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

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
Oct 21, 2019	2019_704682_0027	018675-19, 018708-19	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

AILEEN GRABA (682)

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): September 27, 30, October 1, 2, 3, 4, 8, 9, 10, 11, 2019.

The following Complaint inspections were conducted concurrently with Critical Incident Inspection 2019_704682_0028:
018675-19 related to prevention of abuse and neglect
018708-19 related to prevention of abuse and neglect

The following Critical Incident inspections were conducted concurrently:
014937-19 related to prevention of abuse and neglect
016980-19 related to prevention of abuse and neglect
017241-19 related to prevention of abuse and neglect
018271-19 related to falls prevention
018398-19 related to prevention of abuse and neglect
019254-19 related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Acting Director of Care (DOC), Manager of Recreation Services, Resident Assessment Instrument (RAI) Coordinator, Nursing Clerk, Office Manager, Maintenance and Housekeeping staff, Registered Staff; Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector(s) toured the home; reviewed investigative notes, staffing schedules, resident health records; meeting minutes, program evaluations,
policies and procedures, complaints binder, maintenance request logs, Critical Incident System (CIS) submissions; observed residents and provision of care.

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

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

4 WN(s)
2 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff involved in the different aspects of care of resident #005 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

A complaint and Critical Incident (CI) was submitted to the Director.

A clinical review included progress notes that resident #005 had a change in health condition on an identified date. Further review included resident's #005 care plan which included a focus for medical interventions. Medical orders also directed staff to monitor with medical interventions.

A review of the resident's #005 clinical records indicated, the resident's had a change in condition. A progress note written by staff #106 stated resident had a change in condition. Staff #100 assessed the resident's change in condition and the medical doctor (MD) was paged. No further documentation was found regarding informing or collaborating with the medical doctor related to resident #005 change in condition.

During an interview staff #106 confirmed that the resident had a change in condition and that they provided a medical intervention which was ineffective. During an interview staff #100, acknowledged that resident #005 had a change in condition. Staff #100 acknowledged the medical order for a medical intervention and stated the MD did not respond to their call and that they did not make any further attempts to inform the MD.

Further review of progress notes, staff #112 indicated that on an identified date, resident #005 had a change in condition. Further review of the resident's clinical record indicated a further change in condition.

During an interview staff #112 stated that they provided a medical intervention to resident #005 for the change in condition but did not notify the MD of resident #005 change in condition but informed staff #117. During an interview, staff #117 confirmed that they did not notify the MD of resident's #005 change in condition. During an interview, staff #109 stated that when a resident has a change in condition further intervention and assessment was expected. Staff #109 also stated that they would notify the MD when the resident was provided a medical intervention that was ineffective.

During an interview, the Acting Director of Care (DOC) #107 acknowledged that they expected registered staff to collaborate and inform the MD when the resident had a change of condition to determine the follow up and plan of care. The home did not ensure that staff and the medical doctor involved in the different aspects of care collaborated with each other in the plan of care so that aspects of resident's #005 care were integrated and complimented each other. [s. 6. (4) (b)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The Licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

A complaint and CI was submitted to the Director.

Ontario Regulation 79/10, section 45, allowed for exceptions for the requirement of one RN on duty and present at all times, under specific situations, for homes with less 129 beds and for small homes at hospitals. Westpark Health Center did not qualify for any exceptions as specified in the regulations.

Westpark Health Center is a long term care home with a licensed capacity of 93 beds. At the time of the complaint, the planned staffing pattern for registered nursing staff in the home, for the direct care of residents, was three Registered Nurses (RN) per 24 hours and seven Registered Practical Nurses (RPNs) per 24 hours, as identified on staffing schedules provided by the home and confirmed by staff #110.

During an interview, staff #110 identified that the home did not have a sufficient number of RN's within the staffing plan to fill all of the shifts related to staffing events. A review of the nursing schedule indicated that on identified dates, a third party RN from a contracted nursing agency was the only RN, on duty. On an identified date there was no RN in the building.

The Executive Director (ED) confirmed in an interview that the need to fill these RN shifts were not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2). The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that interventions for resident #005 completed by staff were documented.

A complaint and Critical Incident (CI) was submitted to the Director.

A clinical review included progress notes that resident #005 had a change in condition.

A review of the policy titled Job Description and Routine (Registered Practical Nurse) last revised, February 2018, stated:
"Assess ill residents, document"; "Document, write orders, process stat orders before 1400 hours and double check prior to leaving unit".

Review of the registered staff shift report located in the shift report binder, indicated resident #005 had an intervention documented by staff #123. The shift report also indicated that staff #106 documented resident #005 had an intervention on an identified date. A review of resident #005's clinical record did not include any documentation that indicated resident #005 had any interventions on the identified dates.

During an interview, the Acting DOC stated it was expected staff document interventions and care provided into the residents clinical records during their shift. The Acting DOC also confirmed that the shift reports were a communication tool and were not part of the resident's record. The Acting DOC confirmed that documentation regarding resident's #005 interventions on identified dates were not documented in clinical records and the home did not ensure that resident #005 interventions were documented. [s. 30. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

A complaint and Critical Incident was submitted to the Director.

A review of policy titled; Preventative Maintenance of Housekeeping Equipment HL-05-01-08 last updated February 2019, directed the housekeeping staff to do the following: "Record required housekeeping equipment needs in the 'Maintenance Request Log' to ensure that these requests are communicated to the maintenance department".

A review of the maintenance request log indicated that on an identified date, a plumbing fixture was non operational. A review of investigation notes, indicated that staff #116 had identified, resident's #005 plumbing fixture was non- operational. Investigation notes also indicated staff #116 identified subsequent identified dates the plumbing fixture was non-operational.

During an interview, staff #116 confirmed that the home's process for contacting the maintenance department about any concerns on the home area was to enter issues into the maintenance log book. During an interview, the Executive Director (ED) also confirmed this, indicating that their expectation was for staff to complete the 'Maintenance Request Log', and they encourage all staff to do so. The ED also confirmed that the maintenance log was to be reviewed daily to address issues identified by staff. The ED acknowledged that during their investigation into the matter, the staff identified that the maintenance log book was missing and therefore they had not reviewed the maintenance requests. The ED confirmed that resident's #005 plumbing fixture was identified as non- operational. During an interview, staff #115, stated that staff #125 was responsible to check the log book daily, and that they were not made aware that the log book was missing. Staff #115 confirmed that they repaired the plumbing fixture. The home's procedure for non-routine maintenance was not implemented by staff. [s. 90. (2) (d)]

Issued on this 21st day of October, 2019

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

Original report signed by the inspector.