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

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

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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
Oct 29, 2021	2021_886630_0033	011694-21, 011756-21, 013833-21, 014510-21, 016167-21	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

AMIE GIBBS-WARD (630), 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): October 18, 19, 20, 21, 22 and 25, 2021.

The following Critical Incident (CI) intakes were completed within this inspection:

Related to falls prevention and management:
Log #013833-21 / CI 2878-000046-21
Log #014510-21 / CI 2878-000049-21
Log #016167-21 / CI 2878-000054-21

Related to the prevention of abuse and neglect:
Log #011694-21 / CI 2878-000041-21
Log #011756-21 / CI 2878-000043-21

An Infection Prevention and Control (IPAC) inspection was also completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care (MRC), the Assistant MRC/IPAC Program Lead, a Resident Care Coordinator (RCC), the Social Worker (SW), Security Guards, the Behavioural Supports Ontario (BSO) Personal Support Worker (PSW), Registered Practical Nurses (RPNs), a Housekeeper, PSWs and residents.

The inspectors also observed resident rooms and common areas, observed IPAC practices within the home, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed COVID-19 Directive #3 and Directive #5 for Long-Term Care Homes and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

4 WN(s)
3 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a written plan of care for two residents that set out the planned care related to intimacy and sexuality, the goals the care was intended to achieve and clear directions to staff and others who provided direct care to the residents.

A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care (MLTC) related to an interaction of a sexual nature between two residents. The home had a decision tool for staff to use when making care decisions related to intimacy and sexuality. This tool directed that residents' care plans were to be updated.

The plan of care for these two residents did not provide clear direction for staff regarding their individual care needs and the role for staff in assessing, monitoring and responding to residents to resident sexual behaviours and intimacy. The "Assessment of Awareness of Actions" was a tool available in the home to determine a resident's ability to understand, appreciate and participate in a relationship, and this was not completed for either resident.

The Manager of Resident Care (MRC) verified that the decision tool directed staff to update the care plan if there was no evidence of resistance in cognitively impaired residents. The MRC acknowledged the documented care plan for one of residents was confusing and the other resident did not have a care plan in place for sexuality and intimacy. The home's Social Worker (SW) stated staff followed the home's sexual intimacy decision tool to determine if residents were not consenting to touching of an intimate or sexual nature with other residents. The SW verified there was no planned care related to intimacy and sexuality, the goals the care was intended to achieve and clear directions to staff and others who provide direct care for one of the residents. The SW also stated staff needed to know their residents very well to know whether the residents were physically and/or verbally consenting to intimacy and that it should be care planned.

The lack of care planning related to the residents' intimacy and sexuality, including their specific evidence of consent or resistance, could potentially put them at risk for sexual exploitation.

Sources: The residents' Point Click Care (PCC) care plan and other clinical records; resident interviews; the S&R LTC Homes Intimacy and Sexuality in LTC Decision Tool; interviews with the MRC and other staff; and observations. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, 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 the Head Injury Protocol, included in the Falls Prevention and Management Program, was complied with for two residents.

O. Reg. 79/10 s. 48 (1) and s. 48 (2) (b) requires a falls prevention and management program to reduce the incidence of falls and the risk of injury and requires the program to provide for assessment and reassessment instruments.

Specifically, staff did not comply with the home's "Head Injury Protocol" dated June 2017.

Two residents had unwitnessed falls and it was determined by the nursing staff that there was a potential for head injuries. The documented assessments of blood pressure, pulse, hand grip, pupils and level of consciousness were not completed in accordance with the home's protocol for both residents.

The MRC said staff were to complete all parts of the Head Injury Protocol for every unwitnessed fall or fall with a known head injury. They said there was a risk of harm associated with the incomplete assessments as both residents were known to have hit their heads during their falls and they needed to be monitored for any declining condition. The MRC said the staff had been trained on the protocol, but required ongoing teaching about the expectations for documentation.

Sources: The home's "Head Injury Protocol" policy RCM 10-02-02 last revised June 29, 2017; two CI reports; the Head Injury Protocols for two residents and other clinical records; interviews with the MRC and other staff. [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 when the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any protocol, the protocol is 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).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an alleged incident of staff to resident neglect, that was reported to the management in the home from a family member, was immediately investigated.

There was a five day delay in the initiation of the investigation into an alleged staff to resident neglect due to a miscommunication and misunderstanding about the incident between managers in the home. The home's investigation documents showed the investigation interviews with staff started 12 days after the incident was reported. There was a potential risk of harm related to the delay in the investigation.

2. The licensee has failed to ensure every action taken related to alleged staff to resident neglect as well as the results of the home's investigation were reported to the Director.

The home notified the Ministry of Long-Term Care (MLTC) of an alleged staff to resident neglect and that they were conducting an investigation. During the inspection it was reported that the leadership team in the home had completed the investigation and specific actions were taken. The CI report was not updated to include the names of the staff, the results of the investigation or the long-standing actions taken to ensure the resident received their required care. The MRC acknowledged that the CI had not been amended with the required information. There was no identified harm to the resident related to the reporting.

Sources: A CI report; the home’s investigation documentation; interview with a resident; an interview with the MRC and other staff. [s. 23. (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 every alleged, suspected or witnessed incident of neglect of a resident by the licensee or staff, that the licensee knows of, or that is reported to the licensee, is immediately investigated and to ensure the results of every investigation undertaken under clause 23 (1) (a), and every action taken under clause 23 (1) (b), are reported to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident and their substitute decision-maker (SDM) were notified of the results of an investigation into alleged staff to resident neglect, immediately upon the completion of the investigation.

The home investigated an alleged incident of staff to resident neglect. There was no documented evidence to show the resident or their SDM had been notified of the results of the investigation. The MRC said they did not recall speaking to the resident or the family after the investigation was completed. There was no specific harm, however there was a potential risk of harm in not reporting the results to the resident or their SDM.

Sources: A CI report; the home's investigation documentation; interview with a resident; an interview with the MRC and other staff. [s. 97. (2)]

Issued on this 29th day of October, 2021

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

Original report signed by the inspector.