Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 12, 2020	2020_833763_0007	020797-19, 021820-19, 024249-19, 024500-19, 000394-20	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

IANA MOLOGUINA (763), 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): February 26 and 28, 2020; March 2, 3, 4, 5 and 6, 2020.

- Log #020797-19, CIS #2848-000046-19 was related to falls,
- Log #021820-19, CIS #2848-000047-19 was related to falls,
- Log #024249-19, CIS #2848-000051-19 was related to falls,
- Log #024500-19, CIS #2848-000053-19 was related to medication and
- Log #000394-20, CIS #2848-000001-20 was related to falls.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Directors of Care (ADOC), Physiotherapist (PT), Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of this inspection, the inspectors also reviewed resident records and conducted observations, including staff-resident interactions and resident care provision.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Pain
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
3 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 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 where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report detailing a fall incident of resident #005 on a specified date.

In accordance with O. Reg. 79/10, s. 48 (1) 1, the licensee was required to develop and implement a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, the staff did not comply with the licensee's "Fall Prevention and Management Program" policy #RC-15-01-01 (dated December 2019), which was part of the licensee's required falls prevention and management program and indicated that the interdisciplinary team/nurse was responsible to hold a post-fall huddle, ideally within the hour of a fall. The policy indicated that an intercepted fall which did not prevent the resident from ending up on the floor, ground or other lower level was considered a fall and that after such a fall, all care staff were to participate in the post-fall huddle.

Record review of resident #005's clinical record indicated that, on the day of the incident, the resident was transferring from their bed to their assistive device when the resident notified the PSW assisting them that they were experiencing a decline in their condition. The PSW then assisted the resident down to a lower level and called RPN #114 to assess the resident.

A review of resident #005's records included documentation by RPN #114 of a late entry

post-fall assessment form initiated two days after the fall. The post-fall assessment indicated that a post-fall huddle was not called on the day of the fall incident.

An interview with RPN #114 indicated that it was their responsibility to complete a post-fall assessment and to call a post-fall huddle after the resident had a fall on their shift. RPN #114 indicated that on the day of the fall, they did not know that resident #005 had a defined fall as per the home's "Fall Prevention and Management Program" policy, so they did not initiate a post-fall assessment form in Point Click Care (PCC), nor call staff to attend a post-fall huddle. RPN #114 also confirmed that they initiated a post-fall assessment two days after the fall, when they realized the resident had a defined fall as per the home's policy.

ADOC #115 acknowledged that an intercepted fall that still resulted with the resident on a lower level was considered a fall according to the home's "Fall Prevention and Management Program" policy. ADOC #115 confirmed that staff were expected to participate in a post-fall huddle within the hour of a defined fall and included any staff available on the floor at the time of the incident. ADOC #115 acknowledged that RPN #114 did not call the post-fall huddle within the hour of resident #005's fall as per the home's "Falls Prevention and Management" policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The MLTC received a CIS report detailing an incident on a specified date, when resident #004's medication patch could not be found on the resident's body when it was due for a change. A new patch was applied. There was no harm identified to the resident.

In accordance with O. Reg. 79/10 s. 114. (2) the licensee was required to ensure that written policies and protocols were 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.

Specifically, staff failed to comply with the licensee's policy titled "Transdermal Drug Delivery", RC-16-01-24, last updated December 2019, that directed the staff to dispose the used transdermal patch and visually confirm the patch during the administration time frame of the patch for resident #004.

Review of the licensee's policy titled "Transdermal Drug Delivery", RC-16-01-24, last updated December 2019, indicated the used transdermal patch needed to be placed on the Patch Disposal Record Sheet and placed into a double-locked, secured, monitored

surplus box by two nurses. The pharmacist and designated nurse were to dispose of and denature the used patch at an assigned time. The policy further stated that all patches had to be visually confirmed on every shift during the administration time frame.

Record review indicated resident #004 was prescribed one medication patch of a specified dose every 72 hours (three days) during a specified period. Several medication administration records indicated that on the day of the incident as well as three days before, at specified times, a medication patch was applied to the resident. On the day of the incident, the used medication patch could not be found. There were no records indicating the patch was visually confirmed between that time period.

Interview with PSW #102 indicated they remembered some time ago that resident #004's medication patch was missing from their body but did not recall exactly when and the details.

Interview with RPN #103 indicated that on the day of the incident, resident #004's medication patch was due for a change at a specified time. When RPN #103 checked resident #004's patch, they discovered it was missing from the resident's body. They searched for the missing patch but were unable to find it. The RPN confirmed the used patch was not discarded according to the home's procedure as it was missing.

Interview with RPN #104 indicated that three days before the incident in question, they applied the medication patch for resident #004. RPN #104 stated that, after the application, registered staff on all shifts were supposed to check on the resident's patch, but it may not have happened. RPN #104 further stated that at that time, there was no reminder in the eMAR requiring registered staff to check the patch on each shift.

Interview with ADOC #110 confirmed that the above-mentioned medication incident occurred. ADOC #110 stated that since the home was unable to find the used medication patch on the day of the incident, it was not discarded according to the home's policy. ADOC #110 further stated that they were unable to identify when the medication patch was last seen on resident #004 because they had no records for any visual confirmation of the patch between the time the patch was placed on the resident to the time it was found missing. ADOC #110 confirmed the visual confirmation of the patch was not done on every shift as required by their policy, and that the used patch was not discarded or

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 where the Act and Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #2: 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 following is further evidence to support the compliance order issued on February 3, 2020, during a Critical Incident System inspection 2019_808535_0018 (CO #002) with a compliance due date of April 3, 2020.

The licensee has failed to ensure that staff used safe positioning techniques when assisting resident #002.

Review of a CIS report indicated that, on a specified date, resident #002 fell from their bed while receiving care from PSW #105. As a result, the resident sustained injuries.

Review of resident #002's plan of care indicated resident #002 had a condition that limited their ability to keep their body in balance while in bed. They required assistance from two staff for bed mobility, dressing, and continence care. Staff were required to provide continence care while the resident was in bed.

Review of the home's incident and investigation records indicated that, on the day of the incident, PSW #105 performed care to resident #002 in bed on their own. PSW #105 determined that resident #002 required continence care and rolled the resident over to apply a continence product. Resident #002 slid off the bed and sustained several injuries.

Interviews with PSWs #107, #108, and RPN #109 indicated that when providing care to resident #002 in bed, including turning and changing the resident, the safe technique to use included having two staff members stand on each side of the bed, with one staff member giving clear instructions to the resident and the second staff member turning the resident to their side. While one staff member performed care to the resident, the second staff member was to support the resident to ensure their safety. The staff stated it was unsafe when PSW #105 provided care to resident #002 without a second staff member present.

Interview with PSW #105 indicated the above-mentioned incident happened when they were providing care to resident #002 on their own. PSW #105 stated that, on that day, while they were providing care to resident #002, the PSW #105 determined the resident required continence care, so they turned the resident onto their side. While the resident was in that position and as the PSW was providing care, the resident slid off from the opposite side of the bed. The PSW tried to pull the resident back but was unsuccessful, and the resident eventually landed on the floor.

Interview with ADOC #110 indicated that, since resident #002 had a condition that limited their ability to keep their body in balance while in bed, their balance was disturbed at the time of the incident when PSW #105 turned the resident in bed. Without two staff members standing on each side of the bed, for the purposes of providing care and supporting the resident at the same time, it was unsafe for the resident. ADOC #110 acknowledged that PSW #105 used unsafe positioning techniques when assisting resident #002 during the above-mentioned incident. [s. 36.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than three business days after the occurrence of an incident that caused an injury to resident #001, for which the resident was taken to a hospital and which the licensee determined that the injury resulted in a significant change in their health condition.

The MLTC received a CIS report on a specified date detailing a fall incident seven business days prior to the submission date involving resident #001. The fall incident resulted in a transfer to hospital and a significant change in the resident’s health status. The CIS report indicated that prior to the fall, resident #001 was cognitively impaired but mobile, tending to wander on the home unit.

A review of resident #001’s progress notes indicated the resident fell on a specified date. Resident #001 sustained injury from the fall and was sent to the hospital for further investigation. Resident #001 was re-admitted the next business day with a diagnosis of a specified injury that was minimal in nature. The physician assessed the resident on re-admission and encouraged ambulation, however progress notes over the next several business days indicated that resident #001's condition declined after hospital re-admission. Progress notes four business days after the initial fall incident indicated resident #001 showed further signs of decline from the original fall, so they were again transferred to the hospital. The following business day, progress notes indicated the home staff called the hospital for a status update and were informed that resident #001

was having a medical procedure related to the incident scheduled in two business days. Two business days later (the same day of the medical procedure), the CIS report was submitted to the MLTC by DOC #101. The resident was then re-admitted to the home on a specified date.

An interview with PSW #112, resident #001's regular PSW, indicated that, prior to the fall, resident #001 was often found wandering on the unit independently, but after the fall they were no longer displaying their usual behaviour and no longer walking. An interview with RPN #113 also confirmed that resident #001 was a wanderer prior to the indicated fall, and that because their condition was not improving after the first hospital visit, they were sent back to the hospital on October 22, 2019.

An interview with DOC #101 confirmed that they should have informed the MLTC of the original fall incident prior to the submitted date, as the CIS report was submitted seven business days after the incident occurred, which is four business days past the submission due date. DOC #101 confirmed that the home was aware of resident #001's significant change in health status before the submission date. DOC #101 confirmed that resident #001 had a change in their typical behavior after the original fall incident, and confirmed that the home was aware of resident #001's significant change in health status five business days after the incident when staff called the hospital for an update on resident #001's condition. [s. 107. (3.1)]

Issued on this 18th day of March, 2020

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

Original report signed by the inspector.