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 prévue le Loi de 2007 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 04, 2017;	2017_575214_0010 (A1)	009893-17, 016527-17	Critical Incident System

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

CATHY FEDIASH (214) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Order r.53(4)(c), has been extended from October 23, 2017, to November 30, 2017.

Issued on this 4 day of October 2017 (A1)

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

Original report signed by the inspector.

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 prévue le Loi de 2007 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 04, 2017;	2017_575214_0010 (A1)	009893-17, 016527-17	Critical Incident System

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

CATHY FEDIASH (214) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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 prévue le Loi de 2007 les foyers de soins de longue durée

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 26, 27, 28, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Resident Assessment Instrument (RAI) Coordinator; and residents. During the course of this inspection, the Inspector reviewed two Critical Incident Systems (CIS); reviewed resident clinical records; reviewed policies and procedures; reviewed minutes of a meeting and observed resident's and a resident bedroom.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **4 VPC(s)**
- **1 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).
(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).
(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for all programs and services, the matters referred to in subsection (1) which identified that the home was to ensure that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, were developed to meet the needs of residents with responsive behaviours and were integrated into the care that was provided to all residents.

A review of the home's policy titled, "Responsive Behaviours" (09-05-01 and dated September 2010) indicated the following:

i) Resident assessment tools used within the home to assess behaviours include: -MDS 2.0 and the Aggressive Behaviour Scale (ABS)-every resident with an ABS score of 2 or higher must have a care plan developed that addresses the risk of the identified behaviour.

A review of resident #100's admission MDS assessment that was dated on an identified date, indicated that the resident was assessed to have demonstrated identified responsive behaviours and an ABS score that was identified as greater than 2. A review of the resident's clinical record, indicated that a written care plan had not been put into place until approximately eight and a half weeks following the resident's admission, to address the risk of the resident's identified behaviours.

ii) During the pre-admission/application phase, the resident application will be reviewed for any indication of prior responsive or aggressive behaviour. If a behaviour of concern is indicated on the application, the admission interview is to include an exploration of the behaviour including, but not limited to the following:

a. What triggers the behaviour;
b. What makes the behaviour better or worse;
c. Is there a pattern to the behaviour (time of day, prior to or after an acitivity or task, etc.);
d. How has the family/caregivers coped with the behaviour;
e. Any assessments or health care professionals who have consulted regarding this behaviour as well as what the outcomes or recommendations of the assessments were.

A review of resident #100's clinical record indicated that the home had reviewed the resident's admission application which had identified that the resident had a history of identified responsive behaviours.

No admission interview notes were included in the resident's clinical record that had included the information identified above.

iii) In homes with Point of Care (POC) documentation tablets, tasks focusing on reporting observed behaviour are to be added to a resident file as soon as the behaviour is observed. For homes without POC, the Responsive Behaviour Record or the Dementia Observation Scale form is to be used by care staff to record behavioural observations. The determination of what tools to be used should be based on the type of behaviour being assessed and the level of detail required to establish patterns to the behaviour and interventions.

A) A review of resident #100's clinical record indicated that documentation on an identified date, indicated that the resident was observed to have demonstrated

identified responsive behaviours with resident #500. A review of the resident's identified behaviour task in the POC system indicated that on the identified date, the first documented entry for this date was several hours following the incident and indicated that behaviour of this type had not been exhibited.

B) A review of resident #100's clinical record indicated that documentation dated five days later than the incident noted above, indicated that the resident had demonstrated an identified responsive behaviour with resident #500. A review of resident #100's identified behaviour task in the POC system indicated that documentation was entered twice on the identified date and indicated that behaviour of this type had not been exhibited on this date.

C) A review of resident #100's clinical record indicated that documentation completed seven days later, indicated that the resident was observed to have demonstrated identified responsive behaviours towards co-residents. A review of the resident's identified behaviour task in the POC system indicated that documentation on the identified date indicated that behaviour of this type had not been exhibited on this date.

An interview with the DOC confirmed that the home used the POC documentation tablets. The DOC confirmed that the home did not ensure that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, as identified in the home's Responsive Behaviours policy, had been developed to meet the needs of resident #100 with known responsive behaviours and had not been integrated into the care that was provided to them. [s. 53. (2) (a)]

2. The licensee failed to ensure that for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A review of resident #100's admission information provided by the placement co-ordinator; a review of two CIS reports submitted by the home on identified dates and a review of the resident's clinical record for an identified period of approximately eight and a half weeks, indicated that the resident had a history of demonstrating known responsive behaviours towards residents and staff.

A review of the resident's clinical record for the identified period above, indicated

the following:

A) On an identified date, the resident demonstrated an identified responsive behaviour when they were not able to participate in an identified desired activity, independently. No further documentation had been included as to what actions were taken including the resident's response to any actions.

B) Two days later, the resident had been observed to demonstrate identified responsive behaviours towards resident #200 that resulted in an identified injury and treatment. No further documentation had been included as to what actions were taken including the resident's response to any actions.

C) Five days later, the resident demonstrated identified responsive behaviours when they were unable to participate in an identified desired activity, independently. No further documentation had been included as to what actions were taken including the resident's response to any actions.

D) Two days later, the resident demonstrated identified responsive behaviours when they were unable to participate in an identified activity, independently. No further documentation had been included as to what actions were taken including the resident's response to any actions.

E) Twenty days later, the resident demonstrated identified responsive behaviours toward a co-resident. Documentation indicated that staff did respond with identified interventions; however, no documentation was included as to the resident's response to these actions.

F) Five days later, the resident demonstrated identified responsive behaviours toward a co-resident. Documentation indicated that staff did respond with identified interventions; however, no documentation was included as to the resident's response to the actions taken.

G) Twelve days later, the resident demonstrated identified responsive behaviours towards resident #500, when they entered the room of resident #100. Documentation indicated that staff did respond with identified interventions; however, no documentation was included as to the resident's response to the actions taken.

H) Seven days later, the resident demonstrated identified responsive behaviours

towards co-residents. No further documentation had been included as to what actions were taken including the resident's response to any actions.

I) Three days later, the resident demonstrated identified responsive behaviours towards staff. No further documentation had been included as to what actions were taken including the resident's response to any actions taken.

J) Five days later, documentation indicated that the resident demonstrated an identified pattern of responsive when staff assisted a co-resident with their bedtime care. Documentation indicated that the resident demonstrated identified responsive behaviours toward the staff and demonstrated identified responsive behaviours when staff asked the resident to wait a few minutes for staff to call the resident's family as other residents were using the telephone. No further documentation had been included as to what actions were taken including the resident's response to any actions taken.

The Administrator and DOC confirmed on an identified date, that when resident #100 demonstrated responsive behaviours, actions taken to respond to the needs of the resident including interventions tried and the resident's response to the interventions, had not been documented. [s. 53. (4) (c)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (6) When a resident is admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44. 2007, c. 8, s. 6 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident was assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44.

A review of two CIS reports that were submitted by the home on identified dates, indicated that resident #100 was observed to have demonstrated responsive behaviours towards resident #200 that resulted in an identified injury and treatment. A review of the second CIS indicated that on an identified date, resident #100 demonstrated responsive behaviours towards resident #300 that resulted in an identified injury.

A review of the resident's clinical record indicated that resident #100 was admitted to the home on an identified date and for an approximate period of eight weeks following, demonstrated identified responsive behaviours towards co-residents and staff.

A review of the Community Care Access Centre (CCAC) admission package, indicated that resident #100 was coded as demonstrating identified responsive behaviours. The corresponding identified narrative RAPS indicated that the resident persistently looked for an identified family member and needed reassurance that their family member was available to them and that the resident could demonstrate an identified responsive behaviour if they lost sight of their family member.

A review of the Personal Health Profile completed by CCAC, indicated that the resident had a history of identified responsive behaviours. It was also identified on

this profile that the resident participated in an identified preferred activity.

A review of the Behavioural Assessment completed by CCAC, indicated that the resident demonstrated specified responsive behaviours.

A review of the admission Minimum Data Set (MDS) coding completed by the home on an identified date, indicated that the resident was coded as exhibiting specified responsive behaviours. A review of the corresponding identified Resident Assessment Protocols (RAPS) indicated that the resident was struggling to adjust to long-term care and had exhibited specified responsive behaviours towards co-residents and staff. It was also identified that the resident demonstrated a specified responsive behaviour when they could not participate in an identified preferred activity and were told they would have to wait for an identified family member to visit. The RAPS indicated that this information would be care planned to minimize risks to self and others.

A review of the resident's written care plan in place since their admission, indicated that an initial plan of care that was based on the assessment, reassessments and information provided by the placement co-ordinator as well as the home's admission MDS coding and assessments in relation to the resident's identified responsive behaviours, had not been created until approximately eight and a half weeks following their admission to the home. No plan had been created at the time of this inspection in relation to the resident's preference to participate in an identified activity.

The Administrator and DOC confirmed that the resident's initial plan of care had not been developed and based on the home's assessments and on the assessment, reassessments and information provided by the placement co-ordinator within the times provided for in the regulations. [s. 6. (6)]

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 when a resident is admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone.

A) A review of a CIS that was submitted by the home, indicated that on an identified date, resident #100 with known responsive behaviours, was observed to have demonstrated a specified responsive behaviour towards resident #200, resulting in an identified injury to resident #200. The CIS indicated that there had been no witnesses to any activities prior to this incident that may have led to the altercation.

An interview with the DOC confirmed that resident #200 had not been protected from abuse by anyone.

B) A review of a CIS that was submitted by the home, indicated that on an identified date, resident #100 with known responsive behaviours, demonstrated an identified responsive behaviour toward resident #300, resulting in an identified injury to resident #300. The CIS indicated that this incident was not witnessed and documentation indicated that it was thought that resident #300 had closed an identified curtain and that resident #100 did not like this action.

An interview with the DOC confirmed that resident #300 had not been protected from abuse by anyone. [s. 19. (1)]

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 all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #4: 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 failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) A review of resident #100's clinical record indicated that on an identified date, staff observed resident #100 to be standing in front of resident #400. Resident #400 had asked resident #100 to move as they were unable to see the television. In response, resident #100 began demonstrating identified responsive behaviours toward resident #400.

Documentation in resident #100's clinical record indicated that identified interventions were put into place with effect. A review of resident #400's clinical record indicated that this incident including any actions taken to ensure resident #400's well-being, had not been documented in their clinical record.

The DOC confirmed that actions taken with respect to the above incident involving resident #400, had not been documented.

B) A review of a CIS that was submitted by the home, indicated that on an identified date, resident #100 was observed to have demonstrated an identified responsive behaviour toward resident #200, resulting in an identified injury to resident #200.

A review of resident #200's clinical record indicated that no documentation of this incident, the injury sustained, treatment or care provided by the home or notification to resident #200's Substitute Decision Maker (SDM) or physician, had been documented.

The DOC confirmed that actions taken with respect to the above incident involving resident #200, had not been documented.

C) A review of resident #100's clinical record indicated that on an identified date, resident #100 demonstrated an identified responsive behaviour toward resident #500. A review of resident #500's clinical record indicated that they responded back by demonstrating an identified responsive behaviour toward resident #100. Resident #100's clinical record had not identified the responsive behaviour demonstrated by resident #500 and had not included any actions including the assessment of resident #100 for possible injury.

The DOC confirmed that actions taken with respect to the above incident, had not been documented in resident #100's clinical record. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A review of resident #100's clinical record for an identified period of eight days, indicated the following:

On an identified date, the resident demonstrated identified responsive behaviour when looking for an identified item required to participate in an identified activity. Staff spoke with the resident and advised that they would assist the resident so that they could participate in the identified activity. When staff did assist the resident, it was identified that the resident was unable to independently complete all tasks required to participate in the identified activity. Documentation indicated that the resident had not demonstrated any responsive behaviours while participating in the identified activity and that they returned back to their unit without incident.

Later the same day, the resident was looking to participate in the identified activity and that staff advised the resident that when staff were available, they would assist the resident. Staff did assist the resident and the resident returned back to their unit.

The following day, the resident was asking to participate in the identified activity. Documentation indicated that staff did assist the resident and the resident had not demonstrated any responsive behaviours.

Later the same day, the resident asked to participate in the identified activity. Documentation indicated that twice, staff assisted the resident. Following this, staff were notified that they were unable to assist the resident in their preferred activity, as per the home's policy.

The following day, documentation indicated that the resident had become worried as they were not allowed to participate in their identified preferred activity. It was indicated that the resident stayed in their room and refused to come for supper. The resident verbalized that the people at the home were mean and that they had been participating in their identified preferred activity their entire life and that they could not be stopped from doing the activity. Staff provided an identified intervention and the resident had not demonstrated any responsive behaviours.

On the following day, documentation indicated that a family member assisted the resident to participate in their identified preferred activity.

The following day, documentation indicated that the resident was asking to participate in their identified preferred activity. Staff advised the resident that their family would have to assist them. Documentation indicated that the resident then demonstrated identified responsive behaviours towards the staff.

Later the same day, staff mistakenly assisted the resident to participate in their identified preferred acitvity. Another staff intervened and documentation indicated that the resident then demonstrated identified responsive behaviours toward staff. Staff intervened by having the resident speak on the telephone to their family member. Documentation indicated that the resident did not demonstrate any further responsive behaviours, following this intervention.

The following day, documentation indicated that the resident was demonstrating identified responsive behaviours as they were not allowed to participate in an identified preferred activity. The resident was not accepting of the explanation provided by staff regarding the home's identified policy. Documentation indicated that the resident then demonstrated identified responsive behaviours towards a staff member.

The following day, documentation indicated that the resident was looking for an identified item. The resident had been assisted by staff earlier to participate in an identified preferred activity. The remainder of the shift the resident was observed to demonstrate identified responsive behaviours.

A review of a CIS that was submitted by the home on an identified date, indicated that resident #100 with known responsive behaviours, demonstrated identified responsive behaviours towards resident #200 that resulted in an identified injury and treatment.

A review of resident #100's clinical record indicated that the resident was admitted to the home on an identified date. The clinical record indicated that the resident had known responsive behaviours and had demonstrated 19 incidents of identified responsive behaviours towards resident's and staff, five days following their admission and over a time period of approximately seven and a half weeks, which had resulted in either harm or a risk of harm to resident #100 and others.

A review of resident #100's written plan of care from their admission to the date of this inspection and confirmed with the Administrator and DOC, identified that procedures and interventions were not developed and implemented to assist residents and staff who were at risk of harm or who were harmed as well as to minimize the risk of altercations and potentially harmful interactions, for approximately eight and half weeks following the resident's admission. No plan had been created at the time of this inspection in relation to the resident's preference to participate in an identified activity. [s. 55. (a)]

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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

Issued on this 4 day of October 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : CATHY FEDIASH (214) - (A1)

Inspection No. / No de l'inspection : 2017_575214_0010 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 009893-17, 016527-17 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Oct 04, 2017;(A1)

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

LTC Home / Foyer de SLD : WEST PARK HEALTH CENTRE
103 Pelham Road, St Catharines, ON, L2S-1S9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Sharon Darby

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To CVH (no.1) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee is to ensure that for each resident demonstrating responsive behaviours, including resident #100, that actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The home shall provide education on documentation requirements for each resident demonstrating responsive behaviours and the requirement to ensure that the resident's responses to interventions are documented. This education shall be provided to all staff who are responsible for documenting resident's behaviours.

The licensee shall conduct auditing activities of resident's clinical records at a

frequency and schedule as they determine to ensure that actions are taken to
respond to the needs of resident's and that the resident's responses to interventions are documented for each resident demonstrating responsive behaviours.

Grounds / Motifs :

1. This Order is being issued based on the application of the factors of severity (3), scope (2) and Compliance history of (4) in keeping with s. 299(1) of the Regulation, in respect to the actual harm to resident #200 and #300, the scope of pattern of incidents and the licensee's history of ongoing non-compliance (VPC), April 5, 2016, Resident Quality Inspection related to r.53(4)(c).

The licensee failed to ensure that for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A review of resident #100's admission information provided by the placement co-ordinator; a review of two CIS reports submitted by the home on identified dates and a review of the resident's clinical record for an identified period of approximately eight and a half weeks, indicated that the resident had a history of demonstrating known responsive behaviours towards residents and staff.

A review of the resident's clinical record for the identified period above, indicated the following:

A) On an identified date, the resident demonstrated an identified responsive behaviour when they were not able to participate in an identified desired activity, independently. No further documentation had been included as to what actions were taken including the resident's response to any actions.

B) Two days later, the resident had been observed to demonstrate identified responsive behaviours towards resident #200 that resulted in an identified injury and treatment. No further documentation had been included as to what actions were taken including the resident's response to any actions.

C) Five days later, the resident demonstrated identified responsive behaviours when they were unable to participate in an identified desired activity, independently. No further documentation had been included as to what actions were taken including the resident's response to any actions.

D) Two days later, the resident demonstrated identified responsive behaviours when they were unable to participate in an identified activity, independently. No further documentation had been included as to what actions were taken including the resident's response to any actions.

E) Twenty days later, the resident demonstrated identified responsive behaviours toward a co-resident. Documentation indicated that staff did respond with identified interventions; however, no documentation was included as to the resident's response to these actions.

F) Five days later, the resident demonstrated identified responsive behaviours toward a co-resident. Documentation indicated that staff did respond with identified interventions; however, no documentation was included as to the resident's response to the actions taken.

G) Twelve days later, the resident demonstrated identified responsive behaviours towards resident #500, when they entered the room of resident #100. Documentation indicated that staff did respond with identified interventions; however, no documentation was included as to the resident's response to the actions taken.

H) Seven days later, the resident demonstrated identified responsive behaviours towards co-residents. No further documentation had been included as to what actions were taken including the resident's response to any actions.

I) Three days later, the resident demonstrated identified responsive behaviours towards staff. No further documentation had been included as to what actions were taken including the resident's response to any actions taken.

J) Five days later, documentation indicated that the resident demonstrated an identified pattern of responsive behaviours when staff assisted a co-resident with their bedtime care. Documentation indicated that the resident demonstrated identified responsive behaviours toward the staff and demonstrated identified responsive behaviours when staff asked the resident to wait a few minutes for staff to call the resident's family as other residents were using the telephone. No further documentation had been included as to what actions were taken including the resident's response to any actions taken.

The Administrator and DOC confirmed on an identified date, that when resident #100 demonstrated responsive behaviours, actions taken to respond to the needs of the resident including interventions tried and the resident's response to the interventions, had not been documented.
(214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Nov 30, 2017(A1)

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 services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4 day of October 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHY FEDIASH

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Service Area Office / Bureau régional de services : Hamilton