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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Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: July 18, 2023

Inspection Number: 2023-1041-0003

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	**Inspector Digital Signature**
Karlee Zwierschke (740732)	Karlee Zwierschke Digitally signed by Karlee Zwierschke Date: 2023.07.25 10:46:25 -04'00'

Additional Inspector(s)
Betty Jean Hendricken (740884)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: June 19-21, 23, 26-29, 2023

The following intakes were inspected:

- Intake: #00003885 (critical incident) related to falls prevention and management.
- Intake: #00004601 (critical incident) related to fracture of unknown origin.
- Intake: #00009354 (critical incident) related to resident-to-resident altercation.
- Intake: #00011503 (critical incident) related to resident-to-resident physical abuse.
- Intake: #00016476 (critical incident) related to responsive behaviours.
- Intake: #00087670 (critical incident) related to improper/incompetent care.
- Intake: #00089002 (complaint) related to diet, behaviours and care/services.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
A resident's plan of care identified actions that staff were to take to communicate meal choices to the resident. Observations revealed that these actions were not implemented. The Executive Director (ED) confirmed that these actions were to be followed as per family request.

Sources: Resident's clinical record, observations, and interview with staff and ED.
[740732]

WRITTEN NOTIFICATION: Plan of Care Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee failed to ensure that the provision of care set out in the plan of care for a resident was documented.

Rationale and Summary
A resident's plan of care identified that they should be toileted every shift and as needed. Task documentation showed that the resident was not toileted on two different dates. A staff member confirmed that the resident was toileted on the dates identified. The staff member acknowledged that they had not documented the toileting on those days due to their Point of Care (POC) login not working. The ED confirmed that they were having issues with the POC login for the staff member, but that care provided should still have been documented.

Sources: Resident's clinical record, interviews with staff members.
[740732]

WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect a resident from physical abuse by another resident.

Rationale and Summary
For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

A resident physically abused another resident resulting in an injury. The ED confirmed that this would be considered physical abuse.

Sources: CI Report, clinical records for both residents, staff interviews
[740884]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.

The licensee failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours were developed for a resident who demonstrated physically responsive behaviours.

Rationale and Summary
A resident physically abused another resident resulting in an injury.

Progress notes demonstrated that a resident had physically responsive behaviours. Staff confirmed that this resident had responsive behaviours. Staff verified that there were no written strategies, including techniques and interventions developed and in resident's plan of care.

Sources: CI Report, resident's clinical records, staff interviews.
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