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_0018	025713-17, 000960-18, 002977-18, 006972-18	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

JULIENNE NGONLOGA (502), MATTHEW CHIU (565)

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): October 15, 16, 17, 18, 19, 22, 23, 24, 25 and 26, 2018.

The following complaint intakes were inspected:
- Log # 025713-17 and #006972-18 related to a multiple care issues.
- Log #002977-18, related to neglect of a resident.
- Log #000960-18 and CIS #2848-000003-18 related to staff to resident abuse.

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), Sale Representative Hunt's healthcare, family members and residents.

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

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
3 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, was fully respected and promoted.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint and Critical Incident System (CIS) report related to staff to resident abuse. According to the CIS, a staff member made a specified statement to resident #016 on an identified date, the resident was upset, and they reported the incident to the home on the same day.

Review of resident #016's current written plan of care and Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment indicated that the resident had physical impairment and was able to recall the current season, location of their own room and staff names or faces.

Review of the home's investigation records indicated that the incident mentioned above had happened. The identified DA #118 had received a disciplinary letter that indicated the staff had violated the home's Standards of Conduct, which states that all staff are to treat residents with respect and dignity.

In an interview, resident #016 stated that during a self-directed activity, DA #118 passed by and made a specified statement. Resident #016 told the inspector that they were upset about the staff's statement as the staff had no right to make such statement. Resident #016 felt DA #118 was disrespectful by saying that to them.

Interview with DA #118 indicated that on an identified date, resident #016 was doing a self-directed activity in an identified area, and they were pushing two carts, and wanted to get by resident #016. During the interaction, DA #118 made a specified statement to resident #016. DA #118 indicated that they were not aware of resident #016 being upset until it was brought to their attention by the home's management. DA #118 indicated that their above mentioned statement to resident #016 was a mistake as it was rude, disrespectful and it hurt resident #016's feelings.

In separate interviews, ADOC #119 and the DOC indicated resident #016 reported the incident mentioned above to the ADOC on the same day, and the resident was upset by DA #118. The home had concluded the investigation, and disciplined DA #118 for their action towards resident #016. The ADOC and DOC indicated that DA #118 was rude and

disrespectful towards resident #016. The DOC stated staff should have another way to communicate the statement mentioned above without being rude and disrespectful. The DOC confirmed resident #016 was not treated with respect by DA #118. [s. 3. (1) 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 resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, was fully respected and promoted, to be implemented voluntarily.

WN #2: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

On identified dates the MOHLTC received two complaints related to a resident's plan of care not being followed. The complainant stated that resident #001 had a specified condition and they required specialized socks that were not being applied by staff.

Review of an identified pictured indicated that the resident was wearing non elastic specialized socks.

Review of the resident's progress notes indicated that on an identified date, the resident sustained an injury during transfer and was transferred to the hospital. The resident returned from the hospital two days later.

Review of resident #001's hospital discharge summary, under the section "plan" item #4, revealed a recommendation related to the resident's health condition that the resident should continue wearing their specialized socks and foot wear appropriately.

Review of resident #001's written plan of care completed on an identified date, did not identify the use of specialized socks.

Observation was not completed as resident had been discharged from the home.

Interview with PSW #102 indicated that they sometimes put identified socks provided by the home on resident #001, but the resident did not like them. The resident liked to wear their own regular socks. They also stated that they did not remember if the resident had specialized socks.

Interview with PSW #101 indicated that they were putting the regular socks on for resident #001, and they did not know if the resident had specialized socks.

Interview with RPN #105 indicated that they were not sure if resident #001 was wearing specialized socks and confirmed that the use of specialized socks was not included in the resident's written plan of care.

In an interview, ADOC #119 told Inspector #502 that the expectation was for the nurse, who completed the medication reconciliation, to have a discussion with the attending physician and document in the progress notes, resident's medical record or the electronic treatment administration record (e-TAR). The ADOC acknowledged that the plan of care was not based on resident #001's needs to wear the specialized socks specified in the hospital discharge summary. [s. 6. (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 the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On identified dates the MOHLTC received two complaints related to unsafe transferring techniques. The complainant alleged that the staff of the home were using a an identified lift instead of another an identified lift required by the resident, as the resident could not weight bear. The complainant reported that the staff were also hitting the resident's legs on the wall while transferring them with the first an identified lift, which resulted in injuries.

Observation was not conducted as resident #001 was not residing in the home at the time of this inspection.

Review of the resident's progress notes and skin assessment indicated that on an identified date and time, resident #001 was being transferred from toilet to specialized chair by PSWs #101 and #109 using a third an identified lift. Once the PSWs lowered the resident into their specialized chair, it suddenly moved forward uncontrolled through the washroom's door and hit the wall, the resident sustained injury. The PSWs were not aware whether the specialized chair was on or off during the transfer.

In separate interviews, PSW #101 and #109 indicated that to ensure the safety of the resident, the specialized chair must be off before any transfer. PSW #101 stated that

they were not aware if the power was turned off on the specialized chair as they did not check it. PSW #109 told the inspector that they did not check to ensure that the power of the specialized chair was off as they believed that PSW #101 had completed all the safety check before calling them for assistance with the resident's transfer.

In an interview, an identified sales representative indicated that resident #001's specialized chair had a switch to turn on and off the power. They stated that the specialized chair could only move during transfer if staff did not turn the power off or disengage the breaks to manipulate the specialized chair manually.

In separate interviews, RPN #105, PT #100 and the DOC indicated that safe transferring techniques for residents using a specialized chair include turning the power off before all transfers. The DOC acknowledged that the PSWs did not use safe transferring techniques when assisting resident #001 as they did not turn the power on the motorized scooter off. [s. 36.]

2. As a result of a non-compliance with O.Reg 79/10, r. 36 that was found for resident #001 related to unsafe transferring techniques, the resident sample was expanded to include resident #002.

On an identified date and time the inspector observed PSWs #104 and #102 transferred the resident from bed to wheelchair. After Both PSWs placed the sling under the resident and the straps were placed under their legs, PSW #104 wheeled the resident's chair from the washroom close to the bed and stood behind the chair; PSW #102 used the lift to raise the resident and moved them unassisted from bed to chair, where PSW #104 was waiting to assist in lowering the resident into the wheelchair.

PSW #102 indicated that the proper way to place the sling was to cross the straps between the resident legs, but did not place the sling that way because the resident had pain and will scream if they did. Also the resident told them not to cross the straps of the sling. PSW #102 indicated that the resident requires two persons to transfer from bed to wheelchair. However, they manipulated the lift and moved the resident from bed to wheelchair without the assistance of PSW #104, as they were standing behind the resident's wheelchair.

In an interview, PSW #104 indicated they were taught that, the proper way to place the sling, was to cross the straps between the resident's legs, or one strap around each leg to ensure the safety of the resident. PSW #104 stated that to transfer resident #002, they

placed the straps of the sling under the resident's legs as they complained about pain, and they tried to make the transfer comfortable for the resident. PSW #104 also indicated that two persons assistance with transfer meant that one staff manipulates the lift and the other staff support and guide the resident to the wheelchair. PSW #104 stated that they were not able to assist PSW #102 during transfer because of the set-up of the room, it was impossible to hold the resident, unless they jump on top the resident's bed.

In an interview, RPN #103 indicated that, before transferring the resident, staff should place the sling properly by crossing the straps between or around the resident's legs to prevent the resident from falling out of the sling. RPN #103 also indicated that resident #002 requires two persons extensive assistance for all transfers. This means that one staff control the lift, and the other staff support the resident not to get off balance, and avoid any risk of injury or falling.

PSWs #102, #104 and RPN #103 indicated that the techniques used to transfer resident #002 from bed to wheelchair was not safe as the sling was not used properly and one staff manipulated the lift and transferred the resident without providing support to the resident by the other staff. [s. 36.]

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 used safe transferring and positioning devices or techniques when assisting residents, 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.