



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Nov 7, Dec 21, 2011; Feb 7, 2012 | 2011\_105130\_0023 | Follow up

Licensee/Titulaire de permis

1508669 ONTARIO LIMITED
c/o Deloitte & Touche Inc. - 181 Bay Street, Brookfield Place, Suite 1400, TORONTO, ON, M5J-2V1

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

GILLIAN HUNTER (130)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, registered staff and personal support workers related to H-002603-11 (related to previous inspection H-001184-11)

During the course of the inspection, the inspector(s) interviewed staff and reviewed clinical records.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Minimizing of Restraining

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care  
Specifically failed to comply with the following subsections:**

**s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).**

**Findings/Faits saillants :**

The licensee did not ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and have convenient and immediate access to it. An identified resident was admitted to the home in 2011; the resident sustained an identified number of falls after admission. Post fall assessments identified the resident as "extreme risk" for falls, however, the initial plan of care, used to direct staff providing care, did not identify the resident to be at risk for falls and did not include interventions an/or strategies to mitigate risk. The electronic document known in the home as the "care plan", identifying interventions and strategies to manage the resident's fall risk, was not printed and made available to staff providing care until November 6, 2011.

**Additional Required Actions:**

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and have convenient and immediate access to it, to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

Specifically failed to comply with the following subsections:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

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**Findings/Faits saillants :**

The licensee did not ensure that the requirements were met where a resident is being restrained by a physical device under section 31 of the Act: (1) That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. In 2011 an identified resident had a seat belt applied to the wheelchair because of repeated attempts by the resident to self rise from the chair, which was resulting in falls. The seatbelt was applied whenever the resident was in the chair for an identified number of days, without a physician's order.

**Additional Required Actions:**

*VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act (2) staff only apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class, to be implemented voluntarily.*

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

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**Findings/Faits saillants :**

The licensee did not ensure that when a resident has fallen that the resident has been assessed and, if required, a post falls assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls. An identified resident was admitted to the home 2011; the resident sustained an identified number of falls after admission. Falls assessments were not completed after each fall.



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***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen that the resident has been assessed and, if required, a post falls assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.***

Issued on this 7th day of February, 2012

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

A handwritten signature in cursive script, appearing to read "J. Tracey".