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 soins 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
Nov 15, 2016	2016_393606_0012	021124-16	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

JANET GROUX (606)

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): August 9, 10, and 11, 2016.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Food Service Manager (FSM), Attending Physician, Pharmacist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), RAI Coordinators (RAI), Substitute Decision Maker (SDM), and the Resident.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

- **2 WN(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-

maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

Review of a complaint received on an identified date reported resident #001 was experiencing terrible side effects related his/her medical condition and alleged the reason was because the home does not administer his/her medication on time. In addition to this, the resident alleged the home has refused to remove a clause in his/her written plan of care that specified for the resident not to call the Ministry of Health (MOH) about his/her complaints.

Review of a letter from resident #001 to the home on an identified date indicated for omissions, additions and revisions to be made to his/her written plan of care related to the delivery of care, programs and services, development and revisions of goals, and interventions related to his/her medication conditions, physical, and psychological well being, and personal preferences.

Review of a second letter on an identified date by resident #001 to the home indicated requests for omissions, additions, revisions, and changes to be made to the written plan of care related to his/her medication conditions, care and services, goals, interventions, and achievements.

Review of resident #001's written plan of care on an identified date indicated the revisions resident #001 requested the home make in his/her written plan of care as indicated in the above letters were not initiated.

Interview with resident #001 revealed he/she has not seen any revisions or updates that he/she had requested the home make in his/her written plan of care. He/she indicated the previous DOC had reviewed his/her written care plan and had indicated that the changes would be made.

Interview with the SDM revealed resident #001 had brought concerns about his/her medication and meal service being provided late and has requested for the home to make revisions to the plan of care prior to the letters resident #001 submitted to the home on an identified date. He/she indicated that a meeting was held with resident #001 and him/her in attendance on an identified date and was informed during this meeting that the home had not made any revisions to resident #001's written plan of care.

Interview with RPN #100 revealed resident #001 has submitted a letter listing several areas of his/her plan of care to be revised and that the DOC and ED were following up on this.

The inspector contacted the previous DOC #115 for a telephone interview three times but was unable to reach him/her.

Interview with the ED revealed the home has not made any revisions in resident #001's plan of care as indicated in the letter from an identified date. [s. 6. (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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: 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 home has failed to ensure that 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 was complied with.

Review of a complaint intake on an identified date reported resident #001 had an identified medical condition and has been receiving his/her medications and breakfast meals late causing him/her to become ill.

Review of an identified home's policy indicates care staff are to ensure residents are in the dining room for posted meal times. Further review of the home's meal service schedule for breakfast states breakfast in an identified unit starts at an identified time.

Review of an identified document posted in the dining room indicated breakfast service in an identified unit starts at an identified time.

The inspector observed the breakfast meal service commenced on the identified unit late on two identified dates.

Interviews with PSWs #103, #104, RPNs #100, #101, DOC, and the FSM revealed breakfast is scheduled to start at an identified time and confirmed the meal service in the dining room was served late. [s. 8. (1) (b)]

Issued on this 20th day of December, 2016

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

Original report signed by the inspector.