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

London Service Area Office
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Original Public Report

Report Issue Date August 8, 2022
Inspection Number 2022_1363_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ______________________________

Licensee
Steeves & Rozema Enterprises Limited

Long-Term Care Home and City
Westmount Gardens LTCH
London ON

Lead Inspector
Cassandra Aleksic (689)

Inspector Digital Signature

Additional Inspector(s)
Ina Reynolds (524)

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 20, 21, 22, 25 and 26, 2022.

The following intake(s) were inspected:

Log #007385-22/ CI #2878-000016-22, Log #009215-22/ CI #2878-000018-22, and
Log #011361-22/ CI #2878-000024-22 related to falls prevention and management;
Log #008531-22 (Complaint) related to falls prevention and management
Log #010430-22 (Complaint) related to cooling requirements and dealing with complaints
Log #012548-22 (Complaint) related to cooling requirements and continence care and bowel management

The following **Inspection Protocols** were used during this inspection:

- Continence Care
- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Safe and Secure Home

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INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6. (10)(b)

A resident had an unwitnessed fall. Observation and interview with a Personal Support Worker (PSW) noted two specific falls interventions in place for the resident. Review of the resident's plan of care, Kardex and bedside logo showed there was no reference to the use of these specific falls interventions.

The Acting Manager of Resident Care (AMRC) acknowledged the plan of care was not revised to include the falls prevention strategies and stated they would update the care plan. Review of the resident's care plan noted that the care plan was updated to include two specific falls prevention strategies. There was low risk to the resident at the time of the observation.

Sources: Resident clinical records; and interviews with the AMRC and a PSW.

Date Remedy Implemented: July 22, 2022 [524]

NC#002 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6. (10)(b)

A resident had fallen on two separate dates. Three Personal Support Worker's (PSWs) stated that since the falls, the resident did not require the use of equipment for transfers and required a specific level of assistance with use of an assistive device.

The residents current plan of care indicated that their transfer status included the use of the equipment and a different level of assistance.

The Acting MRC indicated that a change in condition would require an update to the resident's plan of care. They stated that they would expect that the plan of care be updated to reflect the resident's current care needs, including transfer status and level of assistance. Acting MRC revised the resident's plan of care, removed the equipment as a mobility intervention and changed the transfer status to their current level of required assistance. There was low risk to the resident and no harm was caused as the resident had received the care required based on assessment.

Sources: Resident clinical records; interviews with three PSWs and the Acting MRC.

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Date Remedy Implemented: July 26, 2022 [689]

WRITTEN NOTIFICATION [24-HOUR ADMISSION CARE PLAN]

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 27. (1)

The licensee has failed to ensure that a 24-hour admission care plan was developed for a resident and communicated to direct care staff within 24 hours of the resident's admission to the home.

Rationale and Summary

The resident was admitted to the home and had sustained an unwitnessed fall which resulted in transfer to hospital.

The Resident Assessment Instrument Home Care (RAI-HC) assessment and placement co-ordinator care team notes documented that the resident required a specific fall intervention due to their identified falls risk. In addition, the resident's mobility fluctuated requiring different levels of assistance. Transfers fluctuated as well and the resident required different levels of assistance throughout the day. Resident was at high risk for falls and had a recent fall prior to their admission to the home.

The admission progress notes documented specific requirements for the resident. Fall prevention strategies had been put in place. In addition, the family had requested specific fall prevention interventions as they were worried about the resident self-transferring and a subsequent fall.

There was no documented evidence to support that a 24-hour admission care plan was developed for the resident.

The home's policy titled "Admission and Readmission" stated that "a 24 hour admission care plan will be developed within 24 hours of the resident being admitted to the home using the updated admission assessment and information received from interviewing the resident and or family member on the day of admission. This information will be communicated to direct care staff".

The administrator and a registered nurse (RN) acknowledged they were unable to find a 24-hour care plan in Point Click Care or the resident's hard copy chart. The lack of a 24-hour admission care plan placed the resident at risk for improper care.

Sources: RAI-HC Assessment paper copy; the home's Admission and Readmission policy #RCM 08-01 revised date April 11, 2017; resident's clinical records; and interviews with the Administrator, a RN and other staff.

[524]

WRITTEN NOTIFICATION [SKIN AND WOUND CARE]

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 55. (2)(a)(i)*

The licensee has failed to ensure that a resident, who was at risk for altered skin integrity, received a skin assessment by a member of the registered nursing staff within 24 hours of the resident's admission.

Rationale and Summary
A resident was admitted to the home from hospital with an injury which required specific equipment. The electronic Treatment Administration Record (eTAR) directed registered staff to complete a skin assessment on the evening shift to identify any areas of altered skin integrity. Review of Point Click Care (PCC) noted that an admission Head to Toe skin assessment was not completed until a later date.

The home's policy titled "Skin & Wound Program" stated that the resident would be assessed for the risk of skin breakdown using the designated Skin Assessment in PCC within 24 hours of the resident's admission.

The administrator and a registered nurse (RN) both said that the home's expectation was that a skin assessment should be done within 24 hours of the resident's admission. The lack of an admission skin assessment did not enable the home to track and monitor any areas of altered skin integrity for the resident.

Sources: The home's policy "Skin & Wound Program" #RCM 10-06-01, revised date May 20, 2022; resident clinical records; and interviews with the administrator and a RN.

[524]

WRITTEN NOTIFICATION [CONTINENCE CARE AND BOWEL MANAGEMENT]

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.56 (2) (f)

The licensee has failed to ensure that continence care products were available to two residents at all times.

Rationale and Summary
A Personal Support Worker (PSW) informed the inspector that the home area had been out of a specific continence product for two residents since the weekend.

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A progress note in one of the resident's chart indicated that the resident reported that they were using their own continence product supply since the day prior due to unavailability of their product size. The writer documented that there were none in the stock room and this had required a follow up.

Inspector spoke with a registered nurse (RN) who confirmed that the home did not have the specific size continence product available which was required for the residents. They stated that they informed the nursing clerical coordinator (NCC) of the concern and that the product was ordered.

Inspector and the NCC observed the overstock supply room and the NCC confirmed that there were no continence products available of the required size. The NCC stated that there was more than one resident wearing that product size and the order sheet was not reflective of the amount of product needed.

Inspector spoke with the acting manager of resident care (MRC) who stated that continence products should be made available to residents.

Sources: Resident progress notes; home area observations; and interview with a PSW, RN and NCC

[689]

WRITTEN NOTIFICATION [REPORTS RE CRITICAL INCIDENTS]

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 115 (4)(b)

The licensee has failed to ensure that when the home was unable to determine within one business day of a residents fall, and hospitalization resulting in a significant change in status, that the Director was informed no later than three business days after the occurrence of the incident.

Rationale and Summary

A complaint received from a family member and review of progress notes on Point Click Care (PCC) documented that the resident had sustained an unwitnessed fall. The results of a follow-up exam received by the home, showed that the resident had an injury. During an assessment, staff documented that the resident was guarding their injured area, and had worsening symptoms. The resident was transferred to hospital in consultation with the Nurse Practitioner and family. A family member requested the resident to be discharged from the home and stated there was no plan to discharge the resident from the hospital.

The resident's progress notes showed that the former Assistant Manager of Resident Care and a registered staff were aware that the resident had been diagnosed with an injury and increased pain and transferred to hospital.

Review of the Long-Term Care Homes Critical Incident System portal used to report incidents to the Director, failed to identify a report related to the identified incident.

The administrator acknowledged that the home had not notified the Director of the incident and transfer to hospital for the resident and it should have been. Failing to report to the Director did not pose a risk to the resident.

Sources: The Ministry of Long-Term Care "Long-Term Care Homes Portal"; resident clinical records; and interview with the Administrator.

[524]

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s*. 29 (3) 11*

The licensee has failed to ensure that a resident's plan of care included measures to prevent or mitigate heat related illness.

Rationale and Summary
A resident informed the inspector that they had been feeling hot due to the temperature in their room. When asked if staff assisted them with cooling interventions, they stated no.

A personal support worker (PSW) stated that the home implemented interventions for residents when a heat warning was issued which included heat related illness preventative measures. When asked where interventions to prevent heat-related illness for a resident were documented, they said that specific interventions for a resident would be in their care plan.

There was no documented information related to heat related illness in the resident's care plan on Point Click Care (PCC).

The administrator stated that they would expect heat-related illness interventions be documented in the resident's plan of care.

Sources: Resident care plan; interview with resident; interview with a PSW and Administrator

[689]

WRITTEN NOTIFICATION [DEALING WITH COMPLAINTS]

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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Non-compliance with: O. Reg. 246/22 s. ***108 (1) 1.***

The licensee has failed to ensure that every verbal complaint made to a staff member concerning the care of a resident was investigated and resolved where possible.

Rationale and Summary

The Ministry of Long-Term Care Complaint Information Reports on various dates documented complaints from a resident regarding cooling requirements at Westmount Gardens. The complainant reported concerns related to heat and not being permitted a specific cooling intervention.

The complainant stated that they were a resident of the home and had concerns with the temperature of their room being warm. They stated that they were unsure why the home would not permit the resident to have this specific cooling intervention. The complainant stated that they have seen other residents with the same cooling intervention, and when they brought up the concern with the home, the staff stated that the specific cooling intervention was not allowed. When asked if the home had assisted with their heat concerns, the complainant stated no, and due to health conditions, the warm air made certain activities of daily living more difficult.

On eight different dates, the residents progress notes included documentation that the resident had expressed concerns about the heat and wanting cooling interventions in their room. Notes also included that the writer(s) had documented that they acknowledged the feeling of the resident and told them that they would pass along the request or that the concern required follow up.

A personal support worker (PSW) said that the resident was consistently complaining about the heat, but no one had done anything to address their concerns. The PSW stated that their role related to complaints would be to inform the registered practical nurse (RPN). The RPN would document a note and then inform the registered nurse who would then inform management.

A registered practical nurse stated that their role related to complaints would be to inform the RN and the information should go to management. When asked if there had been any concerns brought forth related to heat, they stated that the resident wanted a specific cooling intervention, but they were not permitted this due to having a roommate. When asked if the residents concerns have been brought forth to management, they stated that it had, but not sure what had been done.

There were no documented records kept in the home related to the heat/temperature complaints for the resident. There was no information in the resident's plan of care related to heat-related illness interventions. The risk to the resident was moderate, as the home did not address or resolve the ongoing concerns related to heat.

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The environmental manager (EM) stated that no concerns have been brought forth to them related to hot temperatures. When asked if there were heat concerns brought forth related to the specific resident, they stated no, and if they did, they would have investigated it.

The home's policy Complaints and Concerns dated June 28, 2022, stated that every written or verbal complaint made to the Home or staff member concerning the care of a resident must be dealt with, which included that the complaint be investigated and resolved where possible.

The administrator stated that a complaint, verbal or written, goes to the administrator to complete the investigation and to the manager of the appropriate department. They would speak to the family or resident who lodged the complaint as soon as possible, and then capture the information in the complaint logs. When asked if the management team had been made aware of a complaint related to the resident's heat concerns, they said yes when the resident had moved into the home. The administrator said that they had provided the resident with information related to public health direction for cooling intervention use in the home. They said that from a home level, the specific cooling intervention was not provided to residents, and the resident would have to purchase this. The administrator stated that if the resident was in need of the specific cooling intervention, they would provide the resident guidelines on how and when to use it. When asked if staff have brought forth repeated concerns from the resident regarding heat and cooling intervention use, they stated no. The administrator stated that they would expect that staff inform them if concerns persisted and that it was considered a verbal complaint.

Sources: Interview with the resident; interview with a PSW, RPN, Environmental Manager and Administrator; resident clinical records; and home policies and procedures.

[689]

WRITTEN NOTIFICATION [DEALING WITH COMPLAINTS]

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. ***108(2)(d)***

The licensee has failed to ensure that a record was kept in the home related to the heat/temperature complaints for a resident, which included documentation of the final resolution.

Rationale and Summary

The Ministry of Long-Term Care Complaint Information Reports documented complaints regarding cooling requirements at Westmount Gardens. The complainant reported concerns related to the use of cooling interventions for a resident due to warm temperatures.

The complainant informed the inspector that they had concerns with the temperatures of the home and that they were informed that they would be removing the specific cooling interventions in the future as the home worked towards servicing the cooling system.

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The inspector spoke with the resident in their room. The inspector observed that the specific cooling interventions were in place at the time. The resident stated that they were not allowed to have the cooling interventions before, but since being implemented, the temperature had been fine.

The resident's plan of care stated interventions for heat-related illness which included a specific intervention to promote cooling.

A "Customer/Team Member Feedback Form" was initiated for a written complaint submitted to the home which included concerns specific to the residents' temperatures in their room and the cooling interventions be discontinued. The concern also documented that the management had not returned their phone calls or emails. An email communication response documented that the concern was received and to be reviewed. Documentation showed that the complainant was contacted and that information was transferred to the correct individuals. There was no documentation indicating the final conclusion/outcome summary of how the concern was resolved.

The home's Complaint and Concerns policy, dated June 28, 2022, stated that the home must keep a documented record of the complaint that included the final resolution, if any.

The administrator stated that the home had written procedures for managing complaints. The administrator said that they were not familiar with the concerns brought forth on behalf of the resident. The risk to the resident was low, as they had heat prevention measures in place, however, the home did not resolve concerns with the complainant.

Sources: Interview with complainant and resident; interview with the Administrator; resident clinical records; written policies and procedures.

[689]