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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 19, 2024	
Inspection Number: 2024-1363-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Steeves & Rozema Enterprises Limited	
Long Term Care Home and City: Westmount Gardens Long Term Care Home, London	
Lead Inspector Rhonda Kukoly (213)	**Inspector Digital Signature** Rhonda Kukoly Digitally signed by Rhonda Kukoly Date: 2024.03.25 15:05:59 -04'00'
Additional Inspector(s) Peter Hannaberg (721821) Henry Otoo (000753)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 21, 22, 23, 26, 27, 2024.

The following intake(s) were inspected:

- Intake: #00109142 - 2024- Proactive Compliance Inspection

Inspector Neelam Patel was also present during the inspection.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

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)
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure that every window that opened to the outdoors and was accessible to residents did not open more than 15 centimeters (cm).

Rationale and Summary
During the initial tour of the home, the window in a resident's room opened more than 15 cm. The Acting Administrator/Director of Resident Care was informed, and the window was fixed the same day by the Environmental Services Manager. The resident was not exit-seeking, not in their room at the time, and was not physically able to open the window.

Sources: Observation, interview, and record review. [000753]
Date Remedy Implemented: February 21, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their 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 their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to fully respect and promote residents' right to have their personal health information kept confidential.

Rationale and Summary
Inspector #000753 observed a medication cart in the hallway in front of a resident's room with the electronic medication records of residents displayed on the computer screen, with no staff present in the hallway, and the door to the resident's room closed. The medication cart was not in view of the registered staff member who was administering medications. The registered staff member said they were aware they needed to have locked the electronic medication records. There was risk that someone could view residents' personal health information without consent.

Sources: Observation and staff interview. [000753]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee failed to ensure that the written plans of care for two residents set out clear directions to staff and others who provided direct care to the resident related to their use of call bells.

Rationale and Summary
During inspection, inspectors observed two residents in their rooms without their call bells in reach. The plans of care for both residents did not provide clear directions for staff who regarding these residents use of their call response system.

Sources: Observations of residents, clinical records for residents, and staff interviews. [000753]

WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. ii.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
ii. equipped with a door access control system that is kept on at all times.

The licensee has failed to ensure that all doors leading to stairways that residents did not have access to, were equipped with a door access control system that was kept on at all times.

Rationale and Summary
An inspector noted that fire alarm testing was being performed and spoke with the Director of Resident Care (DRC) to confirm that doors were remaining locked. The DRC stated that staff were aware of fire alarm testing, that doors were remaining locked, and that the Fire Watch process was in place. The door to stairwells one and

two on the second floor were found to be unlocked and the keypad power not active. Staff members in those areas were unaware that the doors were unlocked and there were residents in the vicinity of the doors.

The Environmental Services Manager (ESM) was notified and on investigation, found that the power to the keypads for the stairwell door locks were not functioning and stated there may have been a glitch when resetting the power during the fire alarm testing. They reset the power, and the power to the keypads for the stairwells was returned and the doors to the stairwells were then locked. The ESM stated they were unaware that these door locks had not been operating properly.

There was at minimum, one hour when there had been no power to the second floor stairwell door locks which put residents at risk for entering a space not designed for resident use. Staff were not observing the unlocked door while at least one resident was walking in that area.

Sources: Observations, Hourly Fire Walk record review, discussions with the DRC and ESM. [721821]

WRITTEN NOTIFICATION: Security of Drug Supply

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.

The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times when not in use.

Rationale and Summary
Inspector #000753 observed a medication cart in the hallway in front of a resident's room that was unlocked with no staff present in the hallway, and the door to the resident's room closed. The medication cart was not in view of the registered staff member who was administering medications. The registered staff member said they aware they needed to have locked the medication cart. There was potential for residents and others to gain access to medications in the unlocked cart.

Sources: Observation and staff interview. [000753]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee has failed to ensure that the continuous quality improvement committee was composed of at least one employee of the licensee, who was a member of the regular nursing staff of the home.

Rationale and Summary

The last three Professional Advisory Committee/Quality and IPAC meeting minutes documented attendance did not include a registered nursing staff member. The Acting Administrator said that due to a shortage of registered nursing staff members, they were not able to pull a staff member off the floor to participate in the quality improvement committee. Input from all required persons was not obtained when developing quality improvement initiatives in the home when a member of the regular registered nursing staff of the home was not included.

Sources: Quality improvement committee minutes, and interview with the Acting Administrator. [213]

WRITTEN NOTIFICATION: Additional training — direct care staff

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

Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.

Additional training — direct care staff

s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

The licensee has failed to ensure that all registered staff who provided direct care to residents, completed their assigned annual training by the home in Fall Prevention and Management, Pain Management, and Skin and Wound Care Management.

Rationale and Summary

The Skin and Wound Care and Education Lead provided copies of the training completed by registered staff that was assigned by the home in Pain Management, Skin and Wound Care, and Falls Prevention and Management, in 2023. It indicated that less than 50% of registered staff had completed the required training in the three areas. The deadline for completion of the training was December 31, 2023.

The Education Lead said that they oversaw the completion of the training but had not followed up with staff to ensure they completed the required training.

Sources: Record reviews and staff interview. [000753]