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 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 17, 2018	2018_563670_0035	029563-17, 004597-18, 008591-18, 010511-18, 017768-18, 029410-18	Critical Incident System

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

DEBRA CHURCHER (670), AMBERLY KERR (435), MELANIE NORTHEY (563)

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): December 10, 11 and 12, 2018.

The following intakes were inspected:
Log# 029563-17 CIS# 2878-000028-17 related to alleged resident to resident physical abuse.
Log# 010511-18 CIS# 2878-000016-18 related to alleged resident to resident sexual abuse.
Log# 004597-18 CIS# 2878-000008-18 related to alleged resident to resident physical abuse.
Log# 017768-18 CIS# 2878-000020-18 related to a fall with injury.
Log# 029410-18 CIS# 2878-000030-18 related to a fall with injury.
Log# 008591-18 CIS# 2878-000012-18 related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, three Personal Support Workers, one Registered Practical Nurse Resident Assessment Instrument Coordinator, two Registered Practical Nurses and one Nurse Practitioner.

During the course of this inspection the Inspectors observed staff to resident interactions, observed provision of care, observed the general maintenance and cleanliness of the home, conducted interviews, reviewed relevant clinical records, reviewed relevant policies and procedures and reviewed relevant internal home documentation.

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

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. (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).

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 care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) report was received by the Ministry of Health and Long-Term Care.

On December 11, 2018, Inspector #435 observed resident #009 utilizing a particular type of medical equipment.

Review of resident #009's most up to date care plan did not include use of the the particular type of medical equipment. Review of the Point of Care tasks did not show that staff were to be monitoring resident #009 related to the use of the medical equipment.

During an interview with Registered Practical Nurse (RPN) #107, it was verified that an order would need to be obtained, consent from Power of Attorney (POA) obtained and signed for in order for staff to be able to use the specific medical equipment.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident’s care needs changed or care set out in the plan was no longer necessary.

A Critical Incident System (CIS) report, received by the Ministry of Health and Long-Term Care, outlined an incident involving resident #009.

Review of resident #009's current care plan in Point Click Care (PCC) stated that a specific intervention was to be used for resident #009.

On December 11, 2018, resident #009 was not observed to have the intervention in place.

On December 11, 2018, Manager of Resident Care (MRC) #101 stated resident #009 no longer utilized the specific intervention.

On December 11, 2018, Personal Support Worker (PSW) #107 acknowledged that resident #009 no longer utilized the specific intervention as their condition had changed.

The licensee has failed to ensure that resident #009's plan of care was reviewed and revised when the resident’s care needs changed. [s. 6. (10) (b)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when (b) the resident’s care needs changed or care set out in the plan was no longer necessary.

A Critical Incident System (CIS) report was received by the Ministry of Health and Long-Term Care, which outlined an incident involving resident #011.

On December 12, 2018, review of resident #011's current care plan listed two specific interventions for resident #011 due to safety risks.

On December 12, 2018, during observation of resident #011's room, neither intervention was noted to be in place.

A progress note dated for a specific date, stated that the Power of Attorney (POA) had requested and insisted that one of the interventions be removed.

On December 12, 2018, during an interview with Resident Assessment Instrument (RAI) Coordinator #104 it was verified that it would be the expectation that the plan of care be updated to reflect that the intervention had been discontinued as per the POA request.

During this interview it was also verified that the care plan was not updated to reflect that the resident no longer required the second intervention as their condition no longer warranted the intervention.

The licensee had failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when (b) the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (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 ensure that the care set out in the plan of care is provided to any resident as specified in the plan and to ensure that any resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 17th day of December, 2018

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

Original report signed by the inspector.