Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Apr 19, 2021	2021_605213_0008	004132-21, 004448-21, 005002-21, 005304-21, 005319-21, 006045-21	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

RHONDA KUKOLY (213), INA REYNOLDS (524)

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): April 6, 7, 8, 9, 12, 13, 2021

The following intakes were completed during this inspection:
Log #004132-21, Critical Incident report #2878-000013-21, related to alleged resident to resident abuse.
Log #004448-21, Critical Incident report #2878-000015-21, related to a resident transfer.
Log #005002-21, Critical Incident report #2878-000016-21, related to alleged staff to resident abuse.
Log #005304-21, Infoline #IL-89024-LO, a complaint related to a resident transfer.
Log #005319-21, Infoline #IL-89032-LO, a complaint related to alleged staff to resident abuse.
Log #006045-21, Critical Cncident report #2878-000019-21, related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Vice President of Culture & Organizational Effectiveness, a Resident Care Coordinator, Registered Practical Nurses, Personal Support Workers, a Housekeeping Aide, residents and a family member.

The inspectors also made observations and reviewed health records, policies and procedures, education records, employee files, internal investigation records and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another

person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected for two residents:
1) Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
8) Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9) Every resident has the right to have his or her participation in decision-making respected.
11) Every resident has the right to give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent.

The Administrator received an anonymous call reporting that a video was taken of a resident during care by staff on an unknown date. Staff member #110 reported that they had recorded a video on their phone with staff member #111, of resident #001, during a transfer, without their consent, for no particular purpose, months prior. Staff member #109 reported that staff member #111 and #110 showed them a video that staff member #110 took of resident #001 during a transfer. Resident #001 had cognitive impairment and was not capable of consenting for videos to be taken of them. Staff member #111 reported that they had recorded a video on their phone with staff member #110, of resident #006, during a transfer, without their consent, for no particular purpose, months prior. Staff member #115 reported that staff member #111 and #110 showed them a video that staff member #111 took of resident #006 during a transfer. Resident #006 had cognitive impairment and was not capable of consenting for videos to be taken of them.

Four staff members did not intervene to ensure the well-being of the residents or report the videos to the charge nurse, the Manager of Resident Care or the Administrator when they became aware of the videos. Two residents were not treated with dignity and their privacy in treatment was at risk. In addition, residents or their substitute decision makers were not provided the opportunity to provide or refuse consent or participate in decision making when videos were taken of them during treatment without consent.

Sources: A Critical Incident report, interviews with the Administrator and four staff members, Minimum Data Set Outcome Scale Scores and care plans for two residents. [s. 3. (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 to ensure that all the rights of residents are fully respected for all residents, to be implemented voluntarily.

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).

Findings/Faits saillants :

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

The Administrator received an anonymous call, reporting that a video was taken of a resident during personal care by staff on an unknown date. Staff member #110 reported that they had recorded a video on their phone with staff member #111, of resident #001, during a transfer, without their consent, for no particular purpose, months prior. Staff member #109 reported that staff member #111 and #110 showed them a video that staff member #110 took of resident #001 during care. Resident #001 had cognitive impairment and was not capable of consenting for videos to be taken of them. Staff member #111 reported that they had recorded a video on their phone with staff member #110, of resident #006, during a transfer, without their consent, for no particular purpose, months prior. Staff member #115 reported that staff member #111 and #110 showed them a video that staff member #111 took of resident #006 during care. Resident #006 had cognitive impairment and was not capable of consenting for videos to be taken of them. Four staff members did not intervene to ensure the well being of the residents or report the videos to the charge nurse, the Manager of Resident Care or the Administrator when they became aware of the videos.

The licensee's prevention of abuse and neglect policy stated: Any employee or volunteer who witnesses an incident of resident abuse, or has knowledge of an incident that constitutes resident abuse or neglect, will intervene and implement strategies to ensure the safety of every resident and staff member. Any employee or volunteer who witnesses an incident of resident abuse, or has knowledge of an incident that constitutes resident abuse or neglect, will immediately inform the Administrator, Manager Resident care (MRC), or in their absence, the Charge Nurse/delegate in the home, of any incident of suspected or witnessed abuse.

The four staff members said they had training related to the resident abuse and neglect policy and reporting and knew their obligation to intervene and to report possible abuse immediately. The Administrator agreed that the four staff members did not follow the resident abuse and neglect policy. Management of the home was not able to complete an investigation and take appropriate actions because no one reported the videos when they were aware of them. This put residents at risk of continued behaviour of taking videos without resident consent.

Sources: A Critical Incident report, S&R Nursing Homes' policy "Resident Abuse and Neglect" #08.05 revised November 7, 2019, interviews with the Administrator and four staff members, Minimum Data Set Outcome Scale Scores and care plans for two residents. [s. 20. (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 to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 215. Police record check

Specifically failed to comply with the following:

s. 215. (2) The police record check must be,
(a) conducted by a police record check provider within the meaning of the Police Record Checks Reform Act, 2015; and
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 451/18, s. 3 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that the police record check for a staff member was conducted within six months before the staff member was hired by the licensee.

The police record check for a staff member was dated having been completed six months after the start date of the employee.

The licensee policy related to criminal record checks and vulnerable sector screening stated: where a team member's criminal record check was conducted greater than six months but less than twelve months, the team member will be required to provide a copy of the report, complete a self declaration form and provide S&R Nursing Homes with a copy of a new report within three months of the date of commencement of employment. The Vice President of Culture & Organizational Effectiveness confirmed that this was the licensee's policy related to police record checks and not aware that the policy was not in compliance with the Ontario Regulations 79/10.

If the home were to hire a staff member with a criminal reference check older than six months from date of hire, as per the policy, there was risk to residents that a staff member who should not have been hired, worked with residents.

Sources: Employee file for a staff member, licensee policy "Criminal Record Checks and VSS" #7.1.38 revised November 2018, interview with the Vice President of Culture & Organizational Effectiveness. [s. 215. (2) (b)]

Issued on this 19th day of April, 2021

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

Original report signed by the inspector.