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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 20, 2017	2017_577611_0008	006339-17	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (no.1) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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 ou des inspecteurs

KELLY CHUCKRY (611), CATHIE ROBITAILLE (536), GILLIAN TRACEY (130), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 28, 29, 30, 31, April 4, 5, and 6, 2017

During the course of this inspection inspector(s) conducted a tour of the home, observed the provision of resident care including meal service and medication administration observations, reviewed applicable clinical health records, policies, procedures, practices, and investigation notes. Eight Critical Incident inspections, and two follow up inspections were conducted concurrently with this Resident Quality Inspection.

The eight Critical Incident inspections included Log # 016872-16, Log # 023953-16, Log # 029250-16, and Log # 030319-16, all pertaining to the Prevention of Abuse and Neglect, Log # 030521-16, pertaining to a missing resident, and Log # 033312-16, Log # 034773-16, and Log # 002976-17, all pertaining to medication management. The two follow up inspections were Log #030209-16 pertaining to the Prevention of Abuse and Neglect, and Log # 030212-16 pertaining to sufficient staffing.

During the course of the inspection, the inspector(s) spoke with the residents, family members, the Administrator, Director of Care (DOC), Ward Clerk, Recreation Manager, Resident Assessment Instrument (RAI) Coordinator, registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), maintenance staff, and housekeeping staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- 5 WN(s)
- 2 VPC(s)
- 0 CO(s)
- 0 DR(s)
- 0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19.	CO #001	2016_250511_0006	611
O.Reg 79/10 s. 31. (3)	CO #002	2016_250511_0006	130

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(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. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident, and the goals the care was intended to achieve.

A) On an identified date, resident #018 was observed to have a treatment in place. Staff #104 acknowledged the resident was receiving prescribed medication at specified times as prescribed by the physician. This resident had a decline in health status as a result of a recent diagnosis. A review of the plan of care revealed there was no written plan in place for the identified treatment, or an intended goal of treatment and any potential complications related to the treatment.

On March 31, 2017, this information was acknowledged by the DOC. [s. 6. (1) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A) The Head to Toe Assessment and Skin-Weekly Impaired Skin Assessment completed for resident #018, on an identified date, upon the resident’s return to the home, revealed the resident was experiencing an alteration in skin integrity. A progress note on an identified date, indicated a second area of altered skin integrity. The Quarterly MDS assessment completed on an identified date, revealed the resident was at risk for alteration in skin integrity.

On March 31, 2017, the DOC acknowledged there was no written plan in place, with goals, objectives and interventions for the management and prevention of alteration in skin.

The plan of care for resident #018 was not based on their assessed needs. (Inspector 130)

B) On an identified date, resident #044 had a Minimum Data Set (MDS) quarterly assessment completed. The Resident Assessment Protocol Summary (RAPS) was reviewed and revealed that this resident had a deterioration in responsive behaviours. The RAPS indicated that this resident has exhibited responsive behaviours.

A review of the current care plan for resident #044 did not include a focus, goal, or intervention to capture the assessed behavioural needs from the RAPS. An interview conducted with the DOC acknowledged that the plan of care for resident #044 was not based on the assessed need of the resident. [s. 6. (2)]

3. The licensee failed to ensure that when the resident was being reassessed and the plan of care was being revised because care set out in the plan has not been effective, that different approaches had been considered in the revision of the plan of care.

A) The clinical record of resident #018, revealed they had sustained 10 falls over a five month period of time in 2016 and 2017. “The FALLS MANAGEMENT - Scott Fall Risk Screen, identified the resident was high risk for falls. A review of the written plan of care revealed that the plan of care related to falls risk had been reviewed quarterly; however, there had been no new interventions considered to prevent future falls and mitigate risk to the resident.

On an identified date, Inspector #130, spoke with the Substitute Decision Maker (SDM) for resident #018, at which time they expressed concerns that the resident would try to get out of bed and fall during the night due to restlessness. On a subsequent date, the home implemented interventions as a result of the expressed concern. The DOC acknowledged these interventions had not been considered until the Inspector inquired about any interventions that were considered for this resident.

Different approaches to care had not been considered in the revision of the plan of care for resident #018. [s. 6. (11) (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 there is a written plan of care for each resident that sets out the planned care for the resident, and the goals the care was intended to achieve, that the plan of care is based on an assessment of the resident and the needs and preferences of that resident, and that when the plan of care is being revised because the care set out in the plan has not been effective, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On an identified date, it was brought to the attention of Inspectors that there was a water leak in an area of the home. This area was being used as resident space.

Upon observing this room, there was a significant leak coming from either the window or the roof of the building. There was extensive water damage to the drywall directly under the leak, as well as excessive water on the floor, window ledge, and wood framing. The water damage was causing the drywall to ripple and had blackened in colour.

In an interview conducted with the Administrator and the Regional Director on an identified date, they indicated that the home completed some work to the floor and wall in the same areas of the home, and were not aware of a leak in this area during the last year. They both acknowledged that the leak would be fixed.

A review of the maintenance request log indicated that on two separate dates between December 2016 and March 2017 there has been a water leak in the same room. One one of the dates, the the corrective action was noted to be that the Administrator was aware.

Staff interviews were conducted with staff #110, #101, #103, #111 and #109. All of these staff members indicated the identified room had leaked during the last six months, and that it typically occurred when it rained, or the snow was melting. The staff members identified that the leak had been an going issue and management was aware of this. [s. 15. (2) (c)]

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 home, furnishings, and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

During the initial tour of the home on March 28, 2017, it was noticed that an activation station connected to the resident-staff communication and response system was not available in the sitting/lounge area on the first floor of the home.

In an interview conducted with the Administrator it was acknowledged that this activation station was missed when the home was adding these stations throughout the building. [s. 17. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The home submitted a Critical Incident (CI) report on an identified date, indicating that resident #065 exhibited inappropriate behaviour towards resident #028.

On an identified date, staff # 106 and #107 indicated that resident #065 had known responsive behaviors. Review of clinical records, the risk management report and the CI report related to this incident, including the amended version of the CI was completed, and this information did not contain the information that resident #028's SDM was notified within 12 hours upon becoming aware of this incident.

The home's "Zero Tolerance of Resident Abuse and Neglect" policy: RC-02-01-02, revised April 2016, stated: "Disclosure of the alleged abuse will be made to the resident/Substitute Decision Maker (SDM)/Power of Attorney (POA), immediately upon becoming aware of the incident, unless the SDM/POA is the alleged perpetrator".

On April 6, 2017, the DOC acknowledged that resident #028's SDM was not notified within 12 hours upon becoming aware of alleged, suspected or witnessed incident of abuse of the resident.

Please note this non compliance was issued as a result of CI: 023953-16, which was conducted concurrently with the RQI. [s. 97. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(i) names of all residents involved in the incident,
(ii) names of any staff members or other persons who were present at or discovered the incident, and
(iii) names of staff members who responded or are responding to the incident.

The home submitted a CI on an identified date, reporting that resident #065 exhibited responsive behaviours towards resident #028.

On April 6, 2017, the DOC acknowledged that staff #108 witnessed the incident. .

Review of clinical records, the risk management report and the CI report related to this incident, including the amended version of the CI was completed. The CI did not contain the description of all residents involved in the incident and names of staff members or other persons present or discovered the incident, which was acknowledged by the DOC on April 6, 2017.

Please note this non compliance was issued as a result of CI: 023953-16, which was conducted concurrently with the RQI. [s. 104. (1) 2.]

Issued on this 24th day of April, 2017

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

Original report signed by the inspector.