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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 20, 2013	2013_214146_0019	H-000066-13	Complaint

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

BARBARA NAYKALYK-HUNT (146)

Inspection Summary/Résumé de l'inspection

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 sous la Loi de 2007 sur les foyers de soins de longue durée

---

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 12, 13, 14, 2013.

This inspection was conducted concurrently with complaint inspection H-000116 -13.

During the course of the inspection, the inspector(s) spoke with the administrator, the Director of Care (DOC), registered staff, restorative care staff, recreation staff, Personal Support Workers (PSW'S), residents and family members.

During the course of the inspection, the inspector(s) observed resident care, reviewed health records and policies and procedures specific to responsive behaviours.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The Substitute Decision Maker (SDM) of resident 02 was not given the opportunity to participate fully in the development and implementation of the plan of care.
i. According to the progress notes, an order for a stronger sedative was requested by staff in June 2012 when resident 02 was becoming agitated at another resident. The medication was ordered on an as needed (PRN) basis in June 2012. The check off box on the doctor`s order sheet to notify Power of Attorney (POA) was blank. According to the SDM/POA of resident 02, when approached by staff about using a stronger medication for the resident at that time, the SDM refused consent stating that the SDM was to be called in immediately to calm the resident instead of using a stronger medication. When advised of the stronger medication order on the medication administration record (MAR), the SDM stated that SDM consent was not provided. The medication had not been used when the past 4 months of MARS were reviewed. The DOC confirmed that the medication had been ordered but she was unaware that the SDM had refused consent. [s. 6. (5)]

2. The licensee did not ensure that the care set out in the plan of care was provided to residents as specified in the plan.
i. The plan of care for resident 02 states to call family to report changes of condition. In January 2013, resident 02 had a sudden change of condition. The SDM was not notified as per the care plan. This information was confirmed by the health record and the SDM.
ii. The plan of care for resident 03 states to apply a therapeutic appliance upon waking and remove each night at bedtime. On a date of inspection, the resident was resting on the bed with no appliance in place. The appliance was in the drawer of the bedside table. According to the PSW documentation for March 2013, the appliance had not been applied for at least the past 14 days with no explanation. This was confirmed by observation, the health record and the Registered Nurse (RN).
iii. The plan of care for resident 02 states to put hearing aids in both ears every morning and remove every night and give to nurse to store in medication cart. If resident refuses aids, bring back to medication cart. In March 2103 it was observed that the resident did not have hearing aids in place. When interviewed, the PSW stated they were in the medication cart and she had not asked for them yet. The medication nurse stated they were not in the medication cart. It was determined that the hearing aids were missing, so the hearing aids had not been brought back to the medication cart as per the plan of care. It was determined the hearing aids had not been seen for several days and were lost.
iv. The plan of care for resident 02 states to toilet the resident before meals, after

meals, at bedtime and as needed. The resident was not toileted according to the plan of care during the 3 days this inspection took place. This information was also confirmed by bedside caregivers. [s. 6. (7)]

3. The licensee did not ensure that, when a resident was reassessed and the plan of care reviewed and revised, because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.
i. Resident 02 sleeps late and does not wish to be wakened by staff, so staff do not waken the resident for medications. As a result, medications on the MAR to be given at either 8 am or noon were not being given every day. In November 2012, these medications were missed 11 out of 30 days; in December 2012, these medications were missed 13 out of 30 days; in January 2013, these medications were missed 4 out of 31 days; in February 2013, daily medications were missed 7 out of 28 days; in March 2013 up to March 12, daily medications were missed 3 out of 12 days. The intervention to give daily medications at either 8 am or noon was not effective and alternative approaches were not considered. This was confirmed by the record and the registered nurse. [s. 6. (11) (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 SDM of all residents is given the opportunity to participate fully in the development and implementation of the plan of care; to ensure that the care set out in the plan of care is provided to residents as specified in the plan; and to ensure that when a resident is reassessed and the plan of care reviewed and revised because care set out in the plan is not effective, different approaches are considered in the revision of the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
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. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee did not immediately report abuse of a resident by another resident that resulted in harm or risk of harm on 2 occasions:
i. In December 2012 a resident grabbed another resident resulting in injury. The report was not sent to the Director until 3 days later.
ii. In March 2013, a resident injured another resident. The incident was not reported to the Director until 5 days later [s. 24. (1)]

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 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, 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 did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.
i. The health record of resident 02 indicated that in December 2012, the resident had swelling and staff would monitor. There was no re-assessment of the swollen area documented in the notes as of the date of this inspection.
ii.The health record of resident 02 indicated that in December 2012, the resident had a reddened area and staff would monitor. There was no re-assessment of the area after the incident until 2 days later when the resident complained of pain, bruising and swelling.
iii. The health record of resident 02 indicated that in January 2013, the resident experienced a sudden change in condition. The incident was documented on a day later as a late entry. There are no further notes for 8 days and no re-assessment was documented.
iv. The health record of resident 02 indicated that in March 2013, the resident complained of a change in condition. There were no further notes for 4 days and no re -assessment was documented.
v. The health record of resident 03 indicated that in December 2012, resident exhibited behaviours and staff would monitor. There were no further notes for 18 days and no re-assessment of this behaviour was documented.
vi. The health record of resident 03 indicated that in January 2013, resident 003 exhibited behaviours and staff would monitor. There were no further notes for 26 days and no re-assessment of the behaviours were documented.
vii. The health record of resident 01 indicates that in October 2012, the resident was found in another area of the home inappropriately clothed and was assisted back to bed. There were no further nursing notes documented until 36 days later when the resident was exhibiting more extreme behaviours. No re-assessment of behaviours was documented between the dates. [s. 30. (2)]
viii. Resident 02 was injured by resident 03 in March 2013. There was no documentation of the incident until a late entry was completed 4 days later. This information was confirmed by the record, the registered staff and the DOC. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee did not ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified.
i. A review of the health record since August 1, 2012 revealed that resident 01 had demonstrated physical aggression on 6 occasions between August 2012 and February 2013. The health record indicated no identification of triggers for the behaviours.
ii. A review of the health record of resident 03 since August 1, 2012 revealed that resident 03 has demonstrated both verbal and physical aggression on 4 occasions between September 2012 and March 2013. The health record indicated no identification of triggers for the behaviours.
This information was confirmed by the health records and registered staff. [s. 53. (4) (a)]

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, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in

accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Protection Act, 2004 kept confidential in accordance with that Act.
i. The personal health information of resident 01, specifically name and date of birth, was on a printed document given by a staff member to the SDM of resident 02. This information was confirmed by the SDM of resident 02 and the DOC. [s. 3. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

The licensee did not ensure that the call bell system was accessible to all residents at all times.
i. When going into the room of resident 014, it was noted the resident was seated beside the bed attempting to reach for a call bell to call for assistance. The call bell was out of resident's reach and tangled under the bed in the lowered bed rail.
ii. On the same date in another room, the call bell was under the bed tied to a lowered bedrail and out of reach of the resident sleeping in the bed.
iii. On the same date in a third room, the call bell of resident 013 was hanging over the grab rail on the wall and out of reach of the resident sleeping on the bed.
All instances were observed by the inspector during the inspection process. [s. 17. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

The licensee did not ensure that the resident's substitute decision maker was notified immediately, upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

i. Resident 02 was grabbed by resident 01 causing injury in December 2012. The SDM was not notified until 2 days later. This information is confirmed by the record, the SDM and the DOC.

ii. Resident 02 was injured by resident 03 in March 2013. The SDM was not notified until 3 days later. This information was confirmed by the record, the SDM and the DOC. [s. 97. (1)]

Issued on this 20th day of March, 2013

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

BARBARA NAYKANYK-HUNT.