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
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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
Jun 24, 2014	2014_263524_0021	L-000412-14	Critical Incident System

Licensee/Titulaire de permis

DEVONSHIRE ERIN MILLS INC.
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

INA REYNOLDS (524)

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): June 19, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Manager of Resident Care, Resident Assessment Instrument (RAI) Manager, 1 Registered Practical Nurse, 2 Personal Support Workers, 1 Activity Aide, 1 Resident and 1 Family Member.

During the course of the inspection, the inspector(s) observed resident and staff interactions, reviewed the critical incident, resident health records, staff education records and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated in the assessment of the resident so that their assessments are integrated and consistent related to transfers, toilet use and dressing.

An identified resident had a fall while one staff member was transferring the resident from bed to wheelchair. At the time of the fall, the resident had a two person transfer logo at bedside.

Record review revealed that the most recent annual assessment for transfers, toilet use and dressing, indicates a Minimum Data Set code of 3 indicating “Extensive Assistance” and “Two+ persons physical assist”. However, care plan review revealed “TRANSFERS: SUPPORT PROVIDED- One person physical assist”, “TOILET USE/ELIMINATION: SUPPORT PROVIDED - One person physical assistance (transferring)” and “DRESSING: SUPPORT PROVIDED - One person physical assistance”.

Observation of the resident's room on June 19, 2014 further revealed the resident had a one person transfer logo and a two person transfer logo at bedside. Staff interviews and record review revealed concerns that resident is not always safe for a one person transfer due to unpredictable weight bearing.

The Administrator and RAI Manager confirmed the assessment of the resident was not consistent with the care plan as related to transfers, toilet use and dressing and will be updated. [s. 6. (4) (a)]

Issued on this 24th day of June, 2014

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