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

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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
Dec 11, 2013	2013_202165_0027	L-000899-13	Complaint

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

THE WESTMOUNT
200 David Bergey Drive, KITCHENER, ON, N2E-3Y4

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

TAMMY SZYMANOWSKI (165), SALLY ASHBY (520)

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): November 26, 27, 2013

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Manager, Two Registered Nurses (RN), One Registered Practical Nurse (RPN), two residents, and one family member.

During the course of the inspection, the inspector(s) reviewed clinical health records, policy and procedure, observation of residents.

The following Inspection Protocols were used during this inspection: Hospitalization and Death

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. 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Licensee did not ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.
A) Resident #001 had a physician's order for a specified treatment and to keep assessment values above a specified percentage. In October 2013, Registered staff confirmed that the resident did not receive treatment for an extended period of time and values fell below the specified percentage.
B) The resident's plan of care indicated that staff were to apply a specified medical device every night and run the tubing through the medical device. An assessment completed by a consulting company in October 2013, indicated that there was no medical device usage for the month of September 2013. Documentation on the Medication Administration Record indicated the resident had refused only nine days for the month of September. [s. 6. (7)]

2. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.
A) Resident #002's plan of care and physicians order directed staff to provide a specified treatment. The physicians note in October 2013, indicated that the resident can be off their treatment at identified times. The resident was observed on two occasions in November 2013, without the use of the treatment. The resident confirmed that they had not been using their treatment for a few weeks. The current plan of care was not revised to reflect the change in the resident's usage of the specified treatment.
B) The plan of care in place in October 2013, for resident #001 directed staff to provide a specified treatment at specific level continuously however, the resident's order for treatment had changed to a lower level in August 2013. [s. 6. (10) (b)]

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 the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The Licensee has failed to ensure that all staff at the home have received training as required and/or received retraining in the areas required as evidenced by:
A) Registered staff working on third floor in October 2013, had received no training on the identified treatment or the use of the medical device despite caring for residents who required the use of these. The RPN confirmed they had not used the medical device nor could identify where to find instructions for the use of it. A review of the training log and an interview with the ADOC verified that the staff had not been trained on the identified treatment or the use of the medical device. The ADOC indicated that the training for the use of the medical device was only provided to the staff that happened to be working on the shift when the resident arrived at the home.[s. 76. (4)]

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 the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The Licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.
A) Staff did not always document resident #001's assessment values on the monitoring record. There were ten days that did not have assessment values documented from August to October 2013, this was confirmed by the nurse manager.
B) The home initiated an hourly monitoring record for resident #001 in October 2013. A review of the record revealed that staff did not document on two occasions on one day, and on three occasions on another day, this was confirmed by the nurse manager.
C) Resident #001 did not receive their treatment for for an extended period of time. Interviews with two Registered staff members confirmed that they had not documented assessment values and the times they were taken after it was discovered the resident did not have their treatment applied. The nurse manager confirmed the expectation of the home was to document the assessment values and verified that staff did not document in the resident's clinical health record.
D) After it was reported to the RN that the treatment for resident #001 was not properly connected for an extended period of time, the resident's treatment was reapplied. However, there was no documentation in the resident's clinical health record that included an assessment or interventions provided to the resident by the RN. [s. 30. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure drugs were stored in a medication cart that was secure and locked.

A) In November 2013, the inspector arrived outside the Rosemont dining room and observed the medication cart unlocked and unattended. After approximately two minutes the registered staff member returned to the medication cart and verified that they left the cart unlocked and unattended when they went to complete a blood pressure for another resident. The Registered staff member locked the cart and verified that the expectation was to have the medication cart locked at all times when unattended. [s. 129. (1) (a) (ii)]

Issued on this 12th day of December, 2013

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