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

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

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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
Jun 13, 2019	2019_526645_0004	032764-18, 033774-18	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

DEREGE GEDA (645)

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): May 27, 28, 29, 30, June 5, 6 and 7, 2019.

The following complaints with Log# 33774-18 related to fall prevention and management and Log# 032764-18 related to staffing and medication administration, were inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Resident Assessment Instrument (RAI) Coordinators, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers, (PSWs), and Residents.

A Voluntary Plan of Action related to LTCHA,2007, c.8, s. 24(1) was identified in this inspection and has been issued in a critical inspection report #2019_526645_0005, dated May 9, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) reviewed the health records for residents #050 and #051, reviewed the home's policies and procedures, Complaints and Medication Administration Records (MAR).

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 following rights of residents are fully respected and promoted: 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.

MOHLTC received a complaint indicating resident #050 was verbally abused by PSW #111 during care. A review of the report indicated that PSW #111 used inappropriate language during the morning care and the resident was upset as a result. RPN #112, who was assisting the PSW at the time, reported the incident to the management team.

Interview with resident #050 revealed that they were upset and reported the PSW for verbal abuse.

A review of the home's investigation notes indicated that PSW #111 admitted to the alleged verbal abuse and was disciplined for violation of the home's policy on Resident Bill of Rights and Dignity.

Interview with RPN #112 confirmed that PSW #111 was frustrated during the care and used profane language towards resident #050. They indicated that the resident was upset at the time. Inspector #645 was unable to interview PSW #111 and the former DOC as they no longer work at the home.

Interview with the Administrator revealed that they were aware of the incident and confirmed that the statement from the PSW towards resident #050 was inappropriate. They reiterated that it is the expectation of the home that staff members communicate with residents in a manner that respects residents' rights and dignity. [s. 3. (1) 1.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated, such as abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations.

During the course of a complaint inspection, resident #050 mentioned to inspector #645 that the ADOC intimidated them on an identified date. Resident #050 stated that the ADOC threatened them and they were concerned about their safety. The resident revealed that they communicated the alleged incident of abuse to the Administrator via email on the same day.

Review of the email conversation between the Administrator and the resident indicated that the Administrator was aware of the alleged incident on the same day. A review of the home's records did not indicate if the allegation of abuse was investigated immediately.

An interview with the Administrator confirmed that they received the email regarding the alleged abuse but did not investigate the allegation. [s. 23. (1) (a)]

Issued on this 25th day of June, 2019

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

Original report signed by the inspector.