



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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
Direction de l'amélioration de la
performance et de la conformité**

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 19, 2015	2015_254610_0030	015567-15, 013525-15	Critical Incident System

Licensee/Titulaire de permis

STEEVES & ROZEMA ENTERPRISES LIMITED
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

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

NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): July 24, 27, 28, 2015

These critical incidents were related to allegations of abuse and were completed concurrently with logs # 010736-15, and 011739-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care, Staff Education Manager, three Personal Support Workers, and two Registered Practical Nurses.

During the course of inspection the inspector reviewed relevant documentation and policy and procedures, conducted interviews, reviewed health care records and completed resident observations.

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

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

2 WN(s)

2 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device



Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

- 1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).**
- 2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).**
- 3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).**
- 4. Consent. O. Reg. 79/10, s. 110 (7).**
- 5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).**
- 6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).**
- 7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).**
- 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).**

Findings/Faits saillants :



1. The licensee has failed to ensure that every use of a physical device to restrain a resident is documented and, without limiting the generality of this requirement, the licensee shall ensure the following are documented: 5. The person who applied the device and the time of application. 6. All assessments, reassessments, and monitoring, including the resident's response. 7. Every release of the device and all repositioning.

Point Click Care (PCC) documentation indicated that the plan of care for Resident # 005 showed that the resident was using a restraint

Further review of the documentation on Point of Care (POC) showed for Resident # 005:

There was no documentation related to who the person was that made the order, what device was ordered and the documentation on instruction relating to that order.

There was no monitoring record including the resident's response for the restraint.

There was no documentation of every release of the device and all repositioning.

There was no documentation as to who applied the restraint and the times of application when the devices were applied.

The Administrator confirmed that there should be documentation in POC for monitoring, applying, releasing the the restraint, who applied the the device , and all repositioning and resident's responses.

The licensee has failed to ensure that all documentation requirements for residents using a physical device to restrain were completed. [s. 110. (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 every use of a physical device to restrain a resident is documented and, without limiting the generality of this requirement, to be implemented voluntarily.



WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,

(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).

(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).

(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).

(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :



1. Before discharging a resident under subsection 145 (1), the licensee shall, (b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; (c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and (d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

The home had not given the resident and the resident's substitute decision-maker, an opportunity to participate in the discharge planning as the only communication to the SDM was a phone call to tell the SDM the resident was discharged and that his or her wishes were not taken into consideration.

The Director of Resident Care confirmed that there was no collaboration with the CCAC, on the discharge as the only correspondence they had received was a bed vacancy. The Director of Resident Care confirmed that they had not given the resident and the resident's substitute decision-maker, an opportunity to participate in the discharge planning as the only communication to the SDM was a phone call to tell the SDM the resident was discharged and that his or her wishes were not taken into consideration. Confirmed there was no written notice to the resident and the SDM setting out a detailed explanation for supporting facts, for the discharge. [s. 148. (2)]



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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 Before discharging a resident under subsection 145 (1), the licensee shall,(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; (c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and (d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident, to be implemented voluntarily.

Issued on this 19th day of October, 2015

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

Original report signed by the inspector.