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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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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 14, 2014	2014_254515_0002	L-000072-14, L-000082-14	Critical Incident System

Licensee/Titulaire de permis

~~DEVONSHIRE ERIN MILLS INC.~~ S+R NURSING HOMES LTD
~~195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7~~

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

RAE MARTIN (515), ELISA AGNELLI (171)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 6 and 7, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Manager of Resident Care, Restorative Care Coordinator, three Residents, two Registered Practical Nurses and five Personal Support Workers.

During the course of the inspection, the inspector(s) toured two resident home areas, reviewed resident clinical records, the home's investigation of critical incidents and observed care provided to residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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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 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on interdisciplinary assessment of the mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A review of a resident's health record revealed two assessments over three months document the resident was verbally and physically abusive with responsive behaviours. Progress notes reviewed over a one month period indicate the resident has behavioural triggers and responsive behaviours that are not easily altered and has escalated.

Staff on the resident's home area confirmed the resident becomes angry and agitated, is more often not settling and medication is not effective.

The plan of care does not include goals and interventions related to mood and behaviour patterns, responsive behaviours, potential behavioural triggers and variations in resident functioning at different times of the day.

The Assistant Manager of Resident Care (AMRC) confirmed the expectation there be an individual plan which documents focus, goals and interventions related to responsive behaviours to provide staff direction. [s. 26. (3) 5.]

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 that the plan of care is based on interdisciplinary assessment of the mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #2: 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,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident, who is incontinent, has an individualized plan, as part of the plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

Review of the current plan of care lists interventions for toileting are to use disposable/reusable briefs in small/medium/large size and for staff to ensure the resident is dry and clean by toileting the resident every two hours.

Staff report they do not toilet the resident every two hours.

The AMRC confirmed the current plan of care is not individualized, and the expectation that the plan of care be individualized to the needs of the resident. There should be an identified size of brief and specific toileting plan noted in the care plan. [s. 51. (2) (b)]

Issued on this 28th day of February, 2014

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