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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 30, 2016	2016_189120_0030	008555-16	Follow up

Licensee/Titulaire de permis

CVH (no.1) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 18, 2016

A follow-up inspection (2016-189120-0012) was previously conducted on March 3, 2016 at which time Order #001 was left outstanding from an inspection completed in August 2015 related to the maintenance program. For this follow-up inspection, the conditions in the Order were met and the Order was closed.

During the course of the inspection, the inspector(s) spoke with the Administrator, maintenance personnel, dietary and laundry staff.

During the course of the inspection, the inspector toured all three levels of the home, randomly toured resident rooms and all tub/shower rooms and common spaces and reviewed maintenance audits and repair schedules.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 90. (1)	CO #001	2016_189120_0012	120

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	Legendé 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. 10. Elevators

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee did not ensure that an elevator in the home was equipped to restrict resident access to areas that were not to be accessed by residents.

The home had two elevators, one which was locked out and not functional, near the nursing station and the other which was functional, located around the corner, out of sight of the nurse's station and down a corridor past several resident rooms. It was not equipped with any restrictions so that it was easy to use by any person to access the lower level of the home. The lower level included a physiotherapy room, activity room, hair salon, laundry, kitchen, open concept dish wash area, offices, washrooms, staff lounge/lunch room, maintenance shop and multiple storage rooms. A hot collator was observed on the floor and accessible in the physiotherapy room under a counter. All rooms were kept inaccessible at the time of inspection except for the dish wash area which was in an open space, outside of the kitchen and at the start of a service corridor. According to the Administrator and dietary staff, the entire lower level was typically vacated by 8:30 p.m.once dietary staff completed their duties after dinner service. Activation staff were required thereafter to lock out the elevator by 9 p.m.. According to at least 5 staff members, at least one identified resident regularly ventured down to the lower level unescorted throughout the day but also in the evening as the elevator was easy to use. The resident often made their way into the kitchen or dish wash area before being observed and redirected during the day, however at night, staff reported that a resident may not be identified as missing until routine rounds were conducted. During the inspection on May 18, 2016, the same identified resident was observed being escorted back into the elevator from the lower level after making their own way down. The resident was described as being confused and who liked to wander around and was easily able to use the elevator buttons.

Post inspection, the Administrator reported that on May 26, 2016, a sliding cover was installed over the elevator button on the identified resident's floor and reported that the resident had not been able to use the elevator independently since that date. As an alternative, the Administrator had received quotes and was prepared to install a coded key pad on the outside of the elevator should the sliding cover be ineffective at restricting resident access to the lower level unsupervised. However, the same modification was not completed for the elevator button on another resident occupied floor. [s. 10. (1)]

Issued on this 30th day of May, 2016

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

Original report signed by the inspector.