



**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**

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**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
May 2, 2014	2014_254515_0012	L-000459-14	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)

**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): May 1, 2014.**

**During the course of the inspection, the inspector(s) spoke with the  
Administrator, Assistant Manager of Resident Care, 1 Registered Practical  
Nurse, 3 Personal Support Workers and 1 Resident.**

**During the course of the inspection, the inspector(s) toured a resident home  
area, reviewed the health record and plan of care for an identified resident and  
observed resident-staff interaction.**

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



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**Personal Support Services**

**Findings of Non-Compliance were found during this inspection.**

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
<b>Legend</b>  WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	<b>Legendé</b>  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.)	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.)
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.



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**WN #1: 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).**

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**Findings/Faits saillants :**

1. On May 1, 2014, at 1240h, observed an unlocked and unattended medication treatment cart containing resident prescription creams in an identified area accessible to residents.

The Assistant Manager of Resident Care was called to the area and confirmed the medication treatment cart was left unlocked and unattended.

She shared the home's expectation is that medication treatment carts are not to be left unlocked and unattended. [s. 129. (1) (a) (ii)]

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**Issued on this 2nd day of May, 2014**

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

RAE MARTIN