Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 23, 25, Feb 7, 2012	2012_060127_0001	Critical Incident

Licensee/Titulaire de permis

1508669 ONTARIO LIMITED
c/o Deloitte & Touche Inc. - 181 Bay Street, Brookfield Place, Suite 1400, TORONTO, ON, M5J-2V1

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

RICHARD HAYDEN (127)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC) and a personal support worker (PSW) regarding H-002348-11.

During the course of the inspection, the inspector(s) reviewed management's documentation of the incident, policies and procedures, a resident's plan of care and an employee's file.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. On January 23, 2012, the inspector confirmed the following:
The licensee failed to ensure that the care set out in an identified resident's plan of care was provided to the him/her as specified in the plan. In 2011, the resident was provided a shower by staff. The plan of care indicated the resident preferred a bath and to allow him/her to independently complete certain tasks during the bath procedure. The resident was resistive to the shower and was heard screaming in protest.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. On January 23, 2012, the inspector confirmed the following:
The licensee failed to protect an identified resident from abuse by anyone. The resident was emotionally abused by a staff member when he/she ignored the resident's request to stop the care being provided to him/her. In 2011, the DOC overheard the resident screaming in protest that staff was giving him/her a shower. The DOC advised that the staff ignored the resident's complaint and request to stop and provided no reassurance to him/her. The staff continued to shower the resident, made statements to him/her that only reflected on the task that needed to be accomplished and gave commands that were sharply toned. The DOC entered the bathroom and observed the resident sitting alone, naked, with no towel around his/her body and drying his/her hair. The DOC stated that the resident was upset and crying.

The DOC and the administrator interviewed the resident later that morning. The interview notes indicated that the resident stated he/she did not want a shower and was upset that staff would not listen to what he/she wanted.

The staff had received training on Resident Non-Abuse in 2011. The staff signed the Staff Evaluation of In-service Education Session form and he/she indicated abuse as one of the main points of the session.

Issued on this 16th day of February, 2012

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