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

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
Aug 15, 2014	2014_229213_0053	002194-14	Complaint

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

RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 13 & 14, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Assistant Director of Care, a Registered Practical Nurse, 4 Personal Support Workers and a Resident.

During the course of the inspection, the inspector(s) made observations and reviewed health records, policies and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the provision of care set out in the plan of care, the outcomes of the care and the effectiveness of the plan of care are documented.

a) Staff interviews with 2 Personal Support Workers and a Registered Nursing Staff member confirmed that Resident #1 requires particular interventions related to personal hygiene, toileting and dressing. Record review of the plan of care for Resident #1 revealed particular interventions required related to dressing, hygiene and toileting. Record review of Point of Care documentation for Resident #1 revealed there was no documentation regarding personal hygiene or dressing or toileting care provided on one date during the day shift and on evening shift on 2 dates. Record review of progress notes on these dates did not indicate any information related to the resident not receiving care.

b) Record review of the plan of care for Resident #4 revealed particular interventions required related to toileting, dressing and hygiene. Record review of Point of Care documentation for Resident #4 revealed there was no documentation regarding care related personal hygiene, toileting or dressing provided on evening shift on 2 dates. Record review of progress notes on these dates did not indicate any information related to the Resident not receiving care.

c) Record review of the plan of care for Resident #7 revealed particular interventions related to dressing, hygiene and toileting. Record review of Point of Care documentation for Resident #7 revealed there was no documentation regarding care provided related to personal hygiene, toileting or dressing provided on one date during the day shift or on another date during the evening shift. Record review of progress notes on these dates did not indicate any information related to this Resident not receiving care.

d) The Administrator and Manager of Resident Care confirmed that it is an expectation that care is provided for every Resident on every shift as per the plan of care and that all care provided is documented in Point of Care by the staff member who provided the care or a reason for the absence of care and interventions taken documented in Progress Notes by the registered staff. [s. 6. (9)]

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 provision of care set out in the plan of care, the outcomes of the care and the effectiveness of the plan of care are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse or neglect of a resident by the licensee or staff, that the licensee knows of, or that is reported to the licensee, is immediately investigated and appropriate action is taken in response to every such incident.

a) The Administrator and the Manager of Resident Care confirmed that they were notified of a concern related to care for Resident #1 on a particular date. They confirmed that a Critical Incident Report was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to this concern and Resident #1's Substitute Decision Maker was notified of the incident and the report to the MOHLTC.

b) Staff interviews with 2 Personal Support Workers and a Registered Nursing Staff member confirmed that Resident #1 requires particular interventions related to personal hygiene, toileting and dressing. Record review of the plan of care for Resident #1 revealed particular interventions required related to dressing, hygiene and toileting.

c) Record review of progress notes for Resident #1 revealed no documentation regarding care provided for Resident #1 on a particular date during the day shift. The Administrator and Manager of Resident Care confirmed that it is an expectation that care is provided for every Resident on every shift as per the plan of care and that all care provided is documented in Point of Care by the staff member who provided the care or any information related to the absence of care documented in Progress Notes by the registered staff.

d) The Administrator and Manager of Resident Care confirmed that staff who worked on the date and shift of the incident on the unit which houses Resident #1 were not interviewed or questioned related to care provided for Resident #1 and no actions were taken related to this concern. The Administrator confirmed that it is an expectation that every alleged, suspected or witnessed incident of abuse or neglect of a resident is immediately investigated and appropriate action is taken in response. [s. 23. (1)]

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 every alleged, suspected or witnessed incident of abuse or neglect of a resident by the licensee or staff, that the licensee knows of, or that is reported to the licensee, is immediately investigated and appropriate action is taken in response to every such incident., to be implemented voluntarily.

Issued on this 15th day of August, 2014

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