Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of Inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
May 3, 2011	2011-155-2880-03May114825	L-000592 Complaint

Licensee/Titulaire
Rgency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, 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(s)
Sharon Perry #155

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection regarding resident care.

During the course of the inspection, the inspector spoke with: Administrator, Director of Care, Assistant Director of Care, Registered Nurse, Registered Practical Nurse, Personal Care Providers, and Resident.

During the course of the inspection, the inspector: observed spa rooms on two living areas; observed the shower chairs in both spa rooms; checked that the brakes on the shower chair in one living area were in working order; reviewed the home's policies on bathing-shower (policy NUR-V-10) and falls-resident (policy NUR-V-66);and reviewed resident clinical records.

The following Inspection Protocols were used in part or in whole during this inspection:
Falls Prevention

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, 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:

1. The identified resident's plan of care indicates that family is not to be called on the cell phone unless it is an emergency but to be called at home and if no answer then to leave a message. When the identified resident had a fall and was injured staff did not phone family.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(11)(b)
(11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings:

1. The identified resident had a fall. The identified resident was assessed. Pain medication was given after the fall. Staff continued to assess, document pain and edema for the identified resident and administered medication for pain.
2. Despite assessment of the identified resident's injury and administering medication for ongoing pain staff did not consider different approaches in the revision of the plan of care.
3. Three days after the identified resident had a fall the physician visited and was notified of the fall. Assessment indicated a need for further investigation/treatment for the identified resident.
4. Investigation revealed that the identified resident had a fracture.

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 different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg. 79/10, s.8(1)(a)(b)
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 all applicable requirements under the Act; and

(b) is complied with

Findings:

1. Review of the home's policy NUR-V-66 entitled Falls-Resident it states that in an event of a fall the nurse manage will:
   - Notify physician of incident, receive orders for treatment or transfer to hospital. This notification may be delayed until reasonable hour of the morning, if there is not apparent injury.
   - Notify family or most responsible person, of the incident, if incident occurs during the night this may be delayed until the morning, if no injury is apparent on assessment.
2. The identified resident had a fall and as a result had pain and edema. The physician was not notified of the incident until three days later.
3. The identified resident's family/power of attorney was not notified of the incident until three days later when the identified resident phoned them.

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's policy and procedure is complied with, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). May 10, 2011