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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 21, 2017	2017_681654_0009	013866-16, 019496-16, 034546-16, 006522-17, 009616-17	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

SIMAR KAUR (654), DEREGE GEDA (645), IVY LAM (646), SARAH KENNEDY (605)

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): June 19, 20, 21, 22, 23, 26, 27, 28, 30, July 04, 05, 06, 07, 10, 11, 12, 13, 14, 18, 19, 20, and 21, 2017.

During the course of inspection following complaint inspections were conducted: Intake #013866-16- related to provision of care, continence care and bowel management, and referral assistance from the home, Intake #019496-16- related to provision of care, prevention of abuse and neglect, and medication, Intake #034546 -16- related to nail and foot care, transfers, G tube feeding, Intake #006522-17- related to bathing, and information and referral assistance from the home, Intake #009616-17- related to transfers, prevention of abuse and neglect, and nutrition and hydration.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Acting DOC, Assistant Director of Care, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Care Aides (PCAs),Dietary Aides, Nutrition Manager, Registered Dietitian (RD), Vendor's Representative of external company of assistive devices, and Physiotherapist.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (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. (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).

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 written plan of care had set out clear directions to staff and others who provide direct care to the resident.

An anonymous complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) regarding provision of care for resident #036.

The Inspector observed a memo posted in an identified resident's care area on an identified date, which directed staff to assist the resident with identified specific directions while providing identified care.

Record review of the resident's written plan of care revised on an identified date, indicated different directions from the directions indicated on the memo mentioned above.

Interview with PSW #195 and #104 indicated that the resident had been receiving care as per his/her written plan of care and not as mentioned on the memo. After reviewing the resident's written plan of care from the unit binder and the memo posted in the resident's care area, PSW #195 indicated the set of directions did not match. PSW #195 indicated staff was expected to follow the resident's written plan of care and the memo

both to provide the identified care to the resident. PSW #195 further revealed that the written plan of care and the memo should give the same directions.

Interview with RAI Coordinator/RN #196 and Acting DOC #198 confirmed that any memo posted in resident's care area was considered a part of resident's written plan of care. They further indicated that it should reflect the same information as resident's written plan of care. RAI Coordinator/RN #196 revealed that resident #036's written plan of care did not provide clear directions to staff for the above mentioned identified provision of care.

2. The licensee has failed to ensure that the resident, the resident's SDM (Substitute Decision Maker), if any, and the designate of the resident/SDM were provided the opportunity to participate fully in the development and implementation of the resident's plan of care.

An anonymous complaint submitted to the MOHLTC involved medication dispensing to resident #036, and SDM had not been notified of a physician order.

Record review of resident #036's health file indicated an identified physician order provided on an identified date. Further review of the order sheet revealed that there was no SDM notification documented by a registered staff.

Interview with RPN #139 indicated that as per the home's procedure SDM/resident should be notified and documented on the physician order sheet by a registered nurse before the administration of new medication. RPN #139 indicated that resident #036's identified family member was his/her SDM of care in 2016. He/she further revealed that the order sheet did not indicate that SDM was notified for the above mentioned order.

Review of the resident's Treatment Administration Record (TAR) for an identified month, and progress notes with RPN #139 revealed that the resident had received the first dose of the above mentioned medicated on an identified date, prior to informing the resident's SDM for the above mentioned physician order.

Interview with the ADOC revealed that the resident or designated SDM should be notified of all new physician orders before the administration of the medication. He/she further revealed that resident #036's physician order did not indicate that the SDM was provided the opportunity to participate fully in the development and implementation of the plan of care as required.

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

An anonymous complaint submitted to the Ministry of Health and Long-term Care (MOHLTC) regarding provision of care for resident #036, indicated that the resident had not been provided with an identified care as scheduled related to his/her continence care.

Record review of resident #036's written plan of care revised on an identified date, directed staff to assist the resident with identified specific directions while providing the above- mentioned identified care.

The inspector observed resident #036 on two identified dates during an identified time period. The resident was not observed being provided the identified care and assistance as mentioned in the plan of care.

Interview with the PSW #194 indicated that resident #036 required the specific assistance with the provision of care due to his/her physical condition. PSW #194 revealed that resident was required to be checked and assisted as a part of the plan of care between the specific time periods. PSW #194 and PSW#195 further revealed that they had not checked or assisted the resident with the provision of care on the above mentioned dates as required, as they were not aware about the resident's written plan of care.

Interview with PSW #194, and #195 confirmed that the resident should have been checked and the identified care should have been provided as per his/her written plan of care on the above mentioned dates.

Interview with RN #148 and ADOC revealed that as per the home's expectations staff was required to check and provide care to resident #036 as per the written plan of care on the above mentioned dates.

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

(A) An anonymous complaint submitted to the MOHLTC regarding provision of care for resident #036, indicated the resident not been provided with an identified care related to

personal support services.

During three observations on identified dates, resident #036 was observed not provided with the identified care.

Record review of resident #036's plan of care revised on an identified date, indicated the resident required the identified provision of care due to his/her medical condition. Interventions revealed that staff to provide the identified specific care with identified specific directions.

Interview with PSW #142 indicated that the resident required the above mentioned identified care. PSW #142 further confirmed that he/she had dressed the resident on an identified date, and did not provide the resident with the identified care as he/she did not check the resident's written plan of care at the start of the shift.

Interview with PSW #194 confirmed that he/she had dressed the resident on another identified date, during an identified shift and did not provide the resident with the above mentioned identified care.

Interview with RPN #192 and ADOC revealed that as per resident #036's written plan care he/she should have been provided with the identified care by the staff.

(B) An anonymous complaint submitted to the Ministry of Health and Long-term Care (MOHLTC) regarding provision of care for resident #036, indicated that resident was not receiving an identified care as scheduled related to bathing.

Review of resident #036's bath list indicated two identified days as his/her bath days.

Record review of resident #036's PSW documentation sheets on two identifies dates, indicated that the resident received a different type of bath than mentioned on his/her written plan of care. The review further indicated no documentation for second identified care provided to the resident.

Interview with the PSW #142 indicated that resident #036 gets the identified bath on his/her bath days. The PSW further confirmed that he/she had provided the resident with the different type of bath instead of bath he/she was required to receive, and did not provide her with above mentioned second identified care on two above mentioned dates, as he/she ran out of time.

Interview with RAI Coordinator/RPN #127 and review of the resident's progress notes did not reveal that the resident had refused the identified care on the above mentioned dates. He/she further revealed that resident #036 did not receive the identified care as scheduled. Further interview with RAI Coordinator/RPN #127 and ADOC revealed that the care set out in the plan of care was not provided to resident #036's as specified in the plan.

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 set out clear directions to staff and others who provide direct care to the resident, and to ensure 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 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 license has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A complaint submitted to MOHLTC, involved multiple care concerns for resident #026, and included the care of resident #026's specific identified equipment.

Review of the home's policy (Document number: CLIN-06-01-04G), reviewed December 2002, on the use of above mentioned identified equipment, revealed a specific procedure for the use of the equipment by RN/RPNs with specific identified directions. No other staff members were specified to perform these procedures, according to the above mentioned policy.

Interviews with PSWs #119 and #121 revealed that they had operated resident #026's above mentioned identified equipment during repositioning the resident or prior to providing an identified care for the resident.

Interviews with PSWs #117, #122, and RPN #120 revealed that it was in PSWs' practice to operate the equipment. PSWs #117 and #122 further revealed that they had been shown by the nurses on how to operate the equipment.

Interview with RPN #209 revealed that he/she believes that it was the home's practice for PSWs to operate the resident #026's identified equipment during the identified care.

Interview with DOC #123 revealed the staff were not following the home's policy, and that according to the above mentioned policy, only registered staff were to operate resident's identified equipment.

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's policy (Document number: CLIN-06-01-04G), reviewed December 2002, is complied with, to be implemented voluntarily.

Issued on this 12th day of September, 2017

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

Original report signed by the inspector.