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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 12, 2019	2019_743536_0004	001515-19, 002305-19	Complaint

Licensee/Titulaire de permis

CVH (No. 1) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes 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

CATHIE ROBITAILLE (536)

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): January 29, 30, 31, February 1, 4 and 5, 2019.

The following intake(s) were completed concurrently with the Complaint Inspection.

Complaint:

Intake #001515-19-related to: Prevention of Abuse and Neglect

Critical Incident System Report:

Intake #002305-19, CIS #1500-000005-19-related to: Prevention of Abuse

Non-compliance related to LTCHA 2007, s. 19(1) related to Duty to Protect was issued in this report as a WN and is further evidence to support the compliance order issued on December 13, 2018, during complaint inspection 2018_575214_0013 to be complied April 29, 2019. [s. 19. (1)]

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW's), registered staff, housekeeping staff, Dietary Manager, Resident Program Manager, Behavioural Support Ontario (BSO) Behavioural Lead, Niagara Seniors Mental Health Outreach Program Case Manager, Nursing Clerk, Resident Assessment Instrument-Minimum Data Set Co-Ordinator (RAI-MDS), Director of Care (DOC) and the Executive Director (ED/Administrator).

During the course of the inspection, the inspector(s) interviewed staff, residents and families, and reviewed relevant documents including but not limited to: health care records, investigation reports, training records and relevant policies and procedures.

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.

4 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. (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 has failed to 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.

On an identified date, a complaint was received at the Ministry of Health and Long Term Care (MOHLTC) regarding an incident of alleged abuse. On an identified date, a Critical Incident System (CIS) Report was submitted to the MOHLTC in relation to the same incident of alleged abuse.

Resident #001 has resided at the home since a specified date. On an identified date in 2018, a referral was sent to a specified resource in regards to a behaviour resident #001 was exhibiting. On an identified date in 2018, the specified resource was in the home and completed their initial assessments for resident #001. On that same day, resident #001 was moved to a new room with resident #002 as a roommate. A progress note by registered staff #114 regarding a conversation with the Substitute Decision Maker (SDM) identified that the SDM was concerned with resident #001 being moved to the room were resident #002 resided.

On a specified date in 2018, when the specified resource staff #104 went to visit resident #001 about a behaviour the resident spoke of their interactions with resident #002. Resident #001 verbalized their desire to protect themself when co-resident spoke threateningly. During interview with staff #104, a review was completed of the documentation for resident #001. The documentation stated they had reported resident #001's allegations towards resident #002 to the registered staff. During interview, the Inspector asked staff #104 if they had been advised of any incidents involving resident #001 by staff at the home. Staff #104 stated if they were, they would have documented it which they did not. Resident #001 was discharged from the support services on a specified date in 2018.

The following progress notes were identified in resident #001's clinical record:

• On an identified date, registered staff #105 documented in resident #001's progress notes that resident #001 displayed responsive behaviours toward resident #002. Resident was redirected and calmed.

• On an identified date, registered staff #110 documented in resident #001's progress notes that resident #001 displayed responsive behaviours with resident #002. Writer calmed resident #001 and the progress note indicated that resident #001 had a subsequent behaviour.

• On an identified date, registered staff #109 documented in resident #001's progress notes that resident #003 told writer that responsive behaviours were demonstrated by resident #001.

A review of resident #001's plan of care which the home refers to as the care plan, did not identify that resident #001 exhibited behaviours. On an identified date, the Director of Care (DOC) confirmed that resident #001's care plan had not been updated to reflect resident's responsive behaviour, triggers or strategies to manage these responsive behaviours.

Resident #002's plan of care, which was in place at the time of the inspection identified that resident #002 had identified behaviours. Specified interventions were in place. On an identified date, staff #118 witnessed resident #001 interacting with resident #002. Staff #118 then reported it to the nurse. Staff #121 when interviewed confirmed that the identified intervention for resident #002 was not in place at the time of this incident.

The home failed to ensure that for resident #001 who demonstrated responsive behaviours, the behavioural triggers for the resident were identified, strategies were developed and implemented to respond to these behaviours, and actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and that resident #001's responses to interventions were documented and failed to ensure that interventions identified for resident #002 were implemented. [s. 53. (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 and ensuring that for residents demonstrating responsive behaviours the behavioural triggers are identified; strategies developed and implemented, and actions taken including assessments, reassessments and interventions and the residents response to the interventions documented, to be implemented voluntarily.

WN #2: 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 has failed to ensure that resident #001's substitute decision-maker, or

any other person specified by the resident,
(a) were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that 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.

On an identified date, a complaint was received at the Ministry of Health and Long Term Care (MOHLTC) regarding an incident of alleged abuse which occurred. On a specified date, a Critical Incident System (CIS) Report related to the same incident was submitted to the MOHLTC.

On an identified date and time, registered staff #102 heard an altercation between residents #001 and #002. Registered staff #102 when interviewed, stated that an altercation between resident #001 and #002 resulted in resident #001 falling and sustaining an injury. Resident #001's Substitute Decision Maker (SDM) when interviewed confirmed that they had not received a call from the home informing them of the altercation between resident #001 and #002.

Registered staff #102, #105, #114 and the Director of Care (DOC) when interviewed, each confirmed that the SDM had not been notified of the incident that occurred. [s. 97. (1) (a)]

2. The licensee has failed to ensure that resident #001's substitute decision-maker, if any, and any other person specified by the resident, (b) were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

On a specified date, registered staff #109 documented in resident #001's progress notes that resident #003 reported responsive behaviours by resident #001.

On a specified date, registered staff #110 documented in resident #001's progress notes that resident displayed responsive behaviours.

On a specified date, registered staff #105 documented in resident #001's progress notes that resident #001 displayed responsive behaviours toward resident #002.

During interview, the Executive Director (ED) confirmed that the SDM for resident #001 was not notified of the incidents that had occurred on the identified dates. [s. 97. (1) (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 and ensuring (a) substitute decision makers if any, or any other person specified by the resident are notified immediately upon becoming aware of alleged, suspected or witnessed abuse that has resulted in injury, pain or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being or (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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to ensure that 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.

The following is further evidence to support the compliance order issued on December 13, 2018, during complaint inspection 2018_575214_0013 to be complied April 29, 2019.

On an identified date and time, registered staff #102 heard an altercation between resident #001 and #002. Registered staff #102 when interviewed, stated that they observed an altercation between resident #001 and #002 which resulted in a fall with injury for resident #001.

On an identified date and time, a progress note by registered staff #105 stated resident #001 was complaining of pain, to a specified area of their body.

On an identified date and time, a progress note by registered staff #110 stated resident #001 again complained of pain, to a specified area of their body.

On an identified date and time, another progress note was recorded by registered staff #110 that indicated resident #001 complained of pain, that was worse with movement.

On an identified date and time, a progress note recorded by registered staff #105 indicated that resident #001 had evidence of an injury to a specified area of their body.

On an identified date and time, a progress note recorded by registered staff #114 stated that a family member identified resident #001 was in pain. Resident was assessed and then sent to hospital were the resident was assessed with identified injury.

On an identified date and time, a progress note recorded by registered staff #114 stated that resident #001 returned to the home. Resident #001 was returned to their room, the same room they shared with resident #002.

The licensee has failed to ensure that resident #001 was protected from abuse by anyone. [s. 19. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was 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 a resident.

On an identified date and time, registered staff #102 observed an altercation between resident #001 and #002 that resulted in injury to resident #001.

On an identified date, a Critical Incident System (CIS) Report was submitted to the Ministry of Health and Long Term Care (MOHLTC).

When interviewed, the Executive Director (ED) confirmed that they filed the CIS twelve days after the alleged incident. The ED then confirmed that they had not filed a CIS at the time of the incident as they didn't treat it as alleged abuse but, as responsive behaviours.

The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of resident #001 by anyone that resulted in harm or risk of harm, immediately reported the suspicion to the Director. [s. 24. (1)]

Issued on this 14th day of February, 2019

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

Original report signed by the inspector.