Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 19, 2014	2014_242171_0003	L-000021-14	Resident Quality Inspection

Licensee/Titulaire de permis

~~DEVONSHIRE ERIN MILLS INC.~~ Steeves & Rozema Enterprises Ltd.
~~195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7~~ 265 North Front St. Suite 200, Sarnia, ON

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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

ELISA AGNELLI (171), NUZHAT UDDIN (532), PATRICIA VENTURA (517), RAE MARTIN (515)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 28,29,30,31, February 4,5,6, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Manager of Resident Care, Resident Assessment Instrument (RAI) Manager, Food Services Manager, Environmental Services Manager, Life Enrichment Manager, Life Enrichment staff, Registered Dietitian, 2 Dietary Aides, Housekeeper, 2 Nursing Administrative Clerks, Physiotherapist Assistant, Restorative Care Coordinator, Social Services, Registered Nurse (RN), 9 Registered Practical Nurses (RPN), 13 Personal Support Workers (PSW), 4 Family Members, and 36 Residents.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas and care provided to residents, reviewed health records and plans of care for identified residents, reviewed policies and procedures of the home, and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee had not ensured that the home was maintained in a safe condition and in a good state of repair.

Observations during tours of the five Tub/Shower/Grooming rooms with the Maintenance Manager and Administrator revealed:

- Tiles in disrepair.
- Floor with stains and eroded by the drain with water pooling.
- The doorway between the grooming room and tub room looked unfinished, missing paint or wall paper.
- Ceiling with paint peeling off in the first floor shower rooms.
- Wall paper missing from a section of the wall 26cm wide revealing a black mould-like substance, in one of the grooming rooms.
- Wall paper split open and peeling off under the sink in one of the grooming rooms.

The Maintenance Manager and Administrator were unaware of the black mould-like substance on the wall until pointed out by inspectors. The Administrator verified this wall would be repaired immediately.

The Administrator and Maintenance Manager verified that all shower room floors were pooling water and that water leaking down from Lily Valley and Yellow Rose shower rooms was causing damage to the ceilings of the shower rooms directly under them (Apple Blossom and Daisy shower room).

The Administrator and Maintenance Manager verified there was a need to prevent further water leaks and repairs were needed to all affected shower room walls and ceilings. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 the home is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee had not ensured the plan of care was reviewed and revised when care needs changed.

Interviews with staff indicated Resident #636's continence levels had been changing. This was confirmed in the Point of Care documentation and the MDS coding which indicated the resident had a certain level of continence. The care plan shows a different level of continence for the resident. The plan of care was not reviewed and revised when the resident's continence care needs changed.

Registered staff confirm the documented plan of care had not been updated with a focus and interventions related to continence to reflect the resident's current care needs. [s. 6. (10) (b)]

2. The licensee failed to ensure when a resident was being reassessed and the plan of care reviewed and revised because care set out in the plan had not been effective, that different approaches had been considered in the revision of the plan of care.

Record review revealed that Resident #597 had a number of falls in a four month period. The resident was reassessed, however, the plan of care was not effective and different approaches were not considered in the revision of the plan of care.

Registered staff confirmed that different approaches were not considered for the resident. [s. 6. (11) (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 the plan of care is reviewed and revised when care needs change and that different approaches are considered when care as set out in the plan of care has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee had not ensured the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Sleep patterns and preferences.

a) In an interview, Resident #636 stated a preference for a different time to get up in the morning, however did not feel there was a choice. Staff indicated they would honour a resident's wishes regarding time to get up if requested and that if a resident makes this request regularly they would try to accommodate by changing staff routines. A review of the plan of care revealed documentation regarding an assessment or plan for this resident's sleep preferences and when to get up in the morning was not included. (171)

b) An interview with a family member revealed a different preference for Resident #616 regarding getting up in the morning than the routine the resident was currently on. An interview with a PSW revealed the resident verbalized this same preference. A review of the plan of care revealed that documentation regarding an assessment or plan with respect to the resident's sleep preferences was not included.

Registered staff confirm that sleep patterns and preferences are not currently part of the documented plan of care. [s. 26. (3) 21.]

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 the plan of care is based on, at a minimum, an interdisciplinary assessment of the resident regarding sleep patterns and preferences, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee had not ensured the recreation and social activities included a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests.

Resident comments during Stage 1 of the Inspection indicated residents were not aware of programs being offered on weekends. The home's annual resident satisfaction survey, completed in October 2013, regarding activities being offered seven days/week showed a 65% positive response.

The activity calendar for January 2014 indicated that three out of four Saturdays the activity was Bingo for all home areas to come to one central area in the afternoon. One home area had manicures in the morning. Four out of four Sundays the activity was Bowling in one central area.

The recreation and social activities were not of a frequency or type to benefit all residents and reflect their interests on the weekends. The Administrator confirmed this was an identified area of concern. [s. 65. (2) (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 the recreation and social activities include a range of activities in a frequency and type to benefit all residents of the home, to be implemented voluntarily.

WN #5: 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 had failed to ensure that the procedure for refrigerator temperature monitoring was complied with.

February 4, 2014, 0904h observed the medication refrigerator on Yellow Rose home area. Refrigerator was dirty with dried liquid spilled in the bottom and frost build up in the freezer. The fridge temperature and cleaning monitoring sheet for the month of February was missing 2/3 signatures for temperature check and there were no signatures for cleaning.

The refrigerator temperature monitoring sheet provides direction to check fridge temperatures nightly and clean fridge once/week. Information on the white board in the medication room directs staff on "Nights" to defrost the fridge freezer every weekend.

The RPN confirmed the February monitoring sheet should have temperatures recorded nightly and there should be a signature for fridge cleaning.

February 4, 2014, 1030h observed the medication refrigerator on Lily home area. The fridge temperature and cleaning monitoring sheet for the month of February was missing 1/3 signatures for temperature check and there were no signatures for cleaning.

February 4, 2014, an interview with the Assistant Manager of Resident Care confirmed the expectation that the fridge temperature and cleaning check list is to be signed every night after it is checked and cleaning is to be done weekly. She further confirmed if there is no signature on the sheet, it is assumed that it is not done. [s. 8. (1)]

2. The licensee had not ensured that the procedure that was put in place regarding food temperatures was complied with.

Food Services has a procedure for taking food temperatures in the kitchen and in each servery prior to meal service. On February 4, 2014, a review of the food temperature charts for February 1-3, 2014 revealed the following missing documentation in the serveries:

Iris: all dinner menu items on February 1 and 2, 2014

Yellow Rose: all dinner menu items on February 1, 2014
Apple Blossom: all dinner menu items on February 3, 2014
Daisy: all dinner menu items on February 1, 2014.

Dining committee minutes and two resident interviews during Stage 1 of the inspection indicated there have been concerns from residents regarding the temperature of food.

The Food Services Manager confirmed the expectation food temperatures be taken in the serveries before each meal service and that the above temperatures were not recorded on the dates as above. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that can be easily seen, accessed and used by resident's staff and visitors at all times.

a) Observed Resident #548 in a chair with the call bell nearby but the button was stuck and was not activating the response system. The RPN confirmed the call bell was not working and would have it fixed immediately. (515)

b) Observations revealed that call bell for Resident #525 was not working. The PSW checked the call bell and confirmed that it was not working and called maintenance staff to fix the call bell system. [s. 17. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that a written staffing plan for nursing and personal support services was put in place that included a back-up plan for personal care staffing that addresses situations when staff cannot come to work.

Interviews with residents and family members during Stage 1 of this inspection indicated some concern with staffing levels.

On February 4, 2014 an interview with the RN and Assistant Manager of Resident Care revealed that Personal Support Workers are moved to different neighbourhoods and short shifts are extended to full shifts to address situations when personal support workers cannot come to work. However,it is not a written plan.

Both Assistant Manager of Resident Care and Registered Staff confirmed that there was no written staffing plan for nursing and personal care to address situations when staff cannot come to work. [s. 31. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee had not ensured that each resident who is incontinent receives an assessment using a clinically appropriate assessment instrument which is specifically designed for assessment of incontinence.

The MDS coding indicated Resident #636's continence levels changed. This was confirmed by Point of Care documentation and by Personal Support Workers. There were no documented Continence assessments found in either Mede-Care or Point Click Care.

Registered staff confirmed the expectation that a continence assessment be completed using a clinically appropriate assessment instrument when there is a change in condition. [s. 51. (2) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee had not ensured proper techniques were used to assist residents with eating.

a) At a lunch meal service it was observed that the person assisting Resident #100 to eat was not using proper techniques for assisting residents with eating.

b) At a second lunch meal service it was observed that the person assisting this same resident was also using inappropriate techniques for assisting.

Two Personal Support Workers confirmed that their training for feeding residents included the appropriate techniques. The Assistant Manger of Resident care confirmed the expectation that these procedures should be followed for this resident. [s. 73. (1) 10.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

February 4, 2014, observed cooked noodles in a plastic lunch storage container in the medication fridge. The RPN confirmed her lunch was in the container and knew she should not have put it in the medication fridge.

An interview with the Assistant Manager of Resident Care confirmed the expectation that staff lunches are not to be stored in the medication fridge. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

February 4, 2014, observed two boxes containing a controlled substance in a medication fridge. The RPN confirmed there is no lock box for this medication but the medication does indicate it needs to be refrigerated.

The Assistant Manager of Resident Care confirmed this medication should be in a locked box in the refrigerator. [s. 129. (1) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure staff participated in the implementation of the infection prevention and control program.

On January 30, 2014, observation of a tubroom revealed a seat pad belonging to the resident lift, a tray, and two tub brushes lying on the floor.

Interview with an RPN confirmed the expectation would be for the tub brushes to be hung up on the hooks on the wall and the seat pad and tray be cleaned and placed in the clean tub after bathing a resident. [s. 229. (4)]

Issued on this 19th day of February, 2014

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

Elisa Agnelli