

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

Public Report

Report Issue Date: February 26, 2025

Inspection Number: 2025-1041-0001

Inspection Type:

Complaint
Critical Incident
Follow up

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 Catharines

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 5-7, 10-12, 14, 2025

The inspection occurred offsite on the following date(s): February 13, 25, 2025

The following intake(s) were inspected:

- Intake: #00131344, Critical Incident System (CIS) #1500-000014-24 - related to the prevention of abuse and neglect;
- Intake: #00132204, CIS #1500-000016-24 related to the prevention of abuse and neglect;
- Intake: #00132205, CIS #1500-000017-24 related to the prevention of abuse and neglect;
- Intake: #00132246, CIS #1500-000019-24 related to the prevention of abuse and neglect;
- Intake: #00132506, CIS #1500-000021-24 related to the prevention of abuse and neglect;
- Intake: #00137730, CIS #1500-000004-25 related to the prevention of abuse and neglect;
- Intake: #00138138, CIS #1500-000008-25 related to the prevention of abuse and neglect;

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- Intake: #00131568 - complaint related to the prevention of abuse and neglect, medication administration and food, nutrition and hydration; and
- Intake: #00131481 - Follow-up to Compliance Order (CO) #001 from inspection #2024-1041-0003 related to doors.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1041-0003 related to O. Reg. 246/22, s. 12 (1) 1.

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

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

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development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A resident experienced a change in status and they were assessed, and new interventions implemented. There was no documentation that the SDM was notified of the change in status, informed of the new interventions initiated or provided an opportunity to participate in the resident's plan of care regarding the specified care area until approximately one month after the change in status.

Sources: A resident's clinical record; home's investigation notes; interview with the Executive Director (ED).

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that several doors on the lower level of the home, which was accessible to a resident, were kept closed and locked when they were not being supervised by staff.

Sources: Tour of the home; interview with the ED.

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WRITTEN NOTIFICATION: Care conference

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)

Care conference

s. 30 (1) Every licensee of a long-term care home shall ensure that,

(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

The licensee has failed to ensure that a care conference of the interdisciplinary team providing care to a resident was held within six weeks following the resident's admission to discuss the plan of care and any matters of importance to the resident and their substitute decision-maker. The care conference was not held for a resident until approximately nine and a half weeks after their admission to the home.

Sources: A resident's clinical record; interview with the ED.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 56 (1) 2.

Continence care and bowel management

s. 56 (1) The continence care and bowel management program must, at a minimum, provide for the following:

2. Treatments and interventions to prevent constipation, including nutrition and hydration protocols.

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The licensee has failed to ensure that treatments and interventions to prevent constipation were provided to a resident as per the home's bowel protocol.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies and protocols developed for the continence care and bowel management program were complied with.

Specifically, the home's bowel protocol indicated that on day four without a bowel movement, a suppository was to be provided and on day five without a bowel movement, a fleet enema was to be provided.

Sources: A resident's clinical record; the home's bowel protocol; interview with the ED.

WRITTEN NOTIFICATION: Pain management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (2)

Pain management

s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, they were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A resident demonstrated signs of pain and they were administered a pro re nata (PRN) medication which was determined to be ineffective. A pain assessment was not completed using a clinically appropriate assessment instrument as required.

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Sources: A resident's clinical record; staff interviews.

WRITTEN NOTIFICATION: Responsive behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(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.

The licensee has failed to ensure that the responsive behaviour debrief tool assessments for a resident were documented. The ED acknowledged that their responsive behaviour debrief tool assessments for three incidents were not completed as per procedures of their responsive behaviour program.

Sources: A resident's clinical record; Responsive Behaviour Best Practices Policy; interview with the ED.

WRITTEN NOTIFICATION: Medication management system

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system

s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

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The licensee has failed to comply with the home's medication management system when a resident's Physician was not notified when they ingested an incorrect medication on two occasions.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies and protocols developed for the medication management system were complied with.

Specifically, the home's Medication Incident Reporting Policy indicated that if an incorrect medication is ingested by a resident, the nurse must notify the Physician to obtain an action plan to assess and maintain the resident's health.

Sources: The home's policy titled Medication Incident Reporting; a resident's clinical record; interview with the ED.

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

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