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
Dec 6, 2013	2013_272533_0002	O-000825-13	Critical Incident System

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

SUSAN MCGLADE (533)

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): December 2, 5, 2013.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, and Personal Support Workers.

During the course of the inspection, the inspector(s) conducted a walk through of the secure unit, made resident observations, observed staff to resident interactions, reviewed resident health care records and reviewed the home's abuse policy.

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

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, s.20 (1) whereby the home's abuse policy was not complied with.

The home's abuse/neglect policy, ADM 5.0, states under "Notification" that the Administrator, Director of Care or designated Charge Nurse will immediately notify the family and the Ministry of Health Inspector of any alleged, suspected or witnessed incidents of abuse or neglect of a resident.

On a specified date, Resident #4 sustained an injury as a result of an altercation with Resident #1. Family were notified approximately four hours after the incident occurred, and the Director was notified four days later when the Critical Incident was submitted.

On a specified date, Resident #6 sustained an injury during an altercation with Resident #1. The Director was not immediately notified of this incident, and a Critical Incident Report was never filed. [s. 20. (1)]

Issued on this 6th day of December, 2013

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

Susan McGlade