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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 19, 2018	2017_524500_0008	010122-17	Resident Quality Inspection

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

NITAL SHETH (500), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): December 20, 22, 27, 28, 29, 2017, January 2, 3, 4, 8, 9, 10, 11, 12, 15, 16, 17, 18, 2018.

The follow-up intake #024266-17 was inspected with this RQI concurrently.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Medical Director (MD), Director of Care (DOC), Assistants Director of Care (ADOCs), Nursing Consultant, Registered Dietitian (RD), Physiotherapist (PT), Office Manager, Nursing Clerk, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Recreational Staff, President of the Residents' Council, Residents and Family Members.

During the course of the inspection, the inspector(s) observed resident home areas, medication administration, staff to resident interactions, reviewed staff schedule, clinical health records, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Reporting and Complaints
Residents' Council
Skin and Wound Care

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_654605_0011	210

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following are documented: the provision of the care set out in the plan of care.

Resident #007 was triggered for an identified care area. A review of resident #007's written plan of care revealed the resident had impaired skin integrity and to be turned and repositioned every two hours according to the repositioning schedule.

Observation on two specified days and interviews with PSW #104 and RPN #103 revealed resident #007 the resident was not turned and repositioned as per the schedule and well as the home do not have a documentation record for the resident being turned and repositioned every two hours. [s. 6. (9) 1.]

2. Resident #003 was triggered for an identified care. A review of resident #003’s written plan of care revealed that the resident required total assistance from two staff members for turning and repositioning every two hours.

A review of the flow sheet documentation revealed that the documentation for staff turning and repositioning the resident every two hours was not available.

Interview with PSW #105, RPN #106 revealed that they are not documenting turning and repositioning every two hours for the resident as the flow sheet had been discontinued by the home.

Interview with the DOC and PT (Physiotherapist) revealed that the staff do not document turning and repositioning record on the flow sheets [s. 6. (9) 1.]

3. A review of resident #003’s written plan of care revealed that the resident is on a specific intervention related to nutrition and hydration.

A review of the resident’s chart and flow sheet binder revealed that the documentation of a specific intervention available.

A review of the home’s policy #RC-18-01-09, updated February 2017, indicated the above mentioned specific intervention to document on an identified intake Sheet if it is not recorded on the eMAR/MAR.

A review of the resident’s MAR record revealed that the specific intervention intake is not documented on MAR. The order for this specific intervention was signed for the start and end time.

Interview with PSW #105 revealed that on the food and fluid intake sheet they only document the type of specific intervention and the registered staff is responsible to document intake of the specific intervention.

Interview with RPN #106 revealed that few years before the registered staff were documenting intake on a sheet, but now they just sign the MAR and don’t use the intake sheet to document this specific intervention intake anymore.

Interview with RD revealed that the amount for specific intervention should have been documented as per the home’s policy. [s. 6. (9) 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 the following are documented: the provision of the care set out in the 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 licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

In accordance to O.Reg 79/10. s. 114 (1) (2) the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

As a part of RQI, the inspector conducted medication observation. Observation on January 8, 2018, at 1200 hours revealed RN#102 was going to administer a specific types of medication to resident #009. RN #102 checked the Medication Administration Record (MAR) and the medication to be administered. Then he/she did not use the appropriate method for the specified medication during administration. Before he/she proceeded with the administration the inspector prompted him/her if he/she would administer the medication without following appropriate procedure and RN #102 said yes and completed the administration.

A review of the policy "How to Administer an identified medication", from Medical Pharmacies, dated February 2017, revealed a procedure for safe and accurate administration of the identified medication.

Interview with DOC and ADOC revealed the expectation for the registered staff to follow appropriate and safe procedure to administer the identified medication to residents. Observation, a review of the policy and interview with DOC and ADOC confirmed that the medication was not properly administered to resident #009 and pharmacy will perform refreshing training to staff. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer’s instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

Observation on January 8, 2018, at 1000 hours on an identified home area revealed identified medications for resident #009, #010 and #011were not labeled for the date when they were opened.

Interview with RN #102 revealed the expectation from the staff was that all the above mentioned medications to be labeled when they are opened because they are good for one month after opening.

A review of the home’s policy #5-2, dated April 2017, revealed an identified medication (kept at room temperatures) expire from the date opened 28 days, to be labeled with date when removed from fridge.

An interview with DOC indicated that all identified medications are good for 28 days after opening and confirmed that this was expectation according to the medication manufacturing instructions and the policy to label the medications when they are opened. [s. 129. (1) (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 drugs are stored in an area or a medication cart, that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b).

A review of the medication incidents quarterly review 2017 revealed there was a Medication Safety Committee meeting held by the home on December 7, 2017, for the incidents that occurred from August to November 2017. The notes from the meeting revealed there were seven incidents involving nurse administration, one incident involving pharmacy dispensing, one incident involving order entry/transcription, two incidents categorized as "other". The attendees at the meeting were the DOC, ADOC and Clinical Consultant Pharmacist. A review of the medication incident record was not able to identify a documentation of the incident involving pharmacy dispensing, order entry/transcription and "other" two incidents.

Interview with the DOC confirmed that no record was available in the home for the above mentioned incidents, no record of the immediate actions taken, and if any changes and improvements that were identified in the review were implemented either in the home or in the pharmacy. [s. 135. (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 a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the Infection Prevention and Control Program (IPAC).

A review of resident #012's written plan of care revealed the resident was supposed to be on an identified precautions since eleven months before, because of a specific health condition. Staff to use correct hygiene care when given resident care. Staff to report any abnormal sign or symptoms to the registered staff. Use Personal Protective Equipment (PPE) placed in front of the room, and maintain an identified precautions. A review of the lab results from eleven months before, confirmed that resident #012's specified health condition requiring an identified precautions by staff.

A review of the home's policy Infection Prevention and Control (IPAC), #IC-05-01-04 from September 2017, revealed the home should implement precautions for any resident with a specified health condition. Staff to take additional precautions with residents including hand hygiene, gloves, and masks, eye/face protection and gown when contamination with any bodily fluid or blood is anticipated. Discontinuation of precautions

should be done when complete lab testing and analysis as per physician's orders and local public health authority's representative to determine when precautions can be discontinued. Precautions can be discontinued from residents after three consecutive negative lab results that are taken at least one week apart in the absence of a specific medication therapy or as directed by the local public health authority.

Interview with PSW #120 revealed that resident #012 required assistance with continence at night and the staff did not wear personal protective equipment (PPE) when providing care. Interview with day shift registered staff #123 revealed that resident #012 required help with care during the day and evening shift and staff did not wear PPE when providing the same. RN #123 confirmed that the expectation was when a resident was on an identified precaution the PPE to be placed in front of the resident room and staff to use it accordingly, but for resident #012 that was not the case. He/she explained that staff were not aware that resident #012's specific health condition. Interview with resident #012's physician confirmed that resident #012 lab results indicated the resident having specific health condition to be on precaution and there were no three consecutive negative lab results.

Inspector #500 interviewed RN #118 and PSW #119 in regards to resident #008's identified precautions while the resident was residing in the facility. Resident #008's written plan of care revealed two years prior, the resident was having specific health condition and staff to use protective precaution when providing care (gloves and gown). RN #118 and PSW #119 revealed they did not use PPE when providing care to resident #008.

Interview with ADOC #114 who is the lead of the Infection Prevention and Control (IPAC) program in the home revealed he/she started the role of IPAC lead in June 2017 and he/she was not aware about resident #012's lab results dated eleven months before nor the written plan of care for the identified precautions. He/she indicated that the registered staff on the unit initiated precautions for resident #012 when they received positive lab results but nobody was aware why and since when they were removed.

Interview with DOC and IPAC lead confirmed that the precautions were not in place all the time since resident #012's and resident #008's lab results were positive for the specific health condition and initiated them right away for resident #012. [s. 229. (4)]

2. Observation on January 18, 2018, at 1100 hours on an identified home area, revealed PSW #128, was wearing gloves in the hallway while getting ready to push a resident in a

wheelchair.

Interview with PSW #128 revealed that he/she just performed a personal care to the resident in his/her room, and according to the home's policy he/she should have removed the gloves in the room after completing the personal care.

A review of the policy "Personal Protective Equipment (PPE) #IC-03-01-08", from September 2017, revealed all care staff should wear gloves when there is a risk of coming in contact with bodily fluids or secretions, or when entering a resident room where additional precautions have been instituted. Once the staff have taken any PPE item off they must discard it.

Interview with the IPAC lead confirmed that gloves should not be worn in hallways, but discarded in the room, and that the PPE policy was not followed by staff. [s. 229. (4)]

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 participate in the implementation of the Infection Prevention and Control Program (IPAC), to be implemented voluntarily.

Issued on this 23rd day of January, 2018

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

Original report signed by the inspector.