Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
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Original Public Report

Report Issue Date: April 4, 2023	
Inspection Number: 2023-1041-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: CVH (No. 1) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)	
Long Term Care Home and City: West Park Health Centre, St Catharines	
Lead Inspector Dusty Stevenson (740739)	**Inspector Digital Signature** Dusty L Stevenson Digitally signed by Dusty L Stevenson Date: 2023.04.12 13:29:13 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 13-15, 21-24, February 28-March 3, March 6-7, 10, 2023

The following intake(s) were inspected:

- Intake: Incident related to food, nutrition and hydration.
- Intake: Incident related to prevention of abuse and neglect.
- Intake: Incident related to prevention of abuse and neglect
- Intake: Complaint related to food nutrition and hydration, and resident care and support services.
- Intake: Incident related to prevention of abuse and neglect, and skin and wound prevention and management.
- Intake: Complaint related to resident care and support services, and safe and secure homes.
- Intake: Incident related to resident care and support services and safe and secure homes.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 20 (1)

The licensee failed to comply with their policy for assessing a resident following an allegation of abuse.

Rationale and Summary

An alleged incident of abuse occurred on a day in October 2021. A review of the resident's clinical records indicated that following the abuse allegation, no assessment of the resident was completed, and no updates were made to their plan of care.

There was risk to the resident as not completing an assessment following an alleged abuse may have missed potential injuries that could have impacted the resident's well-being.

Sources: CI 1500-000024-21, resident records, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting (RC-02-01-02, reviewed January 2022), interview with Executive Director

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WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to provide a resident with an assistive device to manage a condition.

Rationale and summary
A physiotherapy assessment indicated that a resident sometimes used an assistive device to manage a condition.

A progress note by the physician indicated that the resident was admitted with an assistive device and the RN was to follow-up so that the assistive device may be offered to the resident.
A review of the resident's plan of care did not indicate the use of the assistive device or that it was offered to the resident.

As a result, the resident was not offered their assistive device which may have managed their condition.

Sources: resident records, interview with Executive Director

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WRITTEN NOTIFICATION: Bathing

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee failed to ensure that a resident was bathed, at a minimum, twice a week.

Rationale and summary
A resident's clinical records indicated that the resident was not scheduled for or offered a bath for twelve days. During this period there was no documentation that the resident refused a bath or that there was an attempt to offer the resident a bath.

A staff reviewed the task list with the Inspector and indicated that the resident did not receive a bath or was scheduled for a bath during the twelve-day period.

As a result, the resident was not offered interventions that could promote comfort, hygiene and quality of life.

Sources: resident records, interview with staff, Policy: Bathing, Showering and Water Temperature Monitoring RC-06-01-02; reviewed January 2022

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WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee failed to ensure that a resident received a skin assessment upon returning from hospital.

Rationale and Summary:

A resident was sent to hospital on a day in November 2022 with a skin issue and returned the next day. Upon return the resident did not receive a skin assessment.

The homes Skin and Wound Program indicated that a head-to-toe skin assessment is to be completed for all residents upon any return from hospital (admission or emergency room).

As a result, the resident's skin issue was not appropriately captured and documented when the resident returned from hospital and therefore the appropriate assessment and follow-up were not captured or performed.

Sources: interview with Executive Director, Skin and Wound Program (RC-23-01-01, page 2 of 10), resident records

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WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care
The licensee failed to ensure a resident received a skin assessment using a clinically appropriate assessment instrument specifically designed for skin and wound assessment when a new skin issue was identified.

Rationale and summary:
A resident's progress notes indicated that they had a skin issue that originated on a day in November 2022. The resident's records from that day did not identify any documentation that a skin assessment was completed.

The homes Skin and Wound Program indicated to promptly assess all residents exhibiting altered skin integrity on initial discovery using a clinically appropriate assessment tool.

As a result, the resident's skin issue was not appropriately captured and documented when first discovered and therefore the appropriate assessment and follow-up were not performed that may have led to changes in the skin status going unnoticed.

Sources: interview with Wound Care Champion, Skin and Wound Program (RC-23-01-02, page 3 of 8), resident records

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WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iii)

Skin and wound care
The licensee failed to ensure a resident was referred to a registered dietitian after altered skin integrity was identified.

Rationale and summary
A resident's progress notes indicated that on a day in November 2022 they had a new skin issue. The resident experienced increased pain related to this issue and was sent to hospital for further investigation. The next day the resident returned to the home and a referral to the dietitian was not completed for this skin issue.

According to the resident's last nutrition assessment, they were identified as high nutritional risk including factors that may impact skin integrity.

The home's Skin and Wound Program indicated that a referral is to be made to the RD, for all residents exhibiting altered skin integrity so the RD can complete a nutrition assessment.

As a result, the resident was not referred to the dietitian when the skin issue was identified, no assessment was made by the dietitian and no nutrition interventions were put in place that may have impacted the skin issue.

Sources: interview with staff, Skin and Wound Program (RC-23-01-02, page 4 of 8), resident records

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WRITTEN NOTIFICATION: Pain Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

O Reg 246/22 s. 57 (2) Pain Management
The licensee has failed to ensure that a pain assessment was completed when current interventions for pain management were not effective.

Rationale and Summary
A resident's clinical records indicated that the resident had a pain assessment completed upon admission and the resident received scheduled and as needed pain medication for chronic pain.

Over a five-day period in November 2022 prescribed pain medication was administered and was found ineffective four times for a resident's pain before the resident requested transfer to hospital. The following day the resident returned from hospital and the next day the physician prescribed an increase in pain medication.

As a result, the resident's pain was not assessed and managed effectively and the resident experienced pain related to this.

Sources: resident records, interview with Executive Direction, Pain Identification and Management Policy (RC-19-01-01, page 1 of 5, reviewed January 2022)
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WRITTEN NOTIFICATION: Dining and snack service

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.

The licensee failed to have a process in place to ensure staff were made aware of how to accommodate a resident's diet order for thickened fluids.

Rationale and summary

A resident's records indicated that the resident was to be provided thickened fluids.

A staff served the resident a thickened fluid that was not the consistent with what was indicated in the resident's plan of care. The staff indicated that they were not trained on how to thicken beverages and therefore was not aware of the difference in appearance of varying consistencies.

By not having a process in place to ensure staff are aware of how to prepare the resident's fluids to the appropriate consistency increased their risk of choking and aspiration.

Sources: interview with staff, DOC; observation, resident records

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WRITTEN NOTIFICATION: Dining and snack service

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.

The licensee failed to provide a resident with an assistive device at meals to manage risk of choking.

Rationale and summary
A resident's records indicated that they required an assistive feeding device to manage their risk of choking and prevent aspiration.

Staff stated that the dietary staff are to provide the resident with the assistive feeding device as indicated in the diet binder.

The resident was observed in the dining room and the assistive feeding device was not available for the resident to use.

Not providing the resident with their assistive feeding device to support their safety at meals may increase their risk of choking or aspiration.

Sources: resident records, interview with staff, observations

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