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

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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
Dec 14, 2018	2018_563670_0034	030761-18, 031021-18	Complaint

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 10, 11 and 12, 2018.

The following intakes were inspected:
Log #031021-18 IL-62002-LO Complaint related to concerns regarding wound care possibly resulting in the death of a resident.
Log #030761-18 IL-61925-LO Complaint related to concerns regarding wound care possibly resulting in the death of a resident.

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, one Nurse Practitioner and one Physician.

During the course of this inspection the Inspector observed staff to resident interactions, 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:
Hospitalization and Change in Condition
Skin and Wound Care

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. (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 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.

Review of resident #008's clinical record showed that the resident had developed multiple symptoms on a specific date that continued through a specific date when the resident subsequently passed away. The Coroner was notified who subsequently ordered a medical procedure.

Resident #008 was seen by the Nurse Practitioner #105 on the day after the specific symptoms started, and ordered medical testing and a medication.

Review of resident #008's clinical record showed monitoring of the resident's vital signs every shift from a specific date through the date that the resident passed away. The Inspector was unable to find any documentation of a specific assessment in resident #008's clinical record.

On December 11, 2018, Physician #108, who was the coroner for resident #008, stated that a specific medical procedure had been completed and was able to inform the Inspector of the cause of death. Physician #108 expressed that they had concerns that the home had not assessed the resident appropriately and had not recognized a specific condition.

On December 11, 2018, Administrator #100 stated that they would expect that any resident experiencing specific symptoms would have specific assessments completed in addition to vital signs, every shift and as needed. After review of resident #008's documentation in Point Click Care Administrator #100 acknowledged that resident #008 did not receive an appropriate assessment every shift and should have.

The licensee has failed to ensure that the resident #008 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 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.