Ontario

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

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: November 7, 2024	
Inspection Number: 2024-1041-0003	
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	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 22, 2024, October 24 - 25 & October 28 - 29, 2024

The following intake was inspected in the Critical incident (CI) section:

- Intake: #00121022/ CI #1500-000007-24 - relating to abuse resident to resident abuse

The following intake was inspected in the complaint section:

- Intake: #00125179 relating to doors in the home.

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (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.

The license has failed to ensure that a resident was protected from abuse.

In the Ontario Regulation (O.Reg) 246/22, physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

The Long-Term Care Home (LTCH) completed a fire drill with an audible alarm. The loud audible alarm triggered a resident and hit a co-resident resulting in an injury.

The LTCH's policy titled "Possible Signs of Abuse or Neglect" reviewed November 2023, indicated that hitting is a sign of abuse.

The Executive Director acknowledged that physical abuse took place in this incident and that interventions are in place to prevent this from reoccurring.

Failure to protect the resident from physical abuse led to actual harm to the resident.

Sources: CI #1500-000007-24, a resident clinical records, Possible Signs of Abuse or Neglect Policy, reviewed November 2023 and interview with staff.

COMPLIANCE ORDER CO #001 Doors in a home

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall ensure:

1) The retirement door in the basement is locked and secured at all times.

2) The door access system in the basement is kept activated at all times and is equipped with an audible door alarm that is connected to either a resident-staff communication and response system or audio visual enunciator and has a manual reset switch at each door.

3) Daily audits are to be completed for two weeks to ensure the retirement door in the basement is locked and secured, door access system is activated and on at all times and connected to an audible door alarm. Once daily audits are completed, weekly audits are to be completed for another two months.

4) The LTCH shall keep a written record of the audits for an inspector to review.

Grounds
The licensee has failed to ensure that all doors leading to non-residential areas were kept locked, equipped with a door access control system that was kept on at all times, and equipped with an audible door alarm.

Rationale and Summary
On a day in October, the inspector went to the retirement doors that were located in the basement. Inspector attempted to open the retirement doors and was able to open the door and did not observe or hear any alarm sounding.

The inspector went to the second floor and rode down the elevator with a resident indicating that the resident had access to the basement floor where the retirement doors were unlocked and unalarmed.

The ED confirmed the inspector's observations regarding the doors not being secured, the door access system was not kept on and that it was not equipped with an audible door alarm. The ED acknowledged that resident's do have access to the basement and that the doors leading to the retirement side should be locked and secured with a door alarm. During the interview, the ED stated the retirement doors have not been secured and with a door alarm since before February 2023.

The LTCH's policy titled, Restricted Access Areas and Door Surveillance, created August 2024 stated, staff will ensure that all identified restricted access areas in the home are kept locked at all times.

Failure to ensure all doors leading to non-residential areas are locked and equipped with a door alarm posed a risk resident safety.

Sources: Observations, Restricted Access Areas and Door Surveillance policy, created August 2024, Policy no. RFC-02-04 and interview with staff.

Grounds

The licensee has failed to ensure that all doors were equipped with an audible door alarm that was connected to the resident-staff communication and response system.

Rationale and Summary

On a day in October, the inspector and Executive Director (ED) went onto the first floor of the LTCH and checked if the doors leading to the retirement side were connected with an audible door alarm that was connected to a resident-staff response system. The ED opened the door, while the inspector went back to the nurses station to confirm if the door alarm was going off. Inspector observed no

alarm sounding.

A staff who was at the nurses station, confirmed with the inspector's observation that no alarm was sounding.

Inspector went back to the ED that was still holding the retirement doors open and informed them no alarm was sounding. ED confirmed with the inspector that the alarm was not connected at that time.

On the same date, inspector and ED went up to the second floor to check the doors connected to the retirement side, which is attached to the Long-Term Care Home (LTCH) and currently not in use. The ED opened the retirement doors while the inspector went to the second floor nurses station to check if the audible door alarm was going off. Inspector observed no audible alarm was sounding when the retirement door was open.

A staff confirmed the inspector's observation that the alarm was not working.

Inspector informed with the ED about their observations and the ED confirmed that the door alarm was not working.

The LTCH's policy titled "Restricted Access Areas and Doors Surveillance" created August 2024 stated, all exit doors, doors leading to restricted areas must be kept with an audible alarm to support a safe environment for residents.

Failure to have an audible door alarm connected to restricted areas for the resident's posed a safety risk to residents.

Sources: Observations, Restricted Access Areas and Door Surveillance policy,

created August 2024, Policy no. RFC-02-04 and interviews with staff.

This order must be complied with by February 11, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.