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

Public Report

Report Issue Date: May 28, 2025
Inspection Number: 2025-1041-0002
Inspection Type: 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 Catharines

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 20, 22-23, 27-28, 2025

The following intake(s) were inspected:

-Intake: #00142696 -1500-000018-25 - Related to Infection Prevention and Control
-Intake: #00143476 -1500-000020-25 - Related to Prevention of Abuse and Neglect

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect was complied with.

On a specified date in March 2025 a staff member did not immediately report an allegation of neglect for a resident, as required by the home's policy. The Executive Director (ED) acknowledged that the home's policy was not complied with.

Sources: Resident's clinical records, home's investigation notes, home's policy "Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct, August 2024, interview with ED.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg.

246/22, s. 102 (9).

The licensee has failed to ensure that symptoms indicating the presence of infection for a resident were recorded on every shift.

A resident had symptoms monitored and recorded on the day and evening shift but not on the night shift while exhibiting symptoms of infection during specified dates of an outbreak at the home. The Infection Prevention and Control (IPAC) lead acknowledged that symptoms were not monitored and recorded every shift.

Sources: Resident's clinical records, interview with IPAC lead.