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 18, 2017	2017_642606_0010	002257-17	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

JANET GROUX (606), IVY LAM (646)

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 30, July 4, 5, 6, 7, 11, 12, 13, 14, 18, 19, 20, and 21, 2017.

A complaint was inspected regarding allegations of improper care related to medication regimes, pain management, nutrition and hydration, and the resident's bill of rights.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Clinical Practice Lead (CPL), Social Worker (SW), Attending Physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Personal Support Workers (PSW), Capacity Assessor (CA), Palliative Care Consultant, and Substitute Decision Maker (SDM).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

Review of an identified complaint reported care concerns related to resident #001.

Review of resident #001's progress notes indicated the resident was admitted to the home on an identified date, with several identified medical diagnoses. Review of resident #001's identified clinical records indicated resident #001 had been hospitalized on an identified number of times prior to the resident being admitted to the home and had been diagnosed with an identified medical condition.

Review of an identified document indicated resident #001 had authorized an identified

individual as resident #001's primary substitute decision maker (SDM) for his/her care and another identified individual as the alternate SDM should the resident's primary SDM become unable to carry out the SDM responsibilities.

Interview with the alternate SDM indicated resident #001 had a history of an identified medical condition and had been hospitalized for the identified medical condition prior to being admitted to the home. The alternate SDM revealed that he/she had informed the home on several occasions about resident #001's risk for the identified medical condition. The alternate SDM indicated that he/she was concerned because he/she did not feel the staff were monitoring resident #001 enough and had not identified when the resident was developing an identified medical condition and therefore delayed initiating treatment to respond to the resident's change in condition. The alternate SDM indicated that the staff would only initiate treatment when he/she had alerted them to resident #001's change in condition.

Review of resident #001's progress notes on identified dates during identified periods revealed the home had been informed by the primary and alternate SDMs whenever they had observed resident #001 to have a change in his/her condition. The progress notes indicated documentation of the primary SDM and/or alternate SDM notifying the staff and having concerns that resident #001 was developing an identified medical condition. The progress notes indicated that the staff took action after they have been informed by resident #001's SDMs.

Interview with the attending physician indicated resident #001 had episodes of an identified medical condition and had received an identified treatment to manage the symptoms of the identified medical condition when either the SDMs brought it to the attention of the staff.

Interviews with PSWs #100, #101, #102 indicated that they were not aware that resident #001 was at risk for an identified medical condition and had the potential to develop the identified medical condition. They revealed the home's practice was that any resident identified to be at risk for the identified medical condition were monitored for identified signs and symptoms of the identified medical condition and they have been directed to report these observations to the charge nurse for follow up. They indicated resident #001's written care plan did not identify that resident #001 was at risk for developing an identified medical condition and therefore they did not monitor the resident for the identified signs and symptoms of the identified medical condition.

Interview with RN #103 indicated that he/she was not aware that resident #001 had a history of an identified medical condition.The RN revealed the SDMs often informed the home whenever they believed the resident was developing an identified medical condition. RN #103 indicated that when the primary or alternate SDM reported to staff that they felt resident #001 was developing an identified medical condition, the physician was notified and ordered an identified test to verify the resident for the identified medical condition. The RN indicated that from what he/she recalled the identified test results obtained did not indicate that resident #001 was confirmed for the identified medical condition. The RN revealed that there were times when an attempt would be made to obtain an identified lab sample using an identified procedure on the resident but was not always successful, and there had been times when the SDMs did not want an identified test to be obtained. RN #103 indicated that when the SDMs approached the staff with the above mentioned concern the home followed up with a treatment.

Review of resident #001's written care plan last revised on an identified date did not show evidence that identified that the resident was at risk for an identified medical condition and interventions to monitor or manage the risk for an identified medical condition was in place.

Interview with CPL #106 indicated that any resident identified with a potential risk for an identified medical condition should have a focus in the resident's written care plan to provide direction to staff to monitor and manage the identified medical condition. During the interview the inspector and CPL #106 reviewed resident #001's written care plan revised on an identified date, and the CPL indicated there was no focus in the resident's written care plan to indicate he/she was at risk for an identified medical condition. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

Review of a complaint reported care concerns related to resident #001.

Review of resident #001's progress notes indicated the resident was admitted to the home on an identified date with several identified medical conditions.

Review of an identified hospital document for an identified date indicated resident #001

was admitted to the hospital on an identified date and was diagnosed with several identified medical conditions. Further review of another identified hospital document on an identified date indicated resident #001 was transferred to the hospital due to an identified symptom, admitted and was diagnosed with an identified medical condition. Further review of resident #001's clinical records indicated documentation from the attending physician on an identified date, that the resident had an identified medical condition to be treated as needed (PRN).

Interview with resident #001 was not conducted as the resident passed away on an identified date.

Interview with RN #103 indicated resident #001's SDMs were very involved in the resident's care and shared in assisting the resident to make decisions about his/her care.

Interview with resident #001's primary SDM was not available for an interview.

Interview with the alternate SDM indicated resident #001 has a history of an identified medical condition and had been hospitalized for the identified medical condition prior to being admitted to the home. The alternate SDM revealed that he/she had informed the home on several occasions about resident #001's risk for an identified medical condition. The alternate SDM indicated that he/she was concerned because the staff had only initiated treatment when he/she had alerted them to the resident's change in condition.

Review of resident #001's progress notes between identified dates during identified periods, revealed the home had been informed by the two SDMs on several occasions of their concerns regarding resident #001's risk for developing an identified medical condition. The progress notes indicated that on an identified date, five days after resident #001 was admitted to the home, his/her primary SDM informed the home that the resident had a history of an identified medical condition and had concerns that resident #001 would develop another identified medical condition. Further review of the progress notes indicated there was no evidence that the resident's risk for an identified medical condition was communicated with other members that provided care to resident #001 such as the PSWs. The progress notes indicated that the staff took action after they have been informed by the resident's SDMs.

Further review of resident #001's progress notes on identified dates revealed a total of 18 entries by several identified registered staff members indicated that #001's primary and/or alternate SDMs reporting to staff that the resident had exhibited identified signs

and symptoms of an identified medical condition and had requested the staff to follow up on the resident's change in condition.

The following staff members DOC #107, ADOC #108, and RPN #109, who were significantly involved in resident #001's care were contacted by the inspector on three occasions for an interview without success.

Interview with the attending physician indicated resident #001 had episodes of an identified medical condition and had received treatment to manage the symptoms of the identified medical condition when the SDMs brought it to the attention of the staff.

Interviews with PSWs #100, #101, #102 indicated that they were not aware that resident #001 was at risk for an identified medical condition and had the potential to develop an identified medical condition and indicated it was not in his/her written care plan. They revealed the home's practice was that any resident identified to be at risk for an identified medical condition were monitored for identified signs and symptoms of the medical condition and they have been directed to report these observations to the charge nurse for follow up. They indicated they were not aware that resident #001 was at risk for an identified medical condition and indicated they did not monitor the resident for signs and symptoms of an identified medical condition.

Interview with RN #103 indicated that he/she was not aware that resident #001 had a history of an identified medical condition. The RN revealed the SDMs often informed the home whenever they believed the resident was developing an identified medical condition RN #103 indicated that the physician had ordered in the past an identified test to verify the resident for an identified medical condition and the test results obtained did not indicate an identified result for the identified medical condition. The RN revealed that there were times when an attempt would be made to obtain an identified lab test by performing an identified procedure on the resident #001 but was not always successful, and there were times when the SDMs did not want the identified lab test to be obtained. The RN indicated that when the family approached them with the above mentioned concern the home followed up with a treatment.

Review of resident #001's written care plan did not show any evidence that any interventions to monitor or manage resident #001's risk for an identified medical condition was in place.

Interview with CPL #106 indicated the home has a multidisciplinary approach to care and

that all departments communicate with each other regarding any resident who was at risk for an identified medical conditions. CPL #106 indicated that the home’s practice was to ensure that when a resident has been identified to be at risk for an identified medical condition, a plan of care is created to monitor and manage the resident's identified medical condition so all staff are aware. CPL #106 does not know the reason why a plan of care was not initiated for resident #001 if he/she had been identified to be at risk for an identified medical condition. Further interview with CPL #106 indicated any resident identified with a potential risk for an identified medical condition should have a focus in the resident's written care plan to provide direction to staff to monitor and manage the identified medical condition.

Interview with the DOC indicated that when a resident has been identified for a risk for an identified medical condition, the expectation was for the team to communicate with each other and ensure that all staff are aware. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs change.

Review of a complaint reported care concerns related to resident #001.

Review of resident #001's progress notes on an identified dated indicated resident #001 was admitted to the home on an identified date with several identified medical diagnoses.

Interview with the alternate SDM indicated resident #001 was at risk for an identified medical condition and had been hospitalized for the identified medical condition prior to being admitted to the home on the identified date.The alternate SDM indicated he/she informed the home of resident #001's risk for an identified medical condition on several occasions.

Review of resident #001's progress notes indicated that on an identified date, the alternate SDM informed the home that resident #001 was not feeling well and requested the resident to be transferred to the hospital. On an identified date, resident #001 was transferred to the hospital and was admitted with a diagnosis of an identified medical condition. Resident #001 was transferred back to the home on an identified date.

Review of resident #001's written care plan did not show any evidence that resident

#001's plan of care was reviewed and revised to reflect that the resident was at risk for an identified medical condition.

Interviews with RPN #111, RN #103, and CPL #106 indicated the home's practice is to update the written care plan whenever there was a change in condition and this had not been completed for resident #001.

Interview with CPL #106 indicated any resident identified with a potential risk for an identified medical condition should have a focus in the resident's written care plan to provide direction to staff to monitor and manage the identified medical condition.

Interview with DOC #104 indicated that any resident who has had a change in condition should have his/her written care plan revised and updated. He/she revealed he/she does not know the reason why this was not initiated for resident #001. [s. 6. (10) (b)]

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 there is a written plan of care for each resident that sets out the planned care for the resident;
-to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, were documented.

Review of a complaint reported care concerns related to resident #001.

Interview with resident #001's alternate SDM indicated that he/she had concerns regarding resident #001's identified medications. The alternate SDM indicated that he/she was concerned as to why resident #001 was prescribed the identified medications, when he/she was informed by the staff that the resident did not have any issues with an identified medical condition.

Interview with PSWs #102 and #137 indicated the PSWs are responsible to monitor and document on the identified home record the resident's identified activity of daily living (ADL) to indicate if the resident had an identified ADL during the shift or not. They further indicated that the home's practice is to inform the charge nurse when a resident does not have an identified ADL during the shift for further monitoring and follow up.

Review of resident #001's identified home's records during identified periods of the resident's status of an identified ADL the inspector noted over an identified number of missed entries and/or incomplete documentation.

Interview with CPL #106 indicated the PSWs are responsible to monitor the resident's identified ADL by documenting on an identified home record as part of the home's monitoring and evaluation of a resident's identified ADL.

The inspector further completed reviews of resident #002, #003, and #004's identified home's records for identified dates and observed an identified number of missed entries and/or incomplete documentation.

Interviews with RPN #112 and CPL #106 indicated that the PSWs are responsible to ensure that they document and complete the identified home's records every shift.

Interview with the DOC indicated it is the home's expectation that the identified home's records are completed every shift and indicated this was not done for resident #001, #002, #003, and #004. [s. 30. (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 any actions taken with respect to a resident under a program that the resident's responses to interventions, are documented, to be implemented voluntarily.

Issued on this 20th day of September, 2017

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

Original report signed by the inspector.