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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
March 9, 14, 2011	2011_146_1500_09Mar072931	Complaint H-00204

Licensee/Titulaire
1508669 Ontario Limited, c/o Deloitte & Touche Inc., 181 Bay Street, Brookfield Place, Suite 1400, Toronto, ON., M5J 2V1

Long-Term Care Home/Foyer de soins de longue durée
West Park Health Centre, 103 Pelham Road, St. Catharines, ON.,L2S 1S9

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

Barbara Naykalyk-Hunt, #146

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection.

During the course of the inspection, the inspector spoke with: the Administrator, 3 registered staff, a physiotherapist, physio aide and a personal support worker.

During the course of the inspection, the inspector: reviewed the health file of an identified resident and the plan of care for a second identified resident .

The following Inspection Protocols were used during this inspection: Falls Prevention, Minimizing of Restraints

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

9 WN
3 VPC
5 CO

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.22(1)

22(1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

Findings:

1. The home received letters of complaint regarding care issues from a resident's family member on 3 occasions between November 2010 and January 2011. None of these letters were forwarded to the Director.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.24(1)

24(1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

Findings:

1. The Administrator of the home received a letter of complaint from an identified resident's Power of Attorney (POA) alleging emotional abuse and possible neglect of the resident by an identified staff person in the home. The letter states that the staff person's treatment of the resident caused the resident to be "afraid and scared" On the date the letter was provided to the inspector, the administrator confirmed that the home had investigated and dealt with the employee. The alleged abuse was not reported to the Director as of the date of this inspection, March 14, 2011.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 30(1)

30(1) Every licensee of a long term care home shall ensure that no resident of the home is:
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36

Findings:

1. Two identified residents who have been assessed as high falls risk have been prevented from getting out of bed by the use of raised full bedrails as follows:
   - Two registered staff confirmed that one identified resident had both full bedrails up to prevent/restrain the resident from getting out of bed since previous attempts had resulted in falls. The plan of care for the identified resident does not include restraints. The resident was observed on March 14, 2011 to be in bed with both bedrails raised.
   - A second identified resident had both bedrails raised at all times to prevent the resident from getting out of bed and falling but this identified resident's plan of care did not include restraining of the resident. .
2. There is no evidence in a review of 2 health files of 2 identified residents, that alternatives to restraints were considered or tried.
3.. No physician or RN EC orders for the restraints are present in the 2 identified health files.
4. There are no signed consents for using the restraints on the 2 health files.
5. There is no evidence in 2 identified residents' health files of assessments, reassessments or monitoring of the residents and their response
6. The Administrator confirmed that the home does not view bedrails as restraints even when they are used to prevent a resident from getting out of bed.

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 in ensuring that when bedrails are used to restrain a resident, documentation must be in the health file to demonstrate that alternatives were considered, that consent of resident or substitute decision maker (SDM) is obtained, that a physician's or RN EC 's order was obtained and that resident and response is assessed, reassessed and monitored, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(11)

6(11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

Findings:

1. An identified resident fell with injury. The plan of care addressed the resident's falls risk as high and suggested strategies to reduce falls, including keeping the bedrails up.
2. Over the next 3 months, the strategies were ineffective and the resident had 4 more falls including 2 falls over the raised bedrails and several documented attempts to climb over the raised bedrails. The most recent plan of care for falls contained no different approaches and bedrails remained up.
3. The plan of care was revised after the 3 months, however there were no changes or alternative approaches considered despite the resident continuing to have multiple falls.

Additional Required Actions

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #5: The Licensee has failed to comply with O.Reg. 79/10, s.107(3)

107(3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital.

Findings:

1. An identified resident fell with injury and was sent to hospital. The critical incident report was sent to the Director 18 business days later.
2. According to the health file, an identified resident fell over the raised bedrails onto the floor, sustained an injury and was sent to hospital.

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #6: The Licensee has failed to comply with O.Reg. 79/10, s.15(1)

15(1) Every licensee of a long-term care home shall ensure that where bed rails are used, other safety issues related to the use of bed rails are addressed,
(c) including height and latch reliability.

Findings:

1. The health file of an identified resident indicated that a problem with the resident's bed was noted and fixed.
2. A letter of complaint from a family indicated a safety concern regarding the bed had been reported to the home staff on 3 consecutive days. No action was taken. The resident fell and sustained injury before action was taken to repair or replace the bed.

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 in ensuring that the bedrails in the home are safe, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg. 79/10, s.34(1)

34(1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening

Findings:

1. The interventions on the care plans of 2 out of 2 residents reviewed, state to provide daily cleaning of mouth, teeth or dentures.

WN #8: The Licensee has failed to comply with O.Reg. 79/10, s.50(2)

50(2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

Findings:

1. An identified resident's plan of care directed nurses to do a wound treatment morning and at bedtime. According to the treatment record, the resident missed 10 treatments in one month and missed 13 of the wound treatments the following month. No explanations were found for any of the omissions.
2. An identified resident's plan of care directed nurses to change dressings every other day. In 1 month, 5 dressing changes were not done with no explanation for the omissions. The health file indicates deterioration of the wounds.

Additional Required Actions:

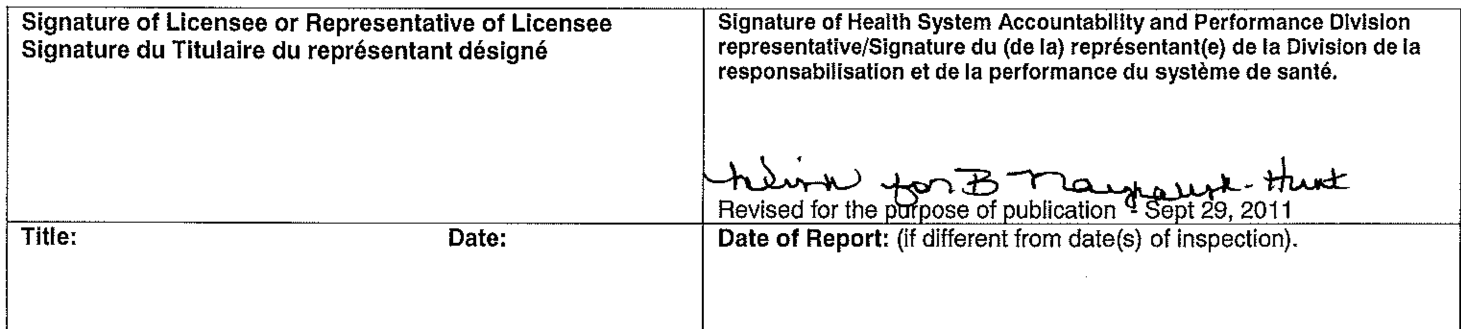
CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #9: The Licensee has failed to comply with O.Reg. 79/10, s. 109(d)

109.Every licensee of a long term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(d) types of physical devices permitted to be used

Findings:
1. The licensee, as required, has a policy regarding the restraining of residents NM-II-R008, September 2010. The policy's list of approved physical restraint devices to be used in the home does not include bedrails. However, bedrails are used as restraining devices on 2 identified residents as indicated by their health files and staff confirmation.

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 in ensuring the home's written policy regarding section 29 of the Act (minimizing restraining of residents) deals with the types of physical devices permitted to be used, to be implemented voluntarily.



Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné		Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Revised for the purpose of publication - Sept 29, 2011
Title:	**Date:**	**Date of Report:** (if different from date(s) of inspection).

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public	
Name of Inspector:	Barbara Naykalyk-Hunt	**Inspector ID #**	146
Log #:	H-00204		
Inspection Report #:	2011_146_1500_09Mar072931		
Type of Inspection:	Complaint		
Date of Inspection:	March 9, 14, 2011		
Licensee:	1508669 Ontario Limited, c/o Deloitte & Touche Inc.,181 Bay Street, Brookfield Place, Suite 1400, Toronto, ON., ., M5J 2V1		
LTC Home:	West Park Health Centre, 103 Pelham Road, St Catharines, ON., , ON.,L2S 1S9		
Name of Administrator:	Marjorie Mossman		

To 1508669 Ontario Limited, you are hereby required to comply with the following orders by the dates set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)
Pursuant to LTCHA, 2007, S.O. 2007, c.8, s.22(1) **Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.**			
Order: The Licensee shall forward all written complaints concerning the care of a resident or the operation of the long term care home immediately to the Director.			
Grounds: 1. The home received letters of complaint regarding care issues from a resident's family member on 3 occasions between November 2010 and January 2011. None of these letters were forwarded to the Director. The administrator provided the letters to the inspector upon request on the date of this inspection March 9, 2011.			

This order must be complied with by:	Immediate

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA, 2007, S.O. 2007, c.8, s.24(1)
24(1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

Order: The Licensee shall immediately report to the Director all allegations of abuse of a resident by anyone or neglect of a resident by anyone.

Grounds:
1. The Administrator of the home received a letter of complaint from an identified resident's Power of Attorney (POA) alleging emotional abuse and possible neglect of the resident by an identified staff person in the home. The letter states that the staff person's treatment of the resident caused the resident to be "afraid and scared" On the date the letter was provided to the inspector, the administrator confirmed that the home had investigated and dealt with the employee. The alleged abuse was not reported to the Director as of the date of this inspection, March 14, 2011.

This order must be complied with by:	immediate

Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: LTCHA, 2007, S.O. 2007, c.8, s.6(11)

6(11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

Order: The Licensee shall ensure that, when plans of care are reviewed and revised, and previous approaches have not been effective to prevent or reduce falls, that alternative approaches and strategies for falls prevention are included in the plan of care.

Grounds:
1. An identified resident fell with injury. The plan of care addressed the resident's falls risk as high and suggested strategies to reduce falls, including keeping the bedrails up.
2. Over the next 3 months, the strategies were ineffective and the resident had 4 more falls including 2 falls over the raised bedrails and several documented attempts to climb over the raised bedrails. The most

recent plan of care for falls contained no different approaches and bedrails remained up.
3. The plan of care was revised after the 3 months; however there were no changes or alternative approaches considered despite the resident continuing to have multiple falls.

This order must be complied with by:	immediate

Order #:	004	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O.Reg. 79/10, s.107(3)

107(3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital.

Order: The Licensee shall ensure that a critical incident report is submitted to the Director in relation to the incident that occurred in 2010 and any other incidents involving injury in respect of which a person is taken to hospital, within one business day

Grounds:
1. An identified resident fell with injury and was sent to hospital. The critical incident report was sent to the Director 18 business days later.
2. According to the health file, an identified resident fell over the raised bedrails onto the floor, sustained an injury and was sent to hospital.

This order must be complied with by:	Immediate

Order #:	005	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O.Reg. 79/10, s.50(2)

50(2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

Order: The Licensee shall ensure that all residents exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds receive their treatments and interventions as ordered and/or as indicated in the health file.

Grounds:

1. An identified resident's plan of care directed nurses to do a wound treatment morning and at bedtime. According to the treatment record, the resident missed 10 treatments in one month and missed 13 of the

wound treatments the following month. No explanations were found for any of the omissions. 2. An identified resident's plan of care directed nurses to change dressings every other day. In 1 month, 5 dressing changes were not done with no explanation for the omissions. The health file indicates deterioration of the wounds.	
This order must be complied with by:	immediate

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007*.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order 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 or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

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

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Issued on this day of , 2011. - Revised for the purpose of publication - Sept 29, 2011	
Signature of Inspector:	
Name of Inspector:	Barbara Naykalyk-Hunt, #146
Service Area Office:	Hamilton