Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 7, 2020	2019_820130_0016	020688-19, 020869-19, 021115-19, 021690-19, 022249-19	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

GILLIAN HUNTER (130), ROSEANNE WESTERN (508)

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): December 4, 5, 6, 9, 10 11, 12, 13, 16 and 17, 2019.

During the course of the inspection, the inspector(s) toured the facility, observed residents and resident care, reviewed relevant resident clinical records and policies and procedures, investigation notes, critical incident reports and staff education reports.

PLEASE NOTE: This Complaint inspection was conducted concurrently with the following Complaint inspection 2019_820130_0017.

This inspection was conducted related to the following intakes:

Log # 020688-19, related to prevention of abuse and neglect and pain management;
Log # 020869-19, related to prevention of abuse and neglect and responsive behaviours;
Log # 021115-19, related to infection prevention and control;
Log # 021690-19, related to prevention of abuse and neglect, availability of supplies and nursing and personal support services;
Log # 022249-19, related to prevention of abuse and neglect and improper care.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), the Interim Director of Care (IDOC), the Resident Assessment Instrument Coordinator (RAI), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), residents and families.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 WN(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee failed to ensure that the care set out in the plan of care was provided to resident #004 and #009, as specified in their plans.

A) A complaint was reported to the Ministry of Long Term Care on an identified date in 2019, related to staff not following the resident's plan of care. Resident #004 had a specific diagnosis, and an appointed Substitute Decision Maker (SDM).

The resident's SDM had assisted with the development of the resident's current plan of care which provided specific directions to staff regarding sleep and rest and attendance at a specific program.

On an identified date in 2019, the SDM observed the resident and reported to the registered staff, that the resident had not received the care specified in their plan of care.

The staff reported to the SDM that they were working short that shift and apologized for not providing assistance to the resident. Documentation reviewed including nursing staff schedules and the resident's participation report for a specific month in 2019, confirmed the SDM's information. In addition, it was also identified that resident #004 had only attended the specific program once in the identified month in 2019, as the resident had not received assistance from staff to attend.

During interview with RN #107, the Nursing Clerk and the Executive Director, it was identified that the home had difficulty filling nursing shifts including PSW shifts when staff call in absences. On the identified date in 2019, the staff were working short as the home could not replace PSW shifts.

It was confirmed through review of the documentation and during interviews that the care set out in the plan of care had not been provided as specified in the plan.

B) PLEASE NOTE: The following non-compliance was identified during concurrent CIS inspection #2019_820130_0017 and was issued in this report.

Critical Incident #1500-000031-19 was submitted to the Ministry of Long Term Care on an identified date in 2019, related to an incident that occurred two days prior.

PSW #105 provided specific care to resident #009 at a specified time on an identified date in 2019. PSW #105 left the resident to assist with other residents and left the resident unattended before the care was completed. Approximately one and half hours later, the RPN responded to the resident's call bell and found resident lying on the floor.

A review of the resident's clinical records including the resident's care plan, indicated that the resident was a high risk for falls and that staff were to remain with the resident during specific tasks.

It was confirmed during review of the resident's clinical records, the Critical Incident and during interview with the DOC that on November 19, 2019, care was not provided to resident #009 as specified in the plan.

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 care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

The licensee failed to ensure that there was a written staffing plan that included a back-up plan for nursing and personal care staffing that addressed situations when staff, including the staff who provided the nursing coverage required under subsection 8(3) of the Act, cannot come to work.

A complaint was submitted to the Ministry of Long Term Care in 2019, related to nursing staff shortages in the home.

During this inspection, the LTCH inspector reviewed staffing schedules and requested a copy of the home's staffing plan as it was identified that the home was regularly working short when staff called in absences.

During interview, the ED indicated that they had a staffing plan for PSWs; however, they could not provide a staffing plan for when registered staff could not come to work.

It was confirmed during interview with the ED that there was a written staffing plan that included a back-up plan for nursing and personal care staffing that addressed situations when staff, including the staff who provided the nursing coverage required under subsection 8(3) of the Act, could not come to work.

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 staffing plan that includes a back up plan for nursing and personal care staffing that addresses situations when staff, including the staff who provide the nursing coverage required under subsection 8(3) of the Act, cannot come to work, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

A complaint was submitted to the Ministry of Long Term Care in 2019, related to infection prevention and control. It was alleged that at times staff are unaware that residents are symptomatic of infections as no precautionary signage is posted and it's not always shared during shift to shift report.

During review of the resident's clinical records, it was identified that resident #007 starting presenting with symptoms of a rspecific infection on an identified date in 2019. The resident was placed on specified precautions.

During a tour of the home in 2019, LTCH inspector #130 observed the resident in their room, no precaution signage and no Personal Protective Equipment (PPE) was set up outside the resident's room. On another date in 2019, LTCH inspector #508 observed the resident again in their room with no signage and no PPE set up.

It was observed that another resident's room had precaution signage and the PPE cart set up outside their room. During interview with RPN #103, the RPN confirmed that this resident had signs and symptoms of a specified infection and was on special precautions. The RPN also confirmed that resident #007 was on special precautions and should have had the PPE cart set up outside their room and the precaution signage due to their symptoms.

During a tour of a tub room in 2019, two (2) used hairbrushes were observed sitting on the sink with no labels to identified which residents they belonged to. PSW #113 confirmed that these items should have been labelled and disposed of the items.

It was confirmed during this complaint inspection that the staff did not participate in the implementation of the infection prevention and control program.

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 7th day of January, 2020

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

Original report signed by the inspector.