Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
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Original Public Report

Report Issue Date: April 23, 2024	
Inspection Number: 2024-1041-0001	
Inspection Type: Complaint Critical Incident	
Licensee: CVH (No. 1) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)	
Long Term Care Home and City: West Park Health Centre, St Catherines	
Lead Inspector Emily Robins (741074)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 19, 21, 22, 25, 28, 2024 and April 3, 2024.

The following intakes were inspected:
- Intake #00106330 related to the Infection Prevention and Control Program.
- Intake #00107248 - Complainant with concerns regarding plan of care re: transfers, fall prevention and foot care for resident.
- Intake #00107268 - Improper/Incompetent treatment of resident by staff.

The following intakes were completed with this inspection:
- Intake #00095522, #00105199, and #00105344 related to the Infection Prevention and Control Program.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure that the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary

The Director of Care (DOC) indicated that when a new area of skin impairment was identified by any staff it was to be reported to a registered staff member immediately, and documented in the resident's plan of care.

A staff member identified that a resident had a new area of skin impairment while working on a specified date. They forgot to report the new skin impairment to a registered staff member until the following day and did not document the new skin impairment in the resident's plan of care. The home ensured that the staff were re-educated on the process for reporting and documenting new areas of skin

impairment.

Sources: Critical Incident Report #1500-02-24, resident's Documentation Survey Report for a specified month, the home's investigation notes, and interviews with staff [741074].

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The home failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Rationale and Summary

A resident had an unwitnessed fall on a specified date. At the time of the fall, it was noted that the resident's seating device did not comply with the manufacturer's instructions for use. Staff were re-educated on how to properly use this device.

When the home's staff failed to ensure that the resident's seating device was used in accordance with manufacturer's instructions, they may have put the resident at risk of skin breakdown by diminishing the product's effectiveness and increased the

risk of a fall.

Sources: Critical Incident Report #1500-02-24, resident's progress notes, Product Operations Manual, and interview with staff member [741074].

WRITTEN NOTIFICATION: Housekeeping

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer’s specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee failed to ensure that procedures for cleaning and disinfecting contact surfaces was implemented. Specifically, the home was observed to be using expired wipes to clean and disinfect frequently touched contact surfaces.

In accordance with O.Reg. 246/22, s. 11 (1) (b), where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the licensee is required to ensure that the procedure is complied with.

Rationale and Summary

On a specified date, several bottles of the Oxivir TB wipes (1 minute) that were actively being used to clean and disinfect frequently touched surfaces throughout the home, and the stock supply on both floors of the nursing home, were found to be expired.

The home's policy titled Environmental and High-touch Surface Cleaning and Disinfection (last revised February 26, 2024) indicated that expired products should not be used to clean and disinfect frequently touched contact surfaces. The IPAC lead acknowledged that this was because when a product is expired, the efficacy of the product cannot be determined.

Using expired wipes to clean and disinfect frequently touched contact surfaces may have increased the risk of pathogen transmission throughout the home.

Sources: Interviews with staff, observations, and Environmental and high-touch surface cleaning and disinfection policy (last revised February 26, 2024) [741074].

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that the Director was immediately informed of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

The local Public Health unit declared the home to be in a COVID-19 outbreak on a specified date. The home did not inform the Director of the outbreak until later that evening, and the Ministry of Long-term Care after hours reporting line was not called.

Sources: Critical Incident Report #1500-000001-24 and interview with staff member [741074].