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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 23, 2015	2015_263524_0020	014827-15	Resident Quality Inspection

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

THE WESTMOUNT
200 David Bergey Drive KITCHENER ON N2E 3Y4

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

INA REYNOLDS (524), CHAD CAMPS (609), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 29, 30, July 2, 3, 6, 7, 2015.

The following Critical Incident inspection was conducted concurrently during this inspection:
Log # 002582-15 / CI 2880-000006-15 related to a resident care issue.

During the course of the inspection, the inspector(s) spoke with the Administrator, two Director of Care, the Resident Assessment Instrument (RAI) Coordinator, the Personal Support Worker Coordinator, the Environmental Service Manager, the Business Manager, three Registered Nurses, seven Registered Practical Nurses, eleven Personal Support Workers, one Cook, forty-one Residents and four family members.

The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, meal service, medication administration, medication storage areas, resident/staff interactions, infection prevention and control practices, reviewed clinical records and plans of care for identified residents, postings of required information, investigation notes and minutes of meetings related to the inspection, reviewed relevant policies and procedures of the home, and observed the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Record review of the most recent care plan and Kardex for an identified Resident revealed under the fall prevention focus the resident was at risk for falls and directed staff to "clip call bell to pillow for easy access".

On a specific day the resident was observed to be lying in bed, the call bell was not accessible to the resident and was found to be beside the bed on the floor.

The Personal Support Worker (PSW) Coordinator confirmed the call bell was on the floor and further shared that the call bell clip was missing from the cord. The PSW Coordinator confirmed that it was the home's expectation that resident call bells are to be within the residents reach when in their room and that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

2. Record review of the current care plan revealed an identified Resident was at risk for falls and interventions in place included the use of a hi/lo bed and one bed rail was to be raised when the resident was in bed. Nursing staff were to remind the resident to use the call bell and ensure it was within reach and place the resident's personal assistive device beside the bed when the resident was in it.

Observation of the Resident revealed the resident was lying in bed awake. Two bed rails were in use and the hi/lo bed was not in the lowest position. The call bell was dangling on the floor behind the head board and was out of reach. Observation of the Resident while lying in bed on a different day revealed the call bell was attached to the left bed rail behind a pillow out of sight and out of reach of the resident and two bed rails were in use.

Staff interview with the Registered Nurse (RN) confirmed the call bell should have been within reach and accessible to the resident and the hi/lo bed should have been in the lowest position. The RN further shared that staff should have lowered the bed after assisting the resident with the transfer back to bed and before leaving the room and confirmed the care was not provided to the resident as specified in the plan.

Staff interview with the Registered Practical Nurse (RPN) confirmed that the bed rail logo above the resident's bed should have been followed as the picture described for the use of bed rails. The RPN confirmed that the Resident uses one bed rail and confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the "Medication Administration" Policy # LTC-CA-WQ-200-06-01 last revised November 2014 put in place was complied with.

Record review of the "Medication Administration" Policy revealed the registered staff were responsible to ensure medication was taken appropriately. The procedure for medication administration outlined that registered staff were to observe the resident taking all medications with water provided, never leaving medications at the bedside, on the table in the dining room or at the resident's side and ensuring the resident takes the medication.

Record review of the Administration Record in PointClickCare (PCC) revealed two medications for an identified Resident had been signed for by the Registered Nurse (RN). Observation of the resident's room revealed these two medications were sitting on the bedside table. The Director of Care (DOC) confirmed the medications were sitting on the bedside table. The DOC produced a report from the electronic Medication Administration Record (eMAR) which revealed the two medications were signed as administered.

The DOC confirmed it was the home's expectation that the registered staff observed the resident taking all medications appropriately as ordered and the registered staff would only sign the eMAR once the medication had been taken by the resident. [s. 8. (1) (b)]

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 any plan, policy, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Observations made on all six units of the home revealed disrepair to the walls of resident and common use areas.

Observations of the rooms for eleven Residents revealed significant gouges, scratches, crumbling plaster, broken plastic panelling, and black marks to the walls.

Interview with the Environmental Services Manager (ESM) revealed that rooms were repaired and repainted when a resident was discharged, transferred or determined by the Environmental Services Manager through the quarterly audits as being in significant disrepair. The Environmental Services Manager acknowledged that there was only one other full time maintenance person available five days a week to complete repairs in the home which consisted of 159 beds.

Interview with the ESM confirmed that it was the home's expectation that all walls were to be kept in a good state of repair and in the case of the resident rooms cited that this did not occur and should have. [s. 15. (2) (c)]

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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

Observations made of three public restrooms revealed two of the three had significant scaling and corrosion to the sink faucets. Observations of the rooms for seven Residents revealed significant corrosion and scaling to the sink faucets.

Interview with the Environmental Services Manager (ESM) confirmed that it is the home's expectation that all plumbing fixtures were to be kept in a good state of repair and in the case of the resident rooms and restrooms cited that this did not occur and should have. [s. 90. (2) (d)]

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 procedures are implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

Observation of a Home Care Area (HCA) on June 29, 2015 revealed the door to a shower room was unlocked and accessible to residents.

The Shower Room had one spray bottle of ED Disinfectant and a Hydrofoamer with chemical cleaner within reach and accessible to residents.

The Personal Support Worker (PSW) confirmed the door should be locked at all times. Interview with the Director of Care confirmed that it is the home's expectation that all hazardous substances at the home were to be kept inaccessible to residents at all times. [s. 91.]

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 all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber.

Observation of an identified Resident revealed a white paper medicine cup with two medications were sitting on the bedside table in the resident's room. The Director of Care confirmed the medications were sitting on the bedside table.

Record review of Physician's Orders revealed the two medications were to be administered at specific time intervals.

Record review of the "Physician's Order Review" and the "Physician's Digiorders" revealed there was no order for the self-administration of medications.

The Director of Care (DOC) confirmed the Resident did not have a physician's order for the self-administration of medications as indicated in PointClickCare or on paper in the resident's chart and confirmed it was the home's expectation that residents only self-administered medications when ordered by the attending physician. [s. 131. (5)]

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Issued on this 18th day of August, 2015

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

Original report signed by the inspector.