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 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 27, 2018	2018_607523_0029	022309-18, 022800-18, 024917-18	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

ALI NASSER (523)

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): October 29, 30, 31, November 1, 2 and 5, 2018.

This inspection was conducted concurrently with inspection #2018_674610_0021.

The following intake log # were completed during this inspection:

Critical Incident intake Log #022309-18 related to a resident's fall.
Complaint intake Log #022800-18 related to specific resident care concerns.
Complaint intake Log #024917-18 related to allegations of staff to resident abuse/neglect, and specific care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Coordinator (RCC), Physiotherapist, Social Worker, Environmental Services Manager (ESM), three Registered staff members, four Personal Support Worker (PSW), a family member and one resident.

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

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was received on a certain date by the Ministry of Health and Long-Term Care (MOHLTC) infoline related to a specific resident's plan of care was changed without the knowledge and the consent of their substitute decision-maker (SDM).

In an interview the SDM said that on a specific date the resident's plan of care was changed without their knowledge or consent.

In an interview the Director of Care (DOC) said that the home's process was for the staff to inform the SDM of any changes to the plan of care and this would be noted on the clinical record as well.

A clinical record review showed that on a certain date the resident had a specific change in their plan of care and there was no documentation that the SDM was informed.

The DOC reviewed the clinical record and said that there was no documentation that the

SDM was informed of this change in the resident's plan of care and that it was the home's expectation that the resident or SDM be informed and consent to any changes to their plan of care. [s. 6. (5)]

2. 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 complaint was received on a certain date by the Ministry of Health and Long-Term Care (MOHLTC) infoline related to a specific resident's care concern.

A clinical record review of the plan of care showed a specific intervention directing staff to provide specific care to the resident.

Observations during the inspection showed different staff members providing care to the resident not as specified in the plan of care.

The DOC said the expectation was that care would be provided to the resident as specified in the plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A clinical record review for a specific resident showed that on two specific dates the resident had a specific assessment completed that showed a change in the resident's care needs but the plan of care was not reviewed and revised at those dates.

The RCC reviewed the clinical record and said the expectation was for the staff to updated the plan of care to reflect the changes noted from the specific assessments. [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 the resident's substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.
That the care set out in the plan of care was provided to the resident as specified in the plan.
That the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary, 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:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, or system, the licensee was required to ensure that the plan, policy or system was complied with.

In accordance with O. Reg. 79/10, s 48. (1) 1 the licensee was required to develop and implement a falls prevention and management program to reduce the incidence of falls and the risk of injury.

A complaint was received on a certain date by the Ministry of Health and Long-Term Care (MOHLTC) infoline related to a specific resident's fall in the home.

The home's policy RCM 10-02-01 Fall Prevention Program, last revision date; January 9, 2018, included the following under procedure:
"- A head injury protocol will be followed when a resident received an injury to the head, a suspected injury to the head or an unwitnessed fall.
- Completion of the Fall Risk Tool will continue after each fall unless a team decision occurs to discontinue the use of the toll (related to residents who fall repeatedly) and the decision is documented in PCC. The team will include input from MRC and Family).
- A post fall huddle will occur with members of the team on the home area and will be documented in the fall progress note in PCC.
- After each fall the SDM must be made aware. Notify the physician as per home specific Medical Director directions."

A clinical record review, progress notes showed a specific resident had a fall on two consecutive days and specific assessments were completed.

The RCC said in an interview that they were the lead for the Falls Prevention Program, they said that post resident's fall the staff were expected to complete a post fall huddle which would be documented in the progress notes under a Fall Note. A Fall Screening Tool (Scott) would also be completed after each fall. A Head Injury Routine would be initiated if the resident had an unwitnessed fall, head injury or suspected head injury.

The RCC reviewed the clinical record for the specific resident and their own monthly tracking sheets for the falls and said that the resident had those specific falls.

The RCC reviewed the resident's clinical record and said that a HIR was not initiated for the second fall, there was no Fall Screening tool (Scott) completed for the resident post those two specific falls and that a fall huddle or a fall note were not completed for those two falls and there was no documented evidence that the SDM were informed of those falls.

The RCC said that it was the expectations for the staff to comply with the home's falls prevention policy by completing post fall huddles and fall risk tools, a HIR routine would be completed for unwitnessed falls, and to inform the SDM when the resident had a fall. [s. 8. (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 to ensure that the home's fall prevention policy was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone and/or neglect of a resident by the licensee or staff, that the licensee knew of, or that was reported was immediately investigated.

On a certain date a complainant informed inspectors that on a specific date the resident called and informed them of alleged staff to resident abuse. The complainant said that they called the nurse and informed them of what happened, the nurse said that they would follow up and somebody would let them know. Complainant said that they did not hear back from anyone in the home.

Clinical record review for a specific resident showed a progress note on a specific date and time completed by a certain RPN showed that the complainant had called and reported alleged staff to resident abuse and requested a manager to call them and discuss their concerns. RPN informed the oncall manager.

Clinical record review showed a progress note on the next day completed by the same RPN that included discussion with PSWs about what occurred and provided the documentation to management.

In an interview with the specific RPN they recalled the POA calling them about care concerns and said they followed the direction given by the oncall manager and spoke with the staff the next day.

The DOC said in an interview that it was the home's expectations that the investigations for every alleged, suspected or witnessed incident of abuse of a resident, would be initiated immediately. [s. 23. (1) (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 every alleged, suspected or witnessed incident of abuse of a resident by anyone and/or neglect of a resident by the licensee or staff, that the licensee knew of, or that was reported was immediately investigated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls and other special needs.

A complaint was received on certain date by the Ministry of Health and Long-Term Care (MOHLTC) infoline related to specific resident's care concerns.

A clinical record review showed a specific assessment was completed on a certain date indicating a specific fall risk score.

A clinical record review and observations showed that the plan of care was not based on the specific assessment of the resident's fall risk.

The RCC reviewed the resident's clinical record and said that the plan of care was not based on the assessment of the resident. RCC said that the expectation was for the plan of care to be based on an assessment of the resident's fall risk needs. [s. 26. (3) 10.]

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 plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls and other special needs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of a breakdown of major equipment or a system in the home no later than one business day after the occurrence of the incident.

A complaint was received on a certain date by the Ministry of Health and Long-Term Care (MOHLTC) infoline related to the heating, ventilation, and air conditioning (HVAC) system breaking down in the home.

The ESM said in an interview that the HVAC system broke down in the home over the long weekend and was fixed on a later date.

The ESM said that there was no Critical Incident submitted to inform the Director of the breakdown, they said that the expectation was to inform the Director of the major system breakdown. [s. 107. (3) 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 to ensure that the Director was informed of a breakdown of major equipment or a system in the home no later than one business day after the occurrence of the incident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice.

A complaint was received on certain date by the Ministry of Health and Long-Term Care (MOHLTC) infoline related to a specific resident not receiving a bath for two weeks after they were admitted to the home.

The home submitted a Critical Incident System (CIS) report on a certain date related to alleged staff to resident neglect specific to a resident not receiving a bath for two weeks after admission.

The Administrator said in an interview that that they received concerns that the resident did not receive a bath for two weeks after admission, they submitted a CIS related to this concern and initiated an investigation. The investigation showed that the resident did not have a bath for two weeks, corrective measures were put in place.

The Administrator said that it was an expectation of the home to provide the resident a bath, at a minimum, twice per week. [s. 33. (1)]

Issued on this 12th day of December, 2018

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

Original report signed by the inspector.