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: July 16, 2024
Inspection Number: 2024-1363-0004
Inspection Type: Complaint Critical Incident
Licensee: Steeves & Rozema Enterprises Limited
Long Term Care Home and City: Westmount Gardens Long Term Care Home, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 25, 26, 27, 28, 2024 and July 2, 3, 4, 8, 2024.

The following intake(s) were inspected:
Intake: #00114016 – (CIS-2878-000015-24) related to suspected neglect
Intake: #00114432 – Complaint related to resident care and services
Intake: #00114574 – (CIS 2878-000016-24) related to falls prevention and management
Intake: #00117188 – Complaint related to skin and wound care
Intake: #00117992 – (CIS 2878-000023-24) related to responsive behaviors
Intake: #00120398 – Complaint related to suspected neglect

Christy Legouffe, Program Specialist was onsite June 25 and 26, 2024.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

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:

16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure that the rights of a resident were respected by receiving care and services consistent with their needs.

Rationale and Summary

A Critical Incident System(CIS) report was received by the Director regarding allegations of staff to resident neglect.

Interviews with the Administrator and additional staff, they verified that a staff member neglected a resident during a specific incident, acknowledging that the

resident's rights were not respected after the resident had a fall.

The resident was not attended to when they fell and was not assessed before they were moved off the floor. The inaction observed in the response of the staff member to the resident's fall did not ensure that the rights of the resident were respected by receiving care and services consistent with their needs after they fell.

Sources: interviews with Administrator and staff, record reviews of the critical incident system report, investigation files related to the incident and video footage.

[000829]

WRITTEN NOTIFICATION: Safe and Secure Home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure the home was a safe and secure environment for the residents on a specific home area.

Rationale and Summary

During the onsite inspection, Inspector #000829 observed two open areas in the ceiling outside two resident rooms which wires and a call light box were hanging at eye level to the Inspector. A ladder and a tool cart, with power tools and electrical supplies (wire caps, boxes, bags and other small items), were also observed and noted to be unattended, and within reach of residents. During the observation, an

individual was observed replacing the wires into the ceiling. Although residents were observed in the area periodically during the time the concern was identified, no residents were harmed or impacted because of this incident. The licensee took steps to ensure the safety of the residents by directing the tool cart be removed from the hallway.

Sources: Observation of the specific home area; interview with staff.

[000829]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when a person who had reasonable grounds to suspect that improper or incompetent treatment of a resident occurred that resulted in a risk of harm to the resident, that it was reported to the Director.

Rationale and Summary

A complaint was received by the Director concerning a resident. When reviewing the resident's progress notes, a note was identified which indicated a treatment had been provided in the incorrect manner. In interview with the Acting Manager of

Resident Care (MRC) they confirmed that this was an incident of improper or incompetent treatment that resulted in risk of harm for the resident and advised that a Critical Incident System (CIS) report had not been submitted for the incident.

Sources: Resident progress notes, staff interview

[000752]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The licensee has failed to ensure that a resident was assessed after they had fallen.

Rationale and Summary

A Critical Incident System (CIS) report was received by the Director concerning a resident.
During the inspection of the incident, the Inspector #000829 reviewed documentation and video footage of the fall. It was noted that the resident was not assessed when they fell or before being moved. The Acting Manager of Resident Care (MRC) acknowledged in an interview that it was the expectation that staff should have completed specific assessments for the resident after the fall and also that the resident should have been assessed before being transferred. Furthermore, in an interview with staff, they admitted that they did not assess the resident as

expected before the resident was transferred. Additionally, the licensee's policy Fall Prevention and Management Program outlines that staff were to remain with a resident after the resident has fallen and the resident was to be assessed before lifting.

When staff did not assess the resident at the time of the fall and staff did not assess the resident before transferring the resident, they placed the resident at risk.

Sources: Interviews with staff, record review of incident investigation file, licensees policy Fall Prevention and Management Program and video footage from incident.

[000829]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident received immediate treatment and interventions to promote healing, and prevent infection, as required.

Rationale and Summary
A compliant was received by the Director concerning skin and wound care for a resident.

During a record review, a progress note written by a Registered Practical Nurse (RPN) indicated that the resident had an area of altered skin integrity. Additionally, the note stated that the Registered Nurse (RN) had been updated and continue to monitor.

Altered skin integrity assessments were completed on specific dates. Then there was no documentation noted of the area of altered skin integrity again and no interventions implemented for a specific period of time.

In interview the home's Nurse Practitioner informed that they had concerns that the staff did not bring this to their attention earlier.

There was a risk to the resident that they did not receive immediate treatment and interventions to promote healing and prevent infection when staff did not notify the Nurse Practitioner of ongoing concerns for an area of altered skin integrity.

Sources: Resident electronic health records, staff interview.

[000752]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions

are documented.

The licensee has failed to ensure that actions related to a specific care activity and responsive behaviours were taken for a resident, to respond to their needs, including assessments, reassessments and interventions and that their responses to interventions were documented.

Rationale and Summary

A complaint was received by the Director, regarding a specific care activity for a resident. During the inspection of the complaint, Inspector #000829 reviewed progress notes, and other documentation related to responsive behaviours secondary to the specific care activity. Inspector #000829 was unable to determine from document review whether the resident had any triggers related to the care activity or any responsive behaviour interventions developed and implemented to assist the resident to have their care requirements met. During an interview with a staff, it was explained to Inspector #000829 that in the past, the resident was triggered by certain aspects of the care process, however documentation was not present for actions taken to identify strategies and interventions when the resident was experiencing responsive behaviours. Although, staff stated that the resident received a specific intervention, staff were unable to articulate where the documentation could be found to support the implementation of this intervention. In interviews with additional staff, they were unable to clearly demonstrate or articulate to inspector #000829 or to inspector #000752 where the information regarding triggers and interventions related to the specific care activity and responsive behaviours could be found in the residents plan of care, as well as whether the resident had been assessed or reassessed for responsive behaviours.

Sources: interviews with staff, and record review of progress notes, care plan and POC task documentation

[000829]

WRITTEN NOTIFICATION: Police Notification

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

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The licensee failed to ensure that the appropriate police service was immediately notified of any alleged or suspected neglect of a resident.

Rationale and Summary

A Critical Incident System (CIS) report was received, by the Director regarding allegations of staff to resident neglect. During the inspection of the incident, Inspector #000829 reviewed documentation related to the incident. In the CIS, it was documented that Police were called a number of days after the licensee became aware of the incident, to report neglect of staff to resident. The Administrator confirmed in interview that they had not immediately notified the police. They advised that when reviewing their internal investigation checklist, they identified that this had been missed, then notified the police at that time.

This issue did not cause risk or impact to the resident by the late reporting of the incident to the police service.

Sources: CIS report, Interview with Administrator.

[000829]

COMPLIANCE ORDER CO #001 Skin and wound care

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
a) The Director of Nursing and Personal Care or designate shall complete biweekly audits on all residents living on two home areas, who have exhibited altered skin integrity to ensure that assessments, using a clinically appropriate assessment instrument, specifically designed for skin and wound assessment were completed weekly as expected
b) A documented record will be maintained, including the name of the individual completing the audits, date of the audits, names of the residents on which the audit(s) were performed, any concerns identified and corrective actions taken as a result of the audits . Audits will continue until an Inspector has complied the order.

Grounds

a) The licensee has failed to ensure that a resident who was exhibiting altered skin integrity was reassessed at least weekly.

Rationale and Summary

A complaint was received by the Director, regarding skin and wound care for a resident. During the inspection of the complaint, the inspector reviewed progress notes, documentation of skin assessments and the resident's documented responses to wound care. Inspector #000829 noted that documentation was present outlining staff attempts to perform wound care as prescribed. However, documentation was not found regarding the reassessment of the resident's area of altered skin integrity between specific time periods. By not ensuring that reassessments were completed at least weekly using a clinically appropriate assessment instrument, the resident was at risk for increased pain, infection, impaired wound healing and the potential to decrease the resident's quality of life.

Sources: Interview with staff; and record review of progress notes, electronic health records

[000829]

b) The licensee has failed to ensure that a resident who was exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A compliant was received by the Director concerning skin and wound care for a resident.

During a record review it was noted that there was an initial altered skin integrity assessment documented for a wound of the resident. There was no documentation

found of a reassessment until a specific period of time after, when a weekly altered skin integrity assessment of the wound was documented.

In interview the Acting Manager of Resident Care (MRC) explained that the home's process for wound assessments was to complete an initial, then weekly assessments, until documented as resolved. The Acting MRC acknowledged that weekly wound reassessments had not been completed for the resident's wound, as expected.

There was a risk to the resident when their wound was not monitored by weekly assessments.

Sources: Resident electronic health records, staff interview.

[000752]

This order must be complied with by August 19, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.