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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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 30, 2014	2014_382596_0008	T-289-13	Critical Incident System

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

THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 1, 2, 2014.

The inspection was conducted concurrently with the Resident Quality Inspection, inspection # T-114-14 on September 11, 12, 15, 16, 17, 19, 22, 23, 24, 25, 26, 29, 30 and October 1 , 2, 2014.

During the course of the inspection, the inspector(s) spoke with the director of care, quality assurance coordinator/nursing clerk, personal support workers, resident, registered nursing staff.

During the course of the inspection, the inspector(s) conducted observations in the home and resident areas, reviewed policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #1 set out clear directions to staff and others who provide direct care to the resident.

Interview with an identified staff and review of resident #1's care plan confirmed that behavioural goal and interventions were not included in the resident's plan of care until May 6, 2014, after resident #1 had already exhibited several documented episodes of verbal and physical aggressive behavior towards other residents and staff on June 14, December 21, 2013, January 19, April 8, and 9, May 18, July 21, September 5 and 15, 2014. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least annually, the responsive behaviour program is evaluated and updated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices.
Record review and interview with an identified staff revealed that the home did not complete an annual evaluation of the responsive behaviour program in 2013. [s. 53. (3) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Record review of resident #1's plan of care revealed that there was no assessment of the resident,and interventions to address the resident's potentially harmful interactions towards other residents. Resident #1 had several incidents of physical and verbal aggression on June 14, December 21, 2013, January 19, April 8, and 9, May 18, July 21, September 5 and 15, 2014, as documented in the resident's progress notes. There was no assessment for the noted behaviours, and no strategies and interventions implemented to respond to the resident's behaviours. Record review and interview with an identified staff confirmed that behavioural interventions were included on the resident's care plan on May 6, 2014. Record review indicated that a referral was faxed to the Baycrest Long Term Care Behavioral Support Ontario Team on September 15, 2014 for consultation, related to resident's behaviors. [s. 54. (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (3) The licensee shall ensure that the training required under paragraph 2 of subsection 76 (7) of the Act includes training in techniques and approaches related to responsive behaviours. O. Reg. 79/10, s. 221 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that training is offered to all direct care staff related to techniques and approaches related to responsive behaviours.

Record review and staff interview revealed that 24% of direct care staff were not trained in techniques and approaches related to responsive behaviours in 2013. [s. 221. (3)]

Issued on this 4th day of November, 2014

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