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
Jul 8, 2021	2021_661683_0009	004963-21	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 Catherines ON L2S 1S9

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

LISA BOS (683), LISA VINK (168)

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): June 17, 18, 21, 22, 23, 24 and 25, 2021.

This inspection was completed concurrently with critical incident inspection #2021_661683_0008.

The following intake was completed during this complaint inspection:
Log #004963-21 was related to falls prevention and management, skin and wound, safe and secure home, housekeeping and maintenance services.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Former DOC, Environmental/Food Service Manager, Resident Assessment Instrument (RAI) Coordinator, Nursing Clerk, Registered Dietitian, Maintenance, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, resident and staff interactions, infection prevention and control practices and reviewed clinical health records, relevant home policies and procedures, training records, temperature logs, meeting minutes and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Critical Incident Response
Falls Prevention
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (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 (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. Subject to subsection (3.1), 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.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

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

A) A resident sustained an injury following an incident for which they were taken to hospital.
On readmission to the home, a Minimum Data Set (MDS) significant change in status assessment was completed as the resident required an assessment by the care team as the injury impacted more than one aspect of their health condition.

A review of Critical Incident System (CIS) reports submitted to the Director did not include a CIS for the resident related to the injury that resulted in a significant change in condition as confirmed by the Executive Director (ED).

Sources: Progress notes and MDS assessments; a review of CIS reports and interview with the ED.

B) A resident sustained an injury following an incident for which they were taken to hospital.
On readmission to the home a MDS significant change in status assessment was completed as the resident required an assessment by the care team as the injury impacted more than one aspect of their health condition.

A review of CIS reports submitted to the Director did not include a CIS for the resident related to the injury that resulted in a significant change in condition as confirmed by the Director of Care (DOC).

Sources: Progress notes and MDS assessments; a review of CIS reports and interview with the DOC. [s. 107. (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 the Director is informed of an incident that causes 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 no later than one business day after the occurrence of the incident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (3) Subsection (2) does not apply in the case of emergencies or exceptional and unforeseen circumstances, in which case the training set out in subsection (2) must be provided within one week of when the person begins performing their responsibilities. 2007, c. 8, s. 76. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Personal Support Worker (PSW) received training on fire prevention and safety within one week of when the person began performing their responsibilities.

LTCHA s. 2(1) defines staff as "persons who work in the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party."

A complaint was submitted to the Director regarding fire prevention and safety training.

In an interview, a PSW indicated that they did not know what to do in the event of a fire, as they did not have any training on fire prevention and management in the home.

The ED reported that all staff were required to complete training on fire prevention and management in an online application. Upon review of the PSW's records, they acknowledged that there were no training records for the staff member. The nursing clerk confirmed that the PSW worked in the home for more than one week.

A PSW did not receive training on fire prevention and management within one week of when they began performing their responsibilities.

Sources: A complaint submitted to the Director; interviews with a PSW, the nursing clerk and the ED. [s. 76. (3)]

Issued on this 9th day of July, 2021

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

Original report signed by the inspector.