Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 18, 2013	2013_159178_0021	T-513-13/T-524-13/T-530-13	Complaint

Licensee/Titulaire de permis

WEST PARK HEALTHCARE CENTRE
82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5

Long-Term Care Home/Foyer de soins de longue durée

WEST PARK LONG TERM CARE CENTRE
82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 12, 16, 18, 19, 20, 24, 2013

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, registered staff, personal support workers (PSWs), residents, family member of a resident.

During the course of the inspection, the inspector(s) observed resident care, reviewed home records, reviewed resident records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 :

1. The licensee has failed to ensure that the written plan of care for resident # 1 sets out clear directions to staff and others who provide direct care to the resident.
Record review confirms that the written plan of care for resident # 1 does not set out clear direction regarding the resident's behaviours, to staff providing direct care to the resident.
Record review and staff interviews confirm that the resident sometimes resists care and screams at other residents. Two of the resident's full time personal support workers (PSWs) stated that if the resident is approached slowly and care is explained before beginning, the resident is almost always cooperative. The written plan of care does not provide these instructions, and in fact does not indicate that the resident displays any responsive behaviours at all. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Staff interviews and record review confirm that the care set out in resident # 1's plan of care was not consistently provided to the resident as specified in the plan.
Record review and staff interview confirms that resident # 1's plan of care was revised on September 6, 2013 to state that two staff members are to be present to provide physical care to the resident, including hygiene, bathing, toileting and dressing.
According to staff interviews and the resident's Daily Care Flow Sheets which are completed by the PSW staff, physical care was not consistently provided to resident # 1 by two staff members after September 6, 2013. Two evening staff members both stated that two staff members would provide physical care to resident # 1 if the resident was resisting care, but if the resident was cooperative then one staff member would provide the care. [s. 6. (7)]

3. The licensee has failed to ensure that staff and others who provide direct care to the resident have convenient and immediate access to the plan of care. Record review and staff interviews confirm that a recent change in the written plan of care for resident # 1 was not made available to the PSWs providing care to the resident.
Resident # 1's written plan of care was recently revised to indicate that two staff members should be present when physical care is provided to the resident, such as bathing and dressing. This revision was made on the electronic copy of the resident's care plan, but a copy was not printed or placed in the unit's care plan binder. The PSWs who provide direct care to the resident access the resident's care plan via the care plan binder, and are unable to access the care plans electronically. [s. 6. (8)]

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 written plan of care for resident # 1 and all residents sets out clear directions to staff and others who provide direct care to the resident, is accessible to staff and others who provide direct care to the residents, and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

Staff interviews, record review and review of video surveillance confirm that on the morning of September 1, 2013 resident # 1 was handled roughly and slapped by an identified PSW while care was being provided. [s. 19. (1)]

2. Staff interviews, record review and review of video surveillance confirm that on the morning of August 14, 2013 while personal care was being provided to resident # 1, a second identified PSW raised her hand above the resident in a threatening manner. [s. 19. (1)]

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 resident # 1 and all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident # 1 is based on an interdisciplinary assessment of the resident that includes mood and behaviour patterns, identified responsive behaviours, potential behavioural triggers, and variations in resident functioning at different times of the day.

Record review and staff interviews confirm that resident # 1 displays responsive behaviours at times, including screaming and resistance to care.
The resident's plan of care does not address the resident's resistance to care, does not identify potential triggers for this behaviour, and does not identify interventions to assist the staff to prevent or manage the behaviour. [s. 26. (3) 5.]

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 plan of care for resident # 1 is based on an interdisciplinary assessment of the resident that includes mood and behaviour patterns, identified responsive behaviours, potential behavioural triggers, and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities.
Record review and interviews with front line staff and with the home's administrator confirm that staff are not currently being trained in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities. The staff receives training to immediately report any suspected or witnessed abuse of residents to their Administrator, Director of Care or designate. Staff is not trained that it is their responsibility to report suspected abuse to the Director under the Long Term Care Homes Act (LTCHA) or that it is an offense for an employee of the home to fail to do so. [s. 76. (2) 4.]

2. The licensee has failed to ensure that staff receive training in the area of whistle-blowing protections afforded under section 26, prior to performing their responsibilities.
Record review and staff interviews indicate that staff are not being trained in the area of whistle-blowing protections afforded under section 26 of the LTCHA. The home has it's own Whistleblower Protection policy (Reference # OPER-03-01-14), and provided training to staff around this policy. However the staff has not received training regarding the protections against retaliation for disclosure of anything to an inspector or the Director under the LTCHA. [s. 76. (2) 5.]

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 prior to performing their responsibilities, staff receive training in the following areas:
-mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident
-whistle-blowing protections afforded under section 26 of the LTCHA, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.
On September 3, 2013 the home's administration was made aware of, and viewed a video showing resident # 1 being handled roughly and slapped by a PSW on the morning of September 1, 2013. The police were not notified of this incident by the home until September 5, 2013. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (2) The criminal reference check must be,
(a) conducted by a police force; and O. Reg. 79/10, s. 215 (2).
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 79/10, s. 215 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the criminal reference check required before a licensee hires a staff member, as per subsection 75(2) of the LTCHA, is conducted within six months before the staff member is hired.

Staff interviews and record review indicate that of the last three staff members hired by the home, none had criminal reference checks conducted within six months before hire. [s. 215. (2) (b)]

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 criminal reference check required before a licensee hires a staff member, as per subsection 75(2) of the LTCHA, is conducted within six months before the staff member is hired, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports.
Review of the home's policy Resident Abuse-Staff to Resident (Reference # OPER-02 -02-04, version March 2013) does not contain an explanation of the duty of all staff to report suspected abuse to the Director under the LTCHA, and that staff who fail to do so are guilty of an offence. [s. 20. (2)]

Issued on this 29th day of October, 2013

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