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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: May 21, 2024
Inspection Number: 2024-1041-0002
Inspection Type: Complaint Critical Incident
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 Catherines

Lead Inspector	**Inspector Digital Signature**
Olive Nenzeko (C205)	Olive Mameza Nenzeko Digitally signed by Olive Mameza Nenzeko Date: 2024.05.30 11:46:47 -04'00'

Additional Inspector(s) Caroline D'Souza (000848)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 1-3, 6, 7, 9, 10, 2024

The following intake(s) were inspected:

- Intake: #00113058/ CI #1500-000005-24 related to Falls Prevention and Management.
- Intake: #00113175/ CI #1500-000006-24 related to Falls Prevention and Management.
- Intake: #00114539 regarding an anonymous complaint related to Prevention of Abuse and Neglect.

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

Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that they immediately forwarded to the Director a written complaint that had been received concerning the care of a resident.

Rationale and Summary

The Long Term-Care (LTC) home received a written complaint from a staff member reporting an allegation of physical abuse of the resident by another staff member.

The LTC home's investigation notes and interview with the Director of Care (DOC) identified that the allegation of physical abuse was unfounded.

The DOC admitted that the written complaint was not forwarded to the Director.

Not submitting the written complaint to the Director had no impact or risk to the resident, and the allegation of abuse was investigated by the home and found to be unsubstantiated.

Sources: Investigation notes; Interview with DOC.
[C205]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by staff immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received an anonymous complaint reporting that a staff member physically abused a resident.

The home's investigation notes confirmed that the home's management was notified of the alleged physical abuse, and an investigation was conducted with all staff involved. The investigation concluded that the allegation was unfounded.

The DOC acknowledged that they were made aware of the allegation of abuse, but did not report it to Director because they believed it was a workplace harassment case.

Failure to immediately report the allegation of abuse to the Director had low impact and risk to the resident

Sources: Investigation notes; Action line complaint; Interview with DOC.
[C205]

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 1.
24-hour admission care plan
s. 27 (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to themself, including any risk of falling, and interventions to mitigate those risks.

The licensee has failed to ensure that a 24-hour admission care plan was developed for a resident and communicated to direct care staff within 24 hours of admission regarding any risk of falling and interventions to mitigate those risks.

Rationale and Summary
Every resident was to have an admission care plan developed and communicated to direct care staff within 24 hours of the resident's admission to the home.

The resident was admitted to the home on a specific date; a fall risk assessment initiated that date identified that they were a moderate risk for falls and included falls risk factors; however, a 24-hour admission care plan was not developed related to falls. The resident 's initial care plan related to falls was created several days later after the resident experienced a fall with no injury.

The RAI-MDS coordinator acknowledged that the resident's 24-hour admission care plan for falls was not completed when it should have been.

Not developing a 24-hour admission care plan for falls for the resident may have increased the resident's risk of falling, and staff may not have been aware of the resident's falls risk and fall prevention interventions.

Sources : Resident's clinical records; Interview with RAI-MDS Coordinator.
[C205]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the

resident's health condition.

The licensee has failed to inform the Director no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

Rationale and Summary
Resident fell on an identified date, was sent to the hospital the same day and was diagnosed with an injury.

There was a progress note indicating that the long-term care home became aware of the diagnosis of the injury the same day the resident went to the hospital.

A Critical Incident (CI) was submitted to the Ministry of Long-Term Care (MLTC) several days later.

The Executive Director (ED) acknowledged that the fall resulted in a significant change in the resident's health condition and that it was reported late.

Sources: Critical Incident System (CIS); Resident's progress notes; Interview with ED. [C205]