Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
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Original Public Report

Report Issue Date: September 27, 2023	
Inspection Number: 2023-1363-0005	
Inspection Type: Critical Incident	
Licensee: Steeves & Rozema Enterprises Limited	
Long Term Care Home and City: Westmount Gardens Long Term Care Home, London	
Lead Inspector Leah Carrier (000748)	**Inspector Digital Signature** Leah N Carrier Digitally signed by Leah N Carrier Date: 2023.09.28 09:55:52 -04'00'
Additional Inspector(s) Brandy MacEachern (000752)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 22, 25 & 26, 2023

The following intake(s) were inspected:

- Intakes #00095393 [Critical Incident #2878-000037-23], and #00096599 [Critical Incident #2878-000040-23] related to Falls Prevention and Management
- Intake #00092943 [Critical Incident #2878-000034-23) related to Prevention of Abuse and Neglect and Responsive Behaviours

The following intake(s) were also completed:

- Intakes #00090876 [Critical Incident #2878-000032-23], #00090877 [Critical Incident #2878-000031-23], #00091293 [Critical Incident #2878-000033-23], #00093550 [Critical Incident #2878-000035-23], #00095590 [Critical Incident #2878-000039-23] related to Falls Prevention and Management

Inspection Manager Amie Gibbs-Ward (630) was also present for this inspection.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Care Provided as Specified in the Plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the resident's plan of care related to fall interventions were provided to the resident as specified in the plan.

Rational and Summary
A Critical Incident (CIS) System report was received by the Director regarding a fall of a resident.

Throughout a review of the resident's care plan, the falls intervention section indicated the resident required certain falls interventions in place. During an observation of the resident, it was noted that the falls interventions as identified in the care plan were not in place. A Personal Support Worker (PSW) was brought to the room during this observation and acknowledged that the interventions were not in place as they should have been.

There was a risk that the resident could have suffered greater injuries if they had a fall without their specified interventions in place.

Sources: Staff interview, resident care plan, observation of the resident

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WRITTEN NOTIFICATION: Monitoring of Residents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to ensure that when the resident fell, the Head Injury Routine (HIR) protocol was completed for the required assessment intervals.

In accordance with O. Reg. 246/22 s. 11 (1) (b) the licensee is required to ensure the home's falls prevention and management program was in place, and ensure it was complied with. Specifically, staff did not comply with the licensee's Head Injury Protocol which was part of the licensee's policy: Fall Prevention and Management Program Policy.

Rational and Summary
A Critical Incident System (CIS) report was received by the Director for an unwitnessed fall of a resident. According to the CIS, the head injury routine was initiated at the time of the fall.

During a review of the resident's HIR document related to the fall, the resident's neurological vital signs were not completed for all required assessment intervals.

Additionally, day shift neurological vitals were not documented on the resident's HIR form. During a review of Point Click Care (PCC) progress notes and vitals section, there was documentation found for the resident's blood pressure and pulse, but there was no documentation of a pupil assessment.

Procedure eight under the home's Falls Prevention and Management Program Policy stated that the HIR Protocol would be followed when a resident receives an injury to the head, a suspected injury to the head or an unwitnessed fall. Specifically, the HIR documentation form indicated that blood pressure, pulse, level of consciousness, and pupil assessment would be assessed for specific time intervals.

The Manager of Resident Care and a Registered Practical Nurse each acknowledged in interviews that the resident's HIR form was missing assessments. An Assistant Manager of Resident Care also acknowledged in an interview that the assessment was not completed at all time intervals as required.

There was an increased risk that the resident, who had an unwitnessed fall, may have had worsening or new neurological issues that went unnoticed.

Sources: CIS Report, Resident's physical cart, Resident's PCC documentation, Staff Interviews,

HIR form, HIR Protocol Policy, Falls Prevention and Management Program Policy.

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