Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jul 27, 2021	2021_797740_0019	006341-21, 006362-21, 006455-21, 009660-21, 011040-21	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

SAMANTHA PERRY (740), CHERYL MCFADDEN (745), KRISTEN MURRAY (731)

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): July 14, 16, 20, 21, 22 and 23, 2021.

The following intakes were completed within the Critical Incident Systems inspection:
Log#006341-21 / CI# 2878-000023-21 related to responsive behaviours;
Log# 006362-21 / CI# 2878-000022-21 related to responsive behaviours;
Log #006455-21 / CI# 2878-000024-21 also related to responsive behaviours;
Log #009660-21 / CI #2878-000032-21 related to falls management; and
Log #011040-21 / CI #2878-000037-21 related to staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Assistant Manager of Resident Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeepers and residents.

The inspector(s) also made various observations, including Infection Prevention and Control practices, cooling requirements and reviewed residents' clinical records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007 was protected from neglect when staff failed to meet the resident's care needs as per their Plan of Care.

The “Resident Abuse and Neglect” policy, reviewed July 16, 2021 documented, “NEGLECT” means the failure to provide the treatment, care, service or assistance required for health, safety or well-being of a resident. Neglect includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. On specific dates resident #007 failed to receive required care as set out in their plan of care.

Resident #007's Plan of Care documented regular checks at specified times to meet the resident's specific care needs. However, through the home's internal investigation process, including a review of the home's camera footage, it was identified that staff failed to meet resident #007's care needs and falsified documentation.

Manager of Resident Care (MRC) #101 confirmed staff did not provide resident #007 with their care as per the resident’s Plan of Care or legislative requirements, and therefore, staff did not meet the home's expectation to protect resident #007 from neglect. The risk of impaired skin integrity for resident #007 increased when their care needs were not met.

Sources: Observations, staff interviews, the home's investigation notes, review of resident #007's electronic clinical records. [s. 19. (1)]

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 resident #007 and all other residents are protected from neglect, the residents' care needs are met as per legislative requirements and the residents' plans of care are reviewed and updated to meet residents' care needs., to be implemented voluntarily.

Issued on this 28th day of July, 2021

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

Original report signed by the inspector.