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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 1, 2015	2015_396103_0021	O-000518-14	Critical Incident System

Licensee/Titulaire de permis

CROWN RIDGE HEALTH CARE SERVICES INC
106 CROWN STREET TRENTON ON K8V 6R3

Long-Term Care Home/Foyer de soins de longue durée

WESTGATE LODGE NURSING HOME
37 WILKIE STREET BELLEVILLE ON K8P 4E4

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

DARLENE MURPHY (103)

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): March 31, April 1, 2015

The following log numbers were included in this inspection: O-000518-14, O-000577 -14, O-001194-14 and O-001461-14.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers, a Registered Nurse, and the Director of Care (DOC).

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

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	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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 6 (7) whereby care was not provided to a resident in accordance with the plan of care.

Resident #1 had identified diagnoses. On an identified date, PSW's S#103 and S#106 were providing care to the resident. During this time, S#106 was heard making repetitive negative statements to Resident #1 in regards to their sexual behaviours and continence care. S#106 referred to the resident as disgusting and repeatedly asked the resident why they were doing this.

Resident #1's plan of care was reviewed. Under memory and decision making, the resident is described as having:
- a short term memory impairment,
-does not recall after five minutes,
-is moderately impaired and
-has poor decision making abilities.

Additionally, the care plan indicates the resident has socially inappropriate or disruptive behaviours and indicates staff shall display accepting, non-judgemental attitudes when discussing concerns about sexuality.

The Director of Care was interviewed and stated the incident was investigated by the home and the staff member was disciplined for their actions. [s. 6. (7)]

2. Resident #3 had identified diagnoses. On an identified date, the resident reported to their family member that during the night shift they had been spoken to in a rude and upsetting manner by a staff member and felt the care received had been rushed.

The incident was reported to the home and the home immediately investigated the allegations. According to the resident, they had requested to use the bathroom. PSW S#104 advised the resident they would need to get a second staff member to assist with the transfer and when the staff returned, the resident was found on the floor. According to the resident, S#104 commented to the resident, "where were you going" which the resident deemed inappropriate.

Additionally, the resident requested to get up for the day at approximately 0650 hr and was advised by S#104 that it was too early and they would have to wait for the day staff.

According to the DOC, the resident required encouragement to ring for staff assistance. The DOC agreed the care was not provided to the resident in a respectful manner and the staff member did receive disciplinary action. [s. 6. (7)]

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 care is provided to Resident #1 and #3 in accordance with the plan of care, to be implemented voluntarily.

Issued on this 1st day of April, 2015

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

Original report signed by the inspector.