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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
May 18, 2017	2017_262630_0012	008589-17	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

AMIE GIBBS-WARD (630)

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): May 15 and 16, 2017.

The following Critical Incident System inspection was conducted:

Critical Incident Log #008589-17 for Critical Incident System (CIS) report 2878-000013-17 related to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN), one BSO Personal Support Worker, one Registered Nurse (RN), one Registered Practical Nurse (RPN), three Personal Support Workers (PSWs), one family member and three residents.

The inspectors also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents and reviewed policies and procedures of the home.

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 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours the behavioural triggers for the resident were identified, strategies were developed and implemented to respond to these behaviours, where possible and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long Term Care (MOHLTC) about an incident of alleged resident to resident physical abuse. The report showed that and altercation had occurred between two identified residents which resulted in an injury to one of the residents.

During interviews with multiple staff it was reported there was an altercation between two identified residents. Staff reported that both of the identified residents involved in the Critical Incident (CI) previously had responsive behaviours. Staff reported that they would refer to the plan of care and recommendations from the Behavioural Supports Ontario (BSO) team for direction on how to care for residents with responsive behaviours. Staff reported that prior to the CI this identified resident had not been assessed for responsive behaviours by staff in the home area or BSO and had not had interventions implemented related to these responsive behaviours.

Review of the clinical records showed there had been no previous altercations between these two residents however both identified residents had responsive behaviours prior to the CI. The clinical record showed that there had not been documented reassessments

or strategies implemented to respond to the responsive behaviours completed. The plan of care for this identified resident did not include direction for staff regarding interventions for this responsive behaviour.

During an interview with the Administrator and the Director of Care (DOC) it was reported that the altercation that occurred between these two identified residents did result in an injury to one of the residents. The Administrator and DOC said that assessments were completed and interventions put into place to minimize the risk of altercations and acknowledged these were completed after the CI occurred. The Administrator and DOC said it was the expectation in the home that the staff working in the home areas would be assessing behaviours, developing interventions and updating the care for any responsive behaviours.

These interviews and clinical record show that the home failed to ensure that for this identified resident, who was demonstrating responsive behaviours, the behavioural triggers were identified, strategies were developed and implemented and actions were taken to respond to the needs of the resident. This resident did not have reassessments regarding responsive behaviours and interventions documented in the plan of care.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on April 13, 2015, as a Voluntary Plan of Correction (VPC) in Resident Quality Inspection (RQI) #2015_303563_0015, and on August 18, 2016, as a VPC in RQI #2016_508137_0017. [s. 53. (4)]

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 by ensuring that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations and identifying and implementing interventions.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long Term Care (MOHLTC) about an incident of alleged resident to resident physical abuse. The report showed that and altercation had occurred between two identified residents which resulted in an injury to one of the residents.

During an interview with the second identified resident they acknowledged there was an altercation with another resident in the home. This identified resident told Inspector #630 that they had expressed concerns to staff regarding how the other identified resident's responsive behaviours were affecting them. This resident reported that after the altercation assessments were completed and interventions put into place.

During interviews with multiple staff it was reported there was an altercation between two identified residents. Staff reported that both of the identified residents involved in the Critical Incident (CI) previously had responsive behaviours. Staff reported that they would refer to the plan of care and recommendations from the Behavioural Supports Ontario (BSO) team for direction on how to care for residents with responsive behaviours. Staff reported that prior to the CI this identified resident had not been assessed for responsive behaviours by staff in the home area or BSO and had not had interventions implemented related to potential triggers for altercations between residents.

Review of the clinical records showed there had been no previous altercations between these two residents however both identified residents had responsive behaviours prior to the CI. The clinical record showed that there had not been assessments completed and the plan of care for the identified resident did not include the potential for altercations with other residents.

During an interview with the Administrator and the Director of Care (DOC) it was reported that the altercation that occurred between these two identified residents did result in an injury to one of the residents. The Administrator and DOC said that assessments were completed and interventions put into place to minimize the risk of altercations and acknowledged these were completed after the CI occurred. The Administrator and DOC said it was the expectation in the home that the staff working in the home areas would be assessing behaviours, developing interventions and updating the care for any responsive behaviours.

These interviews and clinical records show that the home failed to ensure steps were taken to minimize the risk of altercations and harmful interactions between the identified residents. Staff had been aware of responsive behaviours prior to the altercation and the home did not identify, through assessments and care planning, or implement interventions to minimize risk of altercations until after the CI occurred.

The severity was determined to be a level three as there was actual harm to a resident.

The scope of this issue was determined to be isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 54.]

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 by ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations and identifying and implementing interventions, to be implemented voluntarily.

Issued on this 18th day of May, 2017

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

Original report signed by the inspector.