that the Administrator, Medical Director and Registered Dietitian did not participate.

During an interview the Administrator said they did not participate in the annual medication management system evaluation.

During an interview, the Registered Dietitian (RD) said they did not participate in the annual medication management system evaluation.

Based on these interviews and clinical record review the home's annual evaluation of the effectiveness of the medication management system in the home did not meet the legislative requirement.

The severity was determined to be a level one as there was minimum risk. The scope of this issue was a pattern during the course of this inspection. The home did not have a history of non-compliance in this subsection of the legislation. [s. 116. (1)]

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 by ensuring that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meet annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During an observation of the narcotic count in a specific area of the home, the Inspector observed that a controlled substance for an identified resident was not stored in a separate, double-locked stationary cupboard in the locked area.

During an interview the Administrator and MRC said that these specific controlled substances were not stored in a separate, double-locked stationary cupboard in the locked area and the pharmacy had been contacted to correct the identified area of non-compliance.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this non-compliance was isolated as it was observed as the only neighbourhood with controlled substances not stored in a separate, double-locked stationary cupboard. The home did not have a history of non-compliance in this subsection of the legislation. [s. 129. (1) (b)]

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 by ensuring that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A medication administration observation was completed by an inspector for an identified resident.

A record review conducted by the inspector found that the resident had a specific physician order.

During an interview with an identified staff member it was reported that the medication had not been given to this identified resident as per the physician's specific order.

During an interview the Administrator reported that it was the expectation that staff would be administering medications as per the physician's order.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this non-compliance was isolated. The home did not have a history of non-compliance in this subsection of the legislation. [s. 131. (2)]

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 by ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any other time when the resident's care needs changed.

Multiple observations found an identified resident had a specific device in place.

During interviews with identified staff it was reported that this resident required the specific device to keep them safe. One staff member reported that this resident had experienced a change in condition and the change in their need for this specific device had not been documented in an assessment or in the plan of care.

A review of the clinical record found that the most recent documented assessment and most recent update to the plan of care showed that this resident did not use this specific device.

During an interview the Resident Care Coordinator, Administrator and Manager of Resident Care (MRC) said that it was the expectation in the home that a resident would have a reassessment if there was a change of needs related to the use of this specific device. They also said that it was the expectation in the home that the plan of care would be reviewed and revised whenever a resident's care needs changed related to the use of this specific device.

The severity was determined to be a level one as there was minimum risk. The scope of this non-compliance was isolated. There was a compliance history of this legislation being issued in the home on April 13, 2015, in Resident Quality Inspection (RQI) #2015_303563_0015 as a Voluntary Plan of Correction (VPC), on July 8, 2015, in Critical Incident System (CIS) Inspection #2015_303563_0025 as a VPC, and on August 18, 2016, in RQI #2016_508137_0017 as a VPC. [s. 6. (10) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were analyzed, corrective action was taken as necessary, and a written record was kept.

A review of the home's records showed that medication incidents were being reviewed quarterly at Professional Advisory Committee (PAC) meetings, but there was no documented evidence of an analysis and corrective action being taken.

During an interview the MRC said there was no documentation to support that an analysis and corrective actions were taken. [s. 135. (2)]

2. The licensee has failed to ensure that there was evidence that any changes or improvements identified in the quarterly medication review were identified, implemented and documented.

A review of the home's records showed that medication incidents were being reviewed quarterly at Professional Advisory Committee (PAC) meetings but there was no documentation of any changes or improvements identified in the quarterly medication review that were identified and/or implemented.

During an interview the MRC said there were no documented changes and improvements identified and implemented, during the quarterly review of all medication incidents.

The severity was determined to be a level one as there was minimum harm. The scope of this non-compliance was isolated. The home did not have a history of non-compliance in this subsection of the legislation. [s. 135. (3)]

Issued on this 24th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMIE GIBBS-WARD (630), MARIAN MACDONALD (137)
Inspection No. / No de l'inspection :	2017_262630_0031
Log No. / No de registre :	009954-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 24, 2017
Licensee / Titulaire de permis :	STEEVES & ROZEMA ENTERPRISES LIMITED 265 NORTH FRONT STREET, SUITE 200, SARNIA, ON, N7T-7X1
LTC Home / Foyer de SLD :	WESTMOUNT GARDENS LONG TERM CARE HOME 590 Longworth Road, LONDON, ON, N6K-4X9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mary Alice Barr

To STEEVES & ROZEMA ENTERPRISES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_508137_0017, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee must take action to achieve compliance by ensuring the home is equipped with a resident-staff communication and response system that is properly calibrated so that the level of sound is audible to staff in every area accessible by residents, including all dining rooms, tub/shower rooms and resident bedrooms/bathrooms when doors are closed.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the resident-staff communication and response system was properly calibrated so that the level of sound was audible to staff in every area accessible by residents, including all dining rooms, tub/shower rooms and resident bedrooms/bathrooms, when doors were closed.

On September 29, 2016, during Resident Quality Inspection (RQI) #2016_508137_0017, Compliance Order (CO) #002 was issued and the licensee was ordered to take action to achieve compliance by ensuring that the home was equipped with a resident-staff communication and response system

that, in the case of a system that used sound to alert staff, was properly calibrated so that the level of sound was audible to staff in every area accessible by residents, including all dining rooms, tub/shower rooms and resident bedrooms/bathrooms when doors were closed. This order was to be complied with by October 28, 2016.

During multiple interviews with identified staff it was reported that the resident-staff communication and response system was not audible in the dining rooms, resident bedrooms, bathrooms and tub/shower rooms, if the doors were closed. It was also reported that the call signal from the resident-staff communication and response system was to go to the registered staff pager, if not responded to after five minutes.

Multiple observations by the inspector found that the resident-staff communication and response system was not audible in identified resident care areas throughout the home. During these observations the inspector also found that the signal did not go to the registered staff pager within an identified time period.

During an interview the Administrator said the inaudibility of the resident-staff communication and response system and the delayed time period for the signal to go to the registered staff pagers was not acceptable, posing a potential risk to residents. The Administrator said interventions were going to be put in place to mitigate risk to residents related to the resident-staff communication and response system. The Administrator said it was not acceptable that the resident-staff communication and response system was not properly calibrated so that the level of sound was audible to staff in every area accessible by residents, including all dining rooms, tub/shower rooms and resident bedrooms/bathrooms, when doors were closed.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was widespread during the course of this inspection, as it affected all five neighbourhoods (100 per cent). There was a compliance history of this legislation being issued in the home on April 13, 2015, in Resident Quality Inspection (RQI) #2015_303563_0015 as a Voluntary Plan of Correction (VPC) and on September 29, 2016, in RQI #2016_508137_0017 as a Compliance Order (CO) with a compliance due date of October 28, 2016. [s. 17. (1) (g)] (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 22, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 24th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Amie Gibbs-Ward

Service Area Office / Bureau régional de services : London Service Area Office