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**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 3, 2015 | 2015_378116_0019 | 004075-15 | 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

SARAN DANIEL-DODD (116)

### 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): October 6, 8, 13, 15, 26, 27, 28, 29 and November 2, 4, 2015.**

**During this inspection the inspector reviewed relevant home records including: call bell history report for resident #001 and the home's complaint log, relevant policies and procedures, training records, employee records and resident health records. The inspector conducted a tour of the home, observed meal service, resident care, staff-resident interactions, call bell monitoring and medication administration.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.),Director of Care (DOC), Associate Director of Care (ADOC), staffing clerk, registered staff members, personal support workers (PSW), housekeeping aide, visitors to the home and resident #001.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Medication**
**Personal Support Services**
**Reporting and Complaints**
**Safe and Secure Home**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted.

On an identified date, staff #109 was providing personal care to resident #001. Interviews held with resident #001 and staff #109 provided conflicting information regarding rendering care. An interview held with staff #109 indicated that there was a discrepancy between the staff member and the resident regarding how staff #109 should provide the care. The care requested by resident #001 was not in accordance to the written plan of care. Staff #109 requested staff #114 to attend the resident's room to reinforce that staff #109 was not permitted to provide the requested care made by resident #001. Upon staff #114 attending the resident's room, resident #001 insisted that staff #109 was refusing to provide her with care and made a comment towards staff #109. Staff #109 responded in a negative manner which contravened the home's code of conduct policy.

The home conducted an internal investigation which resulted in discipline of staff #109. Interviews held with the E.D confirmed that the resident was not treated with courtesy and respect. The home reviewed the code of conduct with staff member #109 and how to effectively communicate with residents in the home. [s. 3. (1) 1.]

2. The written plan of care for resident #001 states that the resident requires extensive assistance with personal hygiene.

A review of the resident's heath record and internal investigation documented that on or around an identified date, resident #001 rang the call bell for assistance with personal care. Staff #110 initiated personal care to the resident and exited the room to attain supplies. An identified area of resident #001's body was left exposed. It is unclear whether the resident's privacy curtain and/or room door were closed. Interviews held with staff #112 and staff #107 confirmed that the resident was left exposed and staff #110 should have attained supplies prior to initiating the care to ensure the resident's dignity was fully respected and promoted.

The home conducted an internal investigation and staff #110 was disciplined. Staff #110 is no longer employed by the home and was unavailable for an interview. [s. 3. (1) 1.]

**WN #2: 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 written plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident #001 requires the use of a specified therapy.

The written plan of care does not provide clear directions to staff regarding a specified requirement of the identified therapy.

The medication administration record (MAR) for an identified period was reviewed and revealed that the MAR was not signed on identified dates for a specified requirement of the identified therapy. The progress notes were reviewed and there was no documentation to support that the specified requirement regarding the identified therapy was rendered on the indicated dates.

Interviews held with registered staff members, the ADOC and the E.D. confirmed that all orders entered on the MAR must be signed and documented as provided. The interviews further confirmed that the written plan of care does not set out clear directions to staff and others who provide direct care to the resident in relation to the specified requirements for the identified therapy. [s. 6. (1) (c)]

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's policy on administering an identified medication states the following:
- Registered staff are to follow the manufacturer's instructions and facility policy.
- identified devices contain multiple doses of an identified medication and are meant for use on a single person only, and should never be used for more than one person, even when the instrument is changed.
- the identified device should be clearly labelled with the person's name or other identifying information to ensure that the correct device is used ONLY on the correct individual.

On an identified date, the Power of Attorney for care (POA) of resident #001 reported to the E.D. and the DOC that the resident alleges that staff #104 used an identified instrument and a medical device labelled for another resident on resident #001. An internal investigation was conducted which involved a demonstration performed by the ED and the DOC to resident #001 to outline how the identified device is used and that the instruments are single use with a disposable tip; once discharged the identified instrument is unable to be re-used.

An interview held with staff #104 revealed that he/she attempted to conduct a procedure on resident #001 however, resident #001 indicated to the staff member that he/she was using a device that was assigned to another resident. The registered staff member indicated being unaware of the change in the home's policy regarding the subsequent use of the identified device on residents and was following the homes previous practice. Further interviews held with staff #104, the E.D. and the DOC confirmed that the staff member did not follow nursing best practice and did not comply with the home's policy. [s. 8. (1) (b)]

**Issued on this 7th day of December, 2015**

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

**Original report signed by the inspector.**