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
May 30, 2019	2019_575214_0016	028498-18	Critical Incident System

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

CATHY FEDIASH (214)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 22, 23, 27, 2019.

Please note: this inspection was conducted concurrently with Complaint inspection 2019_575214_0017 / 030329-18, 006752-19.

Complaint intake #030329-18- related to: Prevention of Abuse and Neglect.
Complaint intake #006752-19 - related to: Prevention of Abuse and Neglect.

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 resident quality inspection 2018_575214_0013 to be complied May 28, 2019.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED); Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) reviewed the relevant Critical Incident System (CIS); home`s investigative notes; resident clinical records; and interviewed staff.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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

- **1 WN(s)**
- **0 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 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 protect resident #004 from abuse.

The following is further evidence to support the compliance order issued on December 13, 2018, during resident quality inspection 2018_575214_0013 to be complied May 28, 2019.

A review of Critical Incident System (CIS) #1500-000037-18, submitted to the Ministry of Health and Long Term Care, indicated that on an identified date and time, resident #004, with an identified diagnoses had a specified action made towards them by resident #005, on this date. The CIS indicated that staff #105 had been completing an identified task when they witnessed the specified action by resident #005, towards resident #004.

A review of resident #004's progress notes, for an identified date and time, indicated that on this date, resident #004 had a specified action made towards them by resident #005,

A progress note dated the same date and transcribed by the physician, indicated that resident #004 was assessed and no injuries were noted.

A review of the home's investigative notes indicated that staff #105 had documented that on an identified date and time, they had entered a specified location and observed resident #005 to have made a specified action towards resident #004. The documentation indicated that staff #105 verbalized to resident #005 to leave the identified area, which they did.

An interview with staff #105 and the Ministry of Health and Long Term Care (MOHLTC) Inspector, was conducted on an identified date. The staff member confirmed that on an identified date, they had been completing an identified task when they witnessed the specified action by resident #005, towards resident #004. Staff #105 said that they asked resident #005 to leave the identified area, which they did without incident. Staff #105 indicated that as a result, resident #004 had not demonstrated any ill effects.

During an interview with the ED and the MOHLTC Inspector, on an identified date, the ED said that resident #004 would not have consented to the specified actions and agreed that they had not been protected from abuse. [s. 19. (1)]

Issued on this 30th day of May, 2019

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

Original report signed by the inspector.