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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 19, 2018	2018_759502_0019	013278-17, 021830-17, 021897-17	Critical Incident System

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

JULIENNE NGONLOGA (502), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 29, 30, 31, Novmber 1, 2, 5, 6, 2018.

The following critical incident system (CIS) report intakes were inspected:
- Log #021897-17 (CIS #2848-000056-17) related to injury during transfer.
- Log #021830-17(CIS #2848-000055-17) related to staff to resident abuse.
- Log #013278-17 (CIS #2848-000044-17) related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Personal Support Services (PSW), Nursing Clerk (NC), Dietary Aide (DA), family members and residents.

During the course of this inspection, the inspectors observed residents, the provision of care, staff and resident interaction, review residents' health records, home's record, staffing schedule, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On an identified date, critical incident system (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an injury during a transfer.

Review of resident #005's written plan of care, in the focus titled "transfer related to physical limitations secondary to specified injury and procedure" indicated that resident #005 required one staff extensive assistance for transferring from wheelchair to bed.

Review of the resident's progress notes indicated that on an identified date, RPN #105 informed resident's Power of Attorney (POA) that the resident had two identified bedrails that were always secured down. The POA agreed to have the two identified bedrails removed. Eleven day later, RPN #105 documented that the resident's family had installed a different identified bedrail to one side of the bed to assist the resident with bed mobility and self-transfer from bed to wheelchair. RPN #105 documented that Facility staff will offer above mentioned side bedrail once available.

Review of the work request forms indicated that one day in August 2017, a work request was sent to the environment services to remove the first identified bedrails. Maintenance staff #129 removed the two identified bedrails two week later, and documented that the second identified bedrails were not available.

According to the progress notes, one day in September 2017, resident #005 was being transferred from wheelchair to bed, they held onto the bed rail to stand up and while pivoting to sit on the bed, an identified body part caught on the edge of the bed resulting

in an injury. The resident was transferred to hospital and returned to the home on the same day with special treatment.

Review of the work request forms indicated that four days after the injury during transfer, a requisition was sent to remove the family installed bedrail and install the home approved bedrail. This was completed five days after the resident had an injury during transfer.

In an interview, PSW #130 indicated that on an identified date in September 2017, they assisted resident #005 with care, the resident was one person assist and liked to participate in their transfer. The PSW stated resident #005 held onto the bedrail, and an identified body part got caught on the specific bedrail that the resident's family member installed on the bed. The PSW indicated that there was a sharp edge on the bedrail. When they lifted the resident into the bed they noticed blood. They used a towel to squeeze the cut and then called the nurse for assistance.

In an interview, RPN #105 indicated that during the bedrail and entrapment risk assessment on resident #005's bed completed one day in April 2017, they noticed one identified bedrail in up position that was installed by the family, in addition to the two identified bedrails secured down by the home. They sent a work request to the environment services to remove the bedrails and replace them with the home approved bedrail as they were not safe for the resident. One day in August 2017, while completing the quarterly bedrail and entrapment risk assessment on resident #005's bed, they noted that the bedrails were not removed. They sent another work request to the environmental services. The RPN stated that after the resident sustained an injury during transfer one day in September 2017, they send the third work request to remove the family installed identified bedrail and replace it with the home approved identified bedrail.

In an interview, maintenance staff #129 indicated that they received a work request one day in August 2017, to remove the side rails from resident #005's bed and they did, but left the family installed identified bedrail as the home approved identified bedrail were not available in the home. On an identified date in September 2017, they received a second work request to remove the home installed identified bed rail, which they did one day in September 2017. Maintenance staff #129 acknowledged that the bed was not safe for the resident as the identified bedrail had sharp edges.

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 maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

Issued on this 6th day of December, 2018

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

Original report signed by the inspector.