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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 29, 2014	2014_232112_0041	001925-14	Critical Incident System

Licensee/Titulaire de permis

DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7

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

CAROLE ALEXANDER (112)

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 21, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care and a Personal Support Worker

During the course of the inspection, the inspector(s) reviewed the following: a critical incident, home's internal investigation, a clinical record, policies and procedures for the Prevention of Abuse and Neglect and the Registered Nurse job description.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

A resident's health status was observed to have changed.

An initial assessment by a Registered Practical Nurse was completed and included the monitoring of the resident's vital signs. The resident was not assessed again for 3 hours. The Registered Nurse neglected to assess the resident according to the resident's change in health status. The resident was transferred to hospital and subsequently passed away.

This was confirmed by the Administrator, Director of Care, a Personal Support Worker and the Resident's clinical record. [s. 3. (1) 3.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The home's policy "Resident Abuse & Neglect - Admin 08-05" states that "the team member alleged to have perpetrated the abuse will be suspending pending investigation"
The Licensee became aware of an allegation of neglect by staff. A resident's health status had changed and it was alleged that Registered staff neglected to assess the resident. On the following night, staff members reported to work and completed their shifts, which was prior to the completion of the home's internal investigation. The home did not comply with their policy relating to staff suspension.

The job description for the Registered Nurse states that the Registered Nurse will "collaborate and plan with other disciplines and team members to address health outcomes for residents" A resident had a change in health status and was not assessed as required by the Registered Nurse. The Registered Nurse did not comply with the job description for assessing residents.

This was confirmed by the Administrator, Director of Care and the resident's clinical record. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

A resident had a change in health status that required the communication with family. There was no attempted contact with the family by the Registered staff.

This was confirmed by the Administrator, Director of Care and the resident's clinical record. [s. 107. (5)]

Issued on this 29th day of July, 2014

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