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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 10, 2016	2016_302600_0002	000031-15, 027625-15, 001967-16.	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

GORDANA KRSTEVSKA (600)

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): February 9, 10, 11, 12, 16, 17, 22, 23, 24, 25, 29, March 1, 2, 2016.

During the course of inspection complaints 000031-15, 027625-15 and 001967-16 were inspected. This inspection occurred concurrently with complaint inspection #2016_302600_0003 (005245-16, 003895-16).

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), assistant director of care/educator (ADOCE), assistant director of care (ADOC), support service manager (SSM), social worker (SW), physiotherapist (PT), pharmacist, registered nurses (RN), registered practical nurses (RPN), RAI MDS back up coordinators (RAI MDS), personal support workers (PSW), housekeeping aid, laundry aid, agency registered nurse, family members and residents.

During the course of the inspection, the inspector conducted a tour of the home, conducted a medication administration observation, observed mechanical transfers of residents, observed resident and staff interactions, observed residents' participation in activities, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Review of the daily staffing compliment schedule revealed there is one RN to work a night shift in the home. Further review of the schedule for an identified date, revealed a Registered Nurse (RN) assigned to work night shift called in sick. The evening manager had not been able to replace the RN so left a hand written note below the schedule with an asterix indicating the caller was not able to replace the RN position and a note with initials of the manager on duty to be called.

Review of the daily staffing compliment schedule for another identified date, night shift revealed the name of the RN scheduled to work night shift was crossed out, and an agency staff name with no title was written in ink next to the crossed out name. On a third identified date, for the evening shift, both RNs' names were crossed out and replaced by two names with no title. One of the names was an agency staff.

Interview with DOC confirmed on the identified date, the evening manager was not able to replace the RN for the night shift so the manager on duty (DOC) was notified to be on call. Further the DOC confirmed the manager on duty was not present in the home but remained on call from his/her home. The DOC also confirmed than on the other identified date, night shift and on the third identified date evening shift the RNs called in sick and were replaced by RPNs, one from an agency and one regular staff. Both times the managers on duty were on call but not present in the home. The DOC confirmed they acknowledged the issue of lack of RNs and are in the process of hiring new RNs since beginning of the year. [s. 8. (3)]

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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

Observation conducted on identified dates, in washrooms of the specific rooms revealed black spots of accumulated debris on the flooring seam in the bathrooms. The edge of the baseboard was dusty and dirty with water splashes. Inspector rubbed an area on the floor seam and was able to remove the accumulated debris. Further observations revealed the carpeting in the hallway of an identified home area also had dark soiled areas throughout.

Record review of a deep cleaning and buffing calendar guidelines revealed there is a monthly schedule for each resident room and washroom. Further the calendar guideline

revealed the deep cleaning include high and low dusting, cleaning all fixtures' outside, spot clean walls and doors, raise the beds and dust under, remove privacy curtains to be washed. Clean call bells and try to make sure they work, wash floors wall to wall and baseboard.

Review of the calendar for an identified month indicated the identified rooms were signed off as deep cleaned.

Interview with housekeeping staff #103, #104, #111, and #112 revealed they clean the residents' rooms every day, following the job routine but deep cleaning when they scrub the floor in the washroom and the toilet, clean the walls the fan, the top of the futures, the lights is done about every one and a half months for residents' rooms including the washrooms.

Interview with the housekeeping staff #111 revealed that the areas on the floor in the bathrooms of the identified rooms did not appear cleaned. Further the housekeeping staff revealed this is not his/her regular floor, but when he/she sees dirt on her daily cleaning, or when resident complains, he/she uses a tool given to him/her to scrub the dirt right away, did not wait for the deep cleaning. Further more he/she indicated if they can not remove the dirt, they will notify the janitor to clean with the carpet cleaner.

Interview with the Support Service Manager revealed that the home had provided housekeeping service seven days a week. The rooms are cleaned daily, and scrub each room every month and a half as per deep cleaning schedule. The carpets are vacuumed once a week or when required with steam cleaner that they have. Further the supervisor confirmed they expect the floor to be clean after deep cleaning but also confirmed some of the washrooms have floors that need to be replaced and they are in process of gradually replacing the floors in the washrooms and the rooms. [s. 15. (2) (a)]

2. Observation conducted on an identified date and identified resident home area revealed a smell of urine passing by a group of residents sitting in their wheelchair in the hallway.

Review of the sling/wheelchair/walker cleaning, washing, and inspecting schedule for nights record for an identified period of week 1 indicated that the schedule was not signed off to confirm if the equipment had been clean for the residents in following identified rooms on identified resident home area and another rooms for another period of time.

Interview with ADOC #101 revealed the night staff is expected to clean residents' assisting devices and equipment according to the schedule provided on weekly basis. The RPNs on nights are expected to check if the resident assisting devices and equipment had been cleaned, then initial in the "Special Duty Record" on the specific dates confirming that assisting devices and equipment had been cleaned.

Review of the "Special Duty Record" section "Co-sign with PSW's that wheelchairs have been cleaned as per schedule" revealed no signature by the night nurse.

Interview with the ADOC #101 confirmed by not co-signing the form the RPN confirmed the wheelchairs had not been cleaned on the specified dates listed above and he/she will look into this issue further.

Interview with DOC confirmed the night PSWs are expected to clean and sanitize the resident equipment according to the schedule they have and the RPNs are expected to ensure the PSWs did the cleaning and verify by signing off on the spaces provided in "Special Duty Record" tool. [s. 15. (2) (a)]

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 home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #3: 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 and free from neglect by the licensee or staff in the home.

O.Reg 79/10 s. 19.(1) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Review of the Critical Incident submitted on an identified date, indicated resident #002's POA had been upset because of unprofessional communication of PSW #108 towards his/her family member.

Interview with the resident #002 revealed he/she knew the staff prior moving to this home and they have talked a lot. Further he/she confirmed the staff started calling him/her names, making him/her feel bad and worthless despite resident telling him/her that he/she did not like that.

Review of the investigation notes revealed that staff was disciplined for crossing the boundaries with the resident and crossing the staff-resident professional relationship in communication with the resident.

Interview with the PSW #108 confirmed he/she knew resident #002 before moving to the home and they were always "joking" around. The resident told the PSW the way that he/she talked to resident and the wording used in communication with him/her was not nice and he/she did not like it but the PSW continued thinking the resident was still joking. The staff was not aware of her own action to be verbally abusive towards the resident until the DOC conducted an investigation, disciplined the PSW and provided education about Abuse. The staff was transferred to another resident home area.

Interview with DOC confirmed that staff is expected to be professionals and PSW #108 had crossed the line of professional relationship with resident #002. Further DOC confirmed that kind of communication with the residents was not acceptable in the home. [s. 19. (1)]

2. O.Reg 79/10 s. 19.(1) defines neglect as a failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Interview with resident #004 indicated on an identified date, the resident was due to have a treatment after the shower at identified hour. At five minutes after the hour the resident called the RPN #102 letting him/her that he/she was ready to have the treatment. The RPN #102 had told the resident he/she is in a meeting. The resident had kept calling the RPN #102 but the RPN had not responded to the resident. At the same time the resident had his/her call bell activated and when the PSW responded to the call bell, the resident asked him/her to notify the RPN that he/she need the treatment.

The resident confirmed his/her treatment was not administered until after seven hours when the evening RPN took over and changed the dressing.

Interview with RPN #102 revealed resident #001 did not have impaired skin integrity and did not have a treatment. Registered staff just apply a dry gauze to decrease a moisture. However the RPN confirmed the resident asked the RPN to do the treatment in the morning of the identified date, but the RPN told him/her will provide the treatment after the shower. When the resident called the RPN after the shower, the RPN responded he/she is on a meeting. The RPN #102 confirmed he/she had not responded to the resident's calls after that. By the end of the shift when RPN gave a report to the evening staff the day PSW told RPN #102 that resident had been looking for treatment. Even then, the RPN #102 did not go to see the resident instead, the evening RPN went and provide treatment to the resident. The interview with the RPN #102 confirmed and he/she acknowledged he/she neglected the resident by not responding to resident's calls and not meeting the resident's need to provide the treatment.

Interview with the DOC confirmed the staff should have responded to the resident #004.

PLEASE NOTE: This evidence of non-compliance was found during inspection #2016_302600_0003. [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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Review of resident #002's physiotherapy assessment from identified date, revealed resident is to be transferred with assistance of two staff using an identified equipment. Further physiotherapy assessments revealed that given the past history of injuries and his/her decreased mobility, resident is to be transferred by two staff with an identified equipment. This intervention had been planned for the resident since his/her admission.

Review of resident #002's written plan of care revealed the resident had impaired mobility to identified body parts. Review of the written plan of care for bathing and transfer revealed the resident is to be transferred by two staff using an identified equipment.

Interview with PSW #109 confirmed on an identified date, he/she brought the resident #002 to a shower room to assist with a shower. The resident insisted to show the PSW how he/she transfers from a assisting device to a shower chair independently. The PSW let the resident and observed him/her transferring self from the assisting device to the shower chair. The PSW allowed the resident to perform the self transfer.

After the resident was showered, the PSW removed the resident from the shower and pulled the assisting device next to the resident who was still in the shower chair. After the

PSW dried off the resident, he/she turned away from the resident and wiped the shower floor. The resident tried to transfer self again from the shower chair to the assisting device. During the transfer the resident got stuck between the assisting device and the shower chair.

Interview with a PSW #107 indicated on the same date, around that time he/she was looking for PSW #109 calling his/her name in the hallway. He/she heard voices coming out of the shower room, entered in and saw resident #002 stuck between the assisting device and the shower chair while trying to hold on to the side of the assisting device. The PSW #109 was mopping the floor at the time. Rushing to assist the resident from the awkward position both PSWs confirmed they used a inappropriate equipment during the transfer.

Interview with PSWs #107 and #109 confirmed while they had the resident in the inappropriate equipment, trying to transfer him/her to the assisting device, the resident's leg had not been properly positioned in the equipment. The inappropriate equipment could not be managed because of the assisting device and the staff were not able to move the assisting device. The PSWs were not able to transfer the resident to the assisting device so he/she was left on the inappropriate equipment.

Record review of the investigation statement from RPN #120 revealed entering the shower room he/she saw resident #002 left on the non-identified equipment and PSW #107 managing the equipment. Resident's right leg was dragging behind the resident on the equipment where the body parts were suppose to be. The RPN quickly repositioned resident body part to a proper position. All three of them put the resident back in the shower chair, resident told them how to turn the assisting device on, so they moved the assisting device. After they moved the assisting device, PSWs brought the identified equipment and transferred the resident.

The PSW #107 and #109 confirmed they both were aware that resident #002 needed assistance by two staff using identified equipment for all transfers and also they were aware of resident trying to self transfer, however they used the another equipment first.

Interview with resident #002 confirmed he/she wanted to show PSW #109 that he/she was able to transfer self.

Interview with the ED and the DOC confirmed the staff is expected to follow the guidelines from the written plan of care for all ADLs. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home take immediate action to deal with pests.

Review of the service request log starting last year revealed the respond time from the pests control company on the identified dates was five, seven, and eight days.

Interview with the Environmental Service Supervisor in presence of the executive director confirmed that on an identified date, the presence of ants was reported in one identified home area, the home notified the company but they did not do anything until the company staff came in on another identified date. [s. 88. (2)]

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 home take immediate action to deal with pests, to be implemented voluntarily.

WN #6: 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. (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).

Findings/Faits saillants :

1. 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

On identified dates, observed resident #001 was left at the nursing station in his/her wheelchair after breakfast and after lunch. Resident was awake most of the time, experiencing responsive behaviour. On the desk near to the resident inspector observed a plastic container with some identified material in it. Observation indicated that the resident did not participate in any program or activity. There was no music to be heard around.

Review of the resident #001's written plan of care revealed that the focus plan of care is on activities/psychosocial related to decline in health condition and communication problem. The goal set for this focus was to provide resident with one to one visit/program with some identified activities. Resident had been responding well to the identified activities. Recreation staff and family to take resident to the activity room on identified unit or bring activity material to the resident.

Review of the Activity Pro participation report for resident #001 revealed in the last three months on an identified period (the day of the inspector's visit) no scheduled or self directed activities had been recorded.

Interview with the Activation aid confirmed that he/she used to take resident #001 to participate in the activities before but not lately, and for the period mentioned above the resident was not taken to the programs as specified in the written plan of care.

Interview with the DOC confirmed all the staff is expected to follow the resident's written plan of care. [s. 6. (7)]

2. Interview with the resident #003 revealed resident did not have second bath a week for two consecutive identified days and alternatives were not provided.

Record review of resident #003 regarding his/her personal hygiene revealed the resident is scheduled for a personal hygiene on two separated specified days of the week and time of the days. The resident needed assistance from staff using an identified equipment for transfer. Further review of the PSW's flow sheet revealed on the second specified day of the week, resident #003 did not have a personal hygiene on two consecutive weeks.

Review of the progress notes from an identified date, revealed registered staff documented about resident not receiving a personal hygiene on the first specified date and it had been endorsed to the upcoming shift. No further documentation indicated if the resident received a personal hygiene or any alternative instead. Further record review did not reveal documentation about resident missing a personal hygiene on the second specified date.

Interview with the ED indicated the staff is expected to provide personal hygiene to residents by preference at least twice a week. If for some reason the resident is not to have a personal hygiene, the staff must offer alternatives or the staff are to make an exchange to give a personal hygiene to another resident and the upcoming shift to try to give a personal hygiene to this resident. If the resident refuses to have a personal hygiene, the PSW is expected to report to the nurse in charge to be documented in the progress notes.

The interview with the DOC confirmed that every resident is offered personal hygiene by choice at least twice a week and if for some reason residents did not receive their personal hygiene, staff can switch with another resident, and give a personal hygiene to initial resident next shift, or to provide alternatives.[s. 6. (7)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours include assessment and reassessments.

Review of resident #001's initial MDS report indicated resident was admitted on an identified date, and within the observation period resident had indicators of declined health condition. Further the report indicated there was no change in his/her health condition comparing 90 days prior the assessment. Review of the resident chart and electronic documentation revealed no assessment or reassessment tool although the resident had been referred to the outside resources for treatment.

Interview with the RN lead revealed that the home is using a clinical assessment tool but for this resident did not recall that he/she ever assessed or reassessed resident with this or any other assessment tool.

Interview with the DOC confirmed that there was no completed assessment tool to indicate if resident #001 had been assessed or reassessed since his/her admission in the home. [s. 53. (4) (c)]

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Ministry of Health and Long-Term Care

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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

Issued on this 14th day of March, 2016

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

Original report signed by the inspector.