Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: January 4, 2024	
Inspection Number: 2023-1363-0006	
Inspection Type: Complaint Critical Incident	
Licensee: Steeves & Rozema Enterprises Limited	
Long Term Care Home and City: Westmount Gardens Long Term Care Home, London	
Lead Inspector Meagan McGregor (721)	**Inspector Digital Signature** Meagan McGregor Digitally signed by Meagan McGregor Date: 2024.01.09 12:22:54 -05'00'
Additional Inspector(s) Henry Otoo (000753)	

INSPECTION SUMMARY

The inspection occurred on-site on December 6-7, 11-15, and 18-19, 2023.

The following Critical Incident (CI) intakes were inspected:

- Intake #00095354/CI #2878-000038-23; and
- Intake #00099445/CI #2878-000044-23 related to injuries of unknown cause;
- Intake #00101039/CI #2878-000046-23; and
- Intake #00101656/CI #2878-000047-23 related to unexpected deaths; and
- Intake #00104116/CI #2878-000050-23 related to falls prevention and management.

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The following Complaint intake was inspected:

- Intake #00097524 related to concerns about physiotherapy services, continence care and bowel management, repositioning, weight changes, and dealing with complaints.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of

care, in accordance with that Act.

The licensee failed to ensure that residents rights to have their personal health information (PHI) kept confidential in accordance with the Act were fully respected and promoted.

Rationale and Summary

During the inspection medication strips with residents' PHI were observed in the regular garbage attached to the medication cart in a resident home area. When asked how they dispose of the medication strips, a Registered Practical Nurse (RPN) said the strips with the PHI go into the regular garbage.

The Manager of Resident Care (MRC) confirmed that the home was disposing of medication strips with resident PHI into the regular garbage without getting rid of the information on the packaging. The confidentiality of residents PHI could be compromised when added to regular garbage without rendering the packaging illegible before disposal.

Sources: Observations and staff interviews. [000753]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of continence, toileting and repositioning care set out in the plan of care was documented for a resident.

Rationale and Summary

The home's resident chart documentation policy directed Personal Support Workers (PSWs) to record all pertinent resident care delivery information in the resident's individual record.

The home's continence care and bowel management program policy directed PSWs to document on resident's bladder and bowel function on every shift and this was to be monitored by registered team members daily for the need to implement bowel protocol.

It was identified in the residents' plan of care that they required specific care related to continence, toileting and repositioning and were at risk for impaired skin integrity.

During an identified three-month period the resident had tasks scheduled related to bowel and bladder continence and repositioning and there was no documentation completed as scheduled on multiple shifts.

PSW staff indicated they would document on the continence, toileting, and repositioning care that they provided to residents during their shift as scheduled their individual record. They said that sometimes it was difficult to complete this documentation and it didn't get completed as scheduled or until the end of their shift when agency or new staff members were working in the home, they were working short or had several residents to respond to.

The MRC advised that PSW staff were expected to complete documentation on the continence, toileting and repositioning care provided to residents as scheduled. They said themselves and the Assistant Managers of Resident Care (AMRCs) were responsible for monitoring whether this documentation was being completed by PSWs. They said they did not know why documentation related to the residents continence, toileting and repositioning care was not completed as scheduled on the identified occurrences during this three-month period, however they expected it should have been.

By failing to ensure that the provision of continence, toileting and repositioning care set out in the plan of care was documented for the resident, there was risk of changes in their continence, toileting and repositioning care requirements not being identified and scheduled care being missed putting them at increased risk for impaired skin integrity.

Sources: the home's resident chart documentation policy; the home's continence care and bowel management policy; review of the residents clinical record, including assessments, care plan and tasks; and staff interviews. [721]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(d) a system to monitor and evaluate the food and fluid intake of residents with

identified risks related to nutrition and hydration.

The licensee has failed to ensure that the system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration was complied with for two residents.

Rationale and Summary

In accordance with O. Reg. 246/22, s.11 (1) (b), where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system the licensee was required to ensure that the system was complied with.

The home's dining program policy directed PSWs to record residents' food and total fluid intake and to report any eating difficulties or lack of appetite by a resident to a registered team member.

The home's resident chart documentation policy directed PSWs to record all pertinent resident care delivery information in the resident's individual record. Registered team members were to monitor and ensure that all required documentation was completed prior to end of shift and the MRC, or delegate was responsible to ensure compliance with this policy.

A) It was indicated in a resident's plan of care that they were at high nutrition risk due to specific health conditions and identified a goal of maintaining adequate intake of food and fluid to promote optimal nutrition and hydration status.

There were several documented occurrences in their progress notes during an identified three-month period, where they refused to come to the dining room for

meals or were noted to have poor intake.

During the identified three-month period the resident had a task scheduled three times daily at meals which required staff to document on their food and fluid intake and there was no documentation completed as scheduled on 80 of 279 meals.

Two PSW staff stated they were expected to document on the care that they provided to residents during their shift and residents food and fluid intake as scheduled. They said that sometimes it was difficult to complete documentation and it didn't get completed as scheduled when agency or new staff members were working in the home, if working short or they had several residents to respond to.

The MRC advised that PSW staff were expected to complete documentation on residents' food and fluid intake as scheduled. They said themselves and the AMRCs were responsible for monitoring whether this documentation was being completed by PSWs. They said they were unaware and did not know why documentation related to the resident's food and fluid intake was not completed as scheduled on the identified occurrences in this three-month period, however they expected it should have been.

B) Another resident had a task scheduled three times daily at meals which required staff to document on their food and fluid intake and there was no documentation completed as scheduled at two meals on a specific date. Additionally, their progress notes did not include any documentation related to the eating and nutrition care they were provided on this date.

The PSWs who were working on this date said PSW staff were expected to document on residents' food and fluid intake on each shift and they did not know why this wasn't completed for the resident on this date.

The MRC indicated that PSW staff were expected to document on residents' food and fluid intake as scheduled after each meal and snack and confirmed that documentation was not completed as expected on this date.

When the home failed to comply with the home's system for monitoring and evaluating food and fluid intake for these residents there was risk of significant changes in their food and fluid intake not being identified and accurate assessments of their nutrition and hydration status not being completed to prevent further deterioration of their nutrition status.

Sources: the home's dining program policy; the home's resident cart documentation policy; review of residents clinical records, including progress notes, assessments, weights, care plans and tasks; and staff interviews. [721]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter.

The licensee has failed to ensure that the weight monitoring system to measure and record each residents' weight monthly was complied with for a resident.

Rationale and Summary

In accordance with O. Reg. 246/22, s.11 (1) (b), where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system the licensee was required to ensure that the system was complied with.

The home's weight protocol policy directed staff to record resident weights at minimum monthly as an indicator to assess residents' nutritional status which may require the implementation of nutrition interventions by the Registered Dietitian (RD). Weights were to be recorded in the residents' electronic record by the seventh of each month and if a reweigh was required this was to be recorded by the tenth of each month. All significant weight changes were to be reviewed and assessed by the RD.

It was identified in the residents' plan of care that they were at high nutrition risk and identified goals related to their weight.

Documented records of the resident's weight showed there had been significant variations in their weight since their admission to the home. There was no documented record of their weight for a five-month period and another two-month period, both in which their weight changed. Their weight changed significantly during another identified one-month period, and the RD requested the resident be reweighed. There were no subsequent weights documented for the resident during this month and their next documented weight was obtained one month later which was significantly different than their weight the previous month.

A PSW indicated PSWs were responsible for obtaining resident weights during their first bath of each month and documenting these. They said they typically did not

give this resident their bath so could not speak to whether weight monitoring had been completed for them on a monthly basis.

An RPN said they did not know why there were no documented weights for the resident during the identified time periods or why a reweigh had not been obtained as requested.

The RD said they did not know why there were no documented weights for the resident during the identified time periods or why a reweigh had not been obtained as they had requested.

The MRC said they expected monthly weights should have been obtained and documented for the resident during the identified time periods and that a reweigh should have been obtained as requested.

When the resident's weight was not recorded monthly there was risk of significant changes in their weight not being identified and the RD could not accurately assess their nutrition status.

Sources: the home's weight protocol policy; review of the resident's clinical record, including progress notes, assessments, care plan and weights; and staff interviews. [721]

WRITTEN NOTIFICATION: Security of Drug Supply

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.
Security of drug supply
s. 139 1. All areas where drugs are stored shall be kept locked at all times, when not

in use.

The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including that all areas where drugs were stored were kept locked at all times when not in use.

Rationale and Summary

During the inspection a medication cart was observed unlocked in the hallway of a resident home area with no staff or residents around. Later, an RPN came out of a resident's room and returned to the medication cart. When asked why the medication cart was opened when they were not around, they said they forgot to lock the medication cart and then proceeded to lock the cart.

The MRC said that staff were to always ensure there were no medications left on the medication cart and that the medication cart was locked when they walked away.

Sources: Observations and staff interviews. [000753]

COMPLIANCE ORDER CO #001 Plan of care

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A) Conduct weekly meal and snack time audits for the identified resident to ensure that the nutrition care set out in their plan of care is provided to them as specified in the plan. A documented record must be maintained of these audits, including the date the audit was completed, who completed the audit, any concerns identified, and the corrective action taken as a result of the audit. The auditing process must continue until the Compliance Order has been complied by an inspector.

B) Provide training to all dietary staff, personal support staff and any other staff who may serve residents food on the process and expectations in the home for reviewing each residents individualized nutrition interventions prior to meal and snack service and ensuring that residents are provided these interventions in accordance with their plan of care. A documented record must be maintained of the training provided, which includes the content of the training, date the training was provided, and who attended the training.

Grounds

1.The licensee has failed to ensure that the nutrition care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

It was indicated in the residents' plan of care that they were at nutrition risk and goals were identified related to maintaining adequate intake of food and fluid to promote optimal nutrition and hydration status and their weight.

Assessments of their nutrition and hydration risk and status were completed by the RD during this time which indicated they were assessed to be at nutrition risk

related to variable intake of food and fluids and weight fluctuations and they had nutrition interventions in place to address these concerns.

The resident's care plan and kardex in PCC, and profile on the Meal Service Report in the homes Menu Stream software directed staff to provide individualized nutrition interventions.

During the inspection the resident was observed during a meal and they were provided a meal that was not in accordance with the individualized nutrition interventions specified in their plan of care.

The resident was observed again during a meal on the following day. During this meal a PSW was in front of the servery relaying residents' meal orders to a dietary staff member from a seating plan that had residents' diet, texture and fluid types listed and the dietary staff member was plating food from behind the servery. Individualized nutrition interventions and allergies were not listed on this seating plan for each resident. The PSW and dietary staff member were not observed to be reviewing any information related to residents individualized nutrition interventions or allergies prior to serving residents their meals. The resident was subsequently provided a meal that was not in accordance with the individualized nutrition interventions specified in their plan of care.

A PSW said they would refer to a residents kardex and a "sheet" in the dining room to find information related to a residents' individual nutrition care needs. They said they did not believe this resident had any individualized nutrition interventions in place.

The PSW who served the resident on the second observed date said that both PSW and dietary staff were responsible for checking information related to a residents'

diet, texture, and fluid requirements prior to serving the residents. They indicated they were not aware of this resident having any individualized nutrition interventions in place.

A Dietary Aide indicated PSW staff would relay resident meal choices to dietary staff and dietary staff were responsible for plating each residents' meal and ensuring they were provided with the correct diet, texture and fluid type and any individualized nutrition interventions. They said they would refer to the residents' profile in the Meal Service Report located on the home's electronic Menu Stream software to find this information prior to serving each resident their food at meals.

The Food Service Manager (FSM) advised that dietary staff were responsible for checking each residents' profile in the Meal Service Report located on the home's electronic Menu Stream software prior to serving each resident their meal. The Inspector discussed the observations that were conducted on the identified dates with them and they said they didn't know why staff were not referring to the home's Menu Stream software prior to serving residents their meals or why this resident was not provided a meal in accordance with the individualized nutrition interventions outlined in their plan of care on these dates, however, they expected they should have been.

When the home failed to provide the resident with the individualized nutrition interventions set out in their plan of care there was risk of further deterioration of their nutrition status and weight gain. Additionally, there was risk of other residents not being provided individualized dietary interventions in accordance with their plan of care and being served allergens when staff did not review this information prior to serving the residents their meals.

Sources: observations of meal service; review of the resident's clinical record,

including assessments, weights, and care plan; meal service reports and seating plan; and staff interviews.[721]

2.The licensee has failed to ensure that the transferring care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

It was indicated in the resident's care plan and kardex that they required a specific type of equipment and level of assistance with all transfers related to identified risk factors which affected their ability to transfer safely. Signage was also observed in their room indicating they required this specific type of equipment for transferring.

An assessment of their transfer status indicated they were assessed to be transferred using the same type of equipment and level of assistance specified in their care plan and kardex for all transfers.

During the inspection two PSWs were observed exiting the resident's room with a specific type of equipment that was different from that specified in the residents plan of care.

PSW staff indicated they would refer to a residents kardex to find information related to a residents' transfer care needs. One of these PSWs said that the resident required the specific type of equipment and level of assistance with all transfers, including transferring to the toilet, specified in their plan of care.

One of the PSWs that was observed providing transfer care to the resident on the identified occurrence stated they would refer to signage with transfer logos in each residents' room to find information related to their transfer care needs. They

confirmed that on the identified occurrence, themselves and another PSW provided toileting care to the resident and transferred them to the toilet using a specific type of equipment that was different from that specified in their plan of care. They said staff would use both types of equipment to transfer the resident, depending on how the resident was feeling.

The Physiotherapist (PT) confirmed that at that time the resident was currently assessed to be transferred using another specific type of equipment.

The MRC advised they expected the resident should be transferred using the specific type of equipment specified in their care plan and kardex and assessed transfer status.

There was risk of the resident sustaining an injury when the home failed to provide them with the transferring care set out in the plan of care in accordance with their assessed transfer care needs.

Sources: observations of the resident's room and the transfer care being provided to them; review of the resident's clinical record, including assessments, and care plan; and staff interviews. 721]

This order must be complied with by February 14, 2024

COMPLIANCE ORDER CO #002 Dining and snack service

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a

dining and snack service that includes, at a minimum, the following elements:
3. Monitoring of all residents during meals.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A) Ensure that the identified resident is monitored during meals, including meals eaten in their room.
B) Conduct weekly audits of each meal and snack service to ensure that residents, including residents eating in their room, are monitored during meals. A documented record must be maintained of these audits, including the date the audit was completed, who completed the audit, the meal or snack service the audit was completed for, the home area the audit was completed for, any concerns identified, and any corrective action taken as a result of the audit. The auditing process must continue until the Compliance Order has been complied by an inspector.

Grounds
The licensee has failed to ensure that the homes dining service included monitoring of two residents during meals.

Rationale and Summary

The home's dining program policy indicated that all residents were to be monitored during meal service by nursing team members as per their assessed needs when residents received tray service in their rooms. A recent communication regarding this policy was sent to staff by the MRC which also stated that staff should not be delivering trays to residents until meal service was finished and when residents were delivered trays staff should be within hearing distance of the room or in the room assisting if necessary.

It was indicated in the plan of care for two residents that they required supervision with eating.

On an identified date a PSW served one of the residents a tray of food in their room during meal service and then exited the room leaving them unsupervised while eating during which time an incident occurred.

The PSW who had served the resident their food on the identified date indicated they had provided the resident a tray of food in their room during meal service and proceeded to leave this resident and another resident unsupervised in the room and return to the dining room to continue assisting other residents during meal service. They had been provided training on the home's dining program policy related to tray service prior to the incident and had been told that they were expected to supervise residents at all times when eating in their rooms.

The MRC advised that residents receiving tray service were to be served meals after residents eating in the dining room had been served and if they could eat independently but required supervision with eating staff were expected to be at minimum monitoring them from the hallway so that they could still have eyes on the resident. They confirmed that on the date of the incident the residents were not monitored and they expected that a staff member should have been in the hallway monitoring the residents when a tray was delivered to the resident on this date.

When these residents who required supervision with eating were left unmonitored during meal service an incident occurred which resulted in a significant change in the condition of one of the residents.

Sources: CIS report; the home's dining program policy; the home's investigation

notes related to the incident; review of the residents, including progress notes, assessments, and care plans; and staff interviews. [721]

This order must be complied with by February 14, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.