Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 5, 6, 7, 2012	2012_179103_0011	Critical Incident

Licensee/Titulaire de permis

CROWN RIDGE HEALTH CARE SERVICES INC
106 CROWN STREET, TRENTON, ON, K8V-6R3

Long-Term Care Home/Foyer de soins de longue durée

WESTGATE LODGE NURSING HOME
37 WILKIE STREET, BELLEVILLE, ON, K8P-4E4

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Registered staff and the Administrator.

During the course of the inspection, the inspector(s) reviewed resident health care records and mandatory reports submitted by the home in 2012. The log number for this inspection is O-000930-12.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (7) whereby care set out in a resident plan of care was not provided as specified in the plan.

Resident #1 is cognitively impaired and has been assessed as a moderate risk for falls. According to the plan of care, Resident #1 is not to be left unattended when on the toilet.

On an identified date, two Personal Support worker's (PSW) assisted Resident #1 to the bathroom. One PSW left to attend to another resident and the second PSW left to assist another staff member with the transfer of a resident.

When the PSW's returned to Resident #1's bathroom, they found the resident on the floor calling out in pain. The resident was assessed, sent to hospital and diagnosed with a fracture.

The staff failed to provide care to Resident #1 in accordance with the plan of care. The PSW's received disciplinary measures as a result of the incident.

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 subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 23 (2) whereby the outcome of an investigation into an incident of alleged neglect was not reported to the Director.

A mandatory report was submitted by the home to the Director to report an alleged staff to resident abuse. The home conducted an investigation and acted on the incident, but failed to report the outcome of the investigation to the Director.

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Issued on this 7th day of November, 2012

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