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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 26, 2018	2018_674610_0020	024751-18	Complaint

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

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 30, 31, 2018, November 1, 2 and 5, 2018

This was a complaint inspection IL #59772 Log #024751-18 related allegations of abuse and neglect.

The following intakes were inspected concurrently while in the home:

Log #006559-17 Critical Incident SAC 15192/CIS-2878-000011-17 related to unexpected death.
Log #008932-18 Critical Incident #2878-000014-18 related to missing controlled substances.
Log #010250-18 Critical Incident #2878-000015-18 related to missing controlled substances.
Log #027969-18 Critical Incident #2878-000028-18 related to missing controlled substances.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Resident Manager of Care, the Assistant Resident Manager of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Clinical Consultant Pharmacist, Pharmacist, Director of Pharmacy Projects, Social Worker, London Regional Police Services, Coroner, Resident Care Coordinator, Environmental Care Manager, Registered Dietician, family members and residents.

The inspector(s) also made observations of resident, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were
reviewed. Inspector(s) observed meals, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

2 WN(s)
1 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	Légende 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director; Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm, and Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint for an identified resident from their substitute decision maker (SDM). The SDM alleged in the complaint that they had concerns that the identified resident was being neglected.

During an interview with the identified resident's SDM they said that they had addressed the care concerns with the Administrator of the home, but felt nothing was being done to address the concern from occurring.

Record review documentation showed the identified resident had a significant change in condition and the family wasn't notified until the identified resident had become unresponsive.

The home's Policy & Procedure Manual titled Written Complaint Reporting Policy stated in part "all complaints concerning care of a resident or the operation of the home will be immediately forward to the Director" and a "complaint related to section 24 of the LTCHA 2007 will be submitted to the Director immediately with documentation of the response to the complaint by the licensee"

Inspector had reviewed the homes customer/team member feedback form that were in the homes complaint binder:
1) On an identified date the SDM and other family members verbally complained to Administrator that they had concerns regarding not being notified of a fall, concerns with continence care, change in condition with decreased mobility, concerns with skin and wound, and rest and sleep. Recommendations were noted in addressing the concerns. The follow up summary was incomplete.
2) On an identified date the SDM and other family members verbally complained to Administrator that they had concerns regarding the cleanliness of the room, urine on the floor, inappropriate conversations on the phone, staff member responding inappropriately to the SDM and family, and a request for a certain staff to no longer provide care to the identified resident. Recommendations were noted in addressing the concerns. The follow up summary was incomplete and there was no documentation that showed that the SDM was followed up with by the Administrator.
3) On an identified date the SDM and other family members verbally complained to the Administrator that they had concerns regarding resident being left on the toilet, call bell not in reach, urinary catheter care, inappropriate conversation from staff to the identified resident. Recommendations were noted in addressing the concerns. The follow up summary was incomplete.
4) On an identified date the SDM verbally complained to the RMC that they had concerns of the cleanliness of the floors, improper seating, dentures not in place correctly, drool on their shirt, skin alterations, requests to have resident lay down in the afternoon. The MRC telling the family that the resident does not have a skin infection. Recommendations were noted in addressing the concerns. The follow up summary was completed and documentation showed that the SDM was followed up with by MRC.

The Administrator stated that they were aware of the concerns from the family and had not immediately reported the care concerns and allegations of neglect as they had investigated and felt the concerns did not meet the criteria and had not immediately reported the care concerns regarding allegation of neglect to the Director. The Administrator revealed that the identified resident's family felt that the home was trying to

hurt the identified resident. The Administrator said that the family had been inappropriate and follow up with the family regarding the comment was immediate, however the Administrator had not reported the allegations of improper or incompetent care that could have resulted in harm or a risk of harm to the Director.

The home failed to ensure that all allegations of improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm and abuse and neglect of a resident by the licensee or staff that resulted in harm or risk of harm had been reported to the Director.

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 a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm, and abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident,

Review of the identified resident's plan of care showed the resident had a treatment for bladder continence.

Inspector(s) completed observation of the identified resident for three days that did not show that the resident had the treatment as documented in the plan of care for bladder continence.

During an interview with nursing staff they confirmed that the identified resident no longer required that treatment care, the nursing staff could not confirm when the treatment was discontinued.

During an interview with the identified resident's SDM they stated that the treatment had been stopped at the last hospital visit.

The Administrator confirmed that that the resident did not have a certain treatment and that the plan of care for bladder continence did not provide clear direction to all staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that SDM, if any, and the designate of the resident /

SDM shall provide the opportunity to participate fully in the development and implementation of the plan of care

The MOHLTC received a complaint for an identified resident from their substitute decision maker (SDM). The SDM alleged in the complaint that they had concerns that the identified resident was being provided treatment and medication without consent.

Review the record documentation for the identified resident revealed that consent documentation was not obtained by the SDM for treatment and medication 14 times over a three month period.

Review of the identified resident's health care records showed a note that the SDM would be notified of medication changes.

The home's policy for consent to treatment and stated in part that the Course of treatment means that "a series of sequences of similar treatments administered to person over a period of time for a particular health problem". A plan of treatment means a plan that must be kept informed of changes in "resident status necessitating changes in the plan of care and treatment" and the "response should be documented in the multidisciplinary notes".

During an interview the Administrator stated that staff were to inform the family that direction had been given to the registered staff to follow up with the SDM with changes in care and treatment for the identified resident.

The license failed to ensure that the SDM, if any, and the designate of the resident / SDM shall provide the opportunity to participate fully in the development and implementation of the plan of care for the resident.

Issued on this 12th day of December, 2018

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

Original report signed by the inspector.