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
Sep 21, 2020	2020_767643_0018	011971-20, 016224-20, 016434-20, 016665-20	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

ADAM DICKEY (643)

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): September 4, 8, 9, 10 and 11, 2020.

The following Critical Incident System (CIS) intakes were inspected during this inspection:
Log #011971-20, CIS #2848-000016-20, Log #016434-20, CIS #2848-000022-20 and Log #016665-20, CIS #2848-000023-20 - related to falls prevention and management, and
Log #016224-20, CIS #2848-000021-20 - related to injury with unknown cause.

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

During the course of the inspection, the Inspector conducted observations of staff to resident interactions and the provision of care, reviewed resident health records, the home's incident investigation notes and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to two residents as specified in the plan related to falls prevention and management interventions.

a. Observations by the Inspector showed one resident in bed. Two of the resident's falls prevention and management interventions were not in place as per the plan of care at the time of observation. In interviews, two staff members indicated that the resident should have had the falls prevention and management interventions in place when the resident was in bed. The staff acknowledged these interventions were not in place as required at the time of observation. The resident was at actual risk of harm due to the fall interventions not being in place as required.

Sources: Inspector observations, resident plan of care, and staff interviews.

b. Observation by the Inspector showed a second resident in their room seated in their wheelchair. The resident was observed by the Inspector and two staff members to not have a falls prevention and management intervention in place. The staff members looked for, but could not locate the equipment used to prevent injury from falls in the resident's room. Subsequent observation in the resident's room showed a second piece of equipment used to prevent injury from falls used incorrectly. The resident's plan of care was reviewed and instructed staff when to use the two pieces of equipment for injury prevention. Interviews with staff members indicated that the pieces of equipment were not used in accordance with the resident's plan of care. The resident was at actual risk of harm as they were at risk for falls and did not have the required equipment to prevent

injury from falls in place.

Sources: Inspector observations, resident plan of care, and staff interviews.

Note: The above findings are further evidence to support Compliance Order (CO) #004 issued under inspection report 2019_808535_0018 (A2), served on May 25, 2020, order due date September 24, 2020. [s. 6. (7)]

2. The licensee has failed to ensure that one resident’s plan of care was reviewed and revised when the resident’s care needs changed related to falls prevention.

Review of the resident’s progress notes and post-fall assessments showed that the resident had a fall incident during a treatment administered by a member of the registered staff. The registered staff member indicated they administered the treatment, following which the resident became unsteady and was lowered to the floor. The registered staff member indicated that they did not review and revise the resident care plan as they did not initially consider the incident a fall. Staff did not comply with the home's Falls Prevention and Management Program policy. Specifically, the plan of care was not updated post fall. The resident subsequently fell a second time, approximately four months later, during the same treatment administration with another member of the registered staff. The resident experienced actual harm as they sustained an injury and required hospitalization.

Sources: A Critical Incident System (CIS) report submitted to the Ministry of Long-Term Care, resident progress notes and post fall assessments, the home’s policy titled "Falls Prevention and Management Program", policy #RC-15-01-01, last updated December 2019, and staff interviews. [s. 6. (10) (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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, 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 licensee has failed to ensure that staff used safe positioning techniques when assisting a resident.

A Critical Incident System (CIS) report was submitted to the Director which indicated a resident had a fall incident, while being administered a treatment by a member of the registered staff. Review of the home’s investigation notes and interview with the registered staff member showed the resident was leaning over the bed during treatment and became unsteady and fell following the treatment. According to the resident's progress notes, they had a similar incident when being administered the same treatment with a second member of the registered staff three months earlier. Interview with the registered staff member indicated that after administering the treatment, the resident became unsteady and was lowered to the ground by the staff. Both registered staff members indicated that it was not best practice to administer the treatment with the resident positioned leaning over the bed, and the resident should lie on the bed for administration. Resident #025 experienced actual harm as they sustained an injury and required hospitalization resulting from the second fall incident.

The Physiotherapist (PT) indicated the resident required physical assistance from one staff for transferring and positioning. The PT indicated that the positioning used by the two registered staff members during treatment administration was not safe for the resident as they could become fatigued and unsteady.

Sources: A Critical Incident System (CIS) report submitted to the Ministry of Long-Term Care, resident health records, progress notes, post-fall assessments, plan of care, the home’s investigation notes and staff interviews.

Note: This finding is further evidence to support Compliance Order (CO) #002 issued under inspection report #2019_808535_0018 (A2), served on May 25, 2020, order due date September 24, 2020. [s. 36.]

Issued on this 23rd day of September, 2020

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

Original report signed by the inspector.