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
Nov 10, 2020	2020_808535_0013	002022-20, 002023-20, 002024-20, 002025-20, 002026-20, 002027-20, 002028-20, 006721-20, 006985-20, 007146-20, 008082-20, 009580-20, 009917-20, 011643-20	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

VERON ASH (535), NITAL SHETH (500), SLAVICA VUCKO (210)

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 20, 21, 22, 23, 26, 27, 28, 29, 30, 2020, off-site November 2, 3, 4, 2020.

The following intakes were completed during this inspection: Logs: #006721-20 (related to personal care), #006985-20 (related to medication), #007146-20 (related to personal care), #008082-20 (related to medication and abuse), #009580-20 (related to personal care), #009917-20 (related to abuse) and #011643-20 (related to personal care).

During this inspection, three compliance orders (CO) were followed up from inspection #2019_808535_0017 issued on May 25, 2020, with a compliance due date of September 24, 2020: Logs # 002025-20 - CO #001 (related to Residents' rights), #002026-20 - CO #002 (related to reporting to the Director) and # 002027-20 - CO #003 (related to responsive behavior).

During this inspection, four compliance orders (CO) were followed up from inspection #2019_808535_0018 issued on May 25, 2020, with a compliance due date of September 24, 2020: Logs #002022-20 - CO #001 (related to abuse/neglect), #002023-20 - CO #002 (related to transfer and lifts), #002024-20 - CO #003 (related to dining and snack services) and #002028-20 - CO #004 (related to plan of care).

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Medical Director (MD), Director of Care (DOC), Associate Director of Cares (ADOCs), Program Manager (PM), Social Worker (SW), Food Service Manager (FSM), Physiotherapist (PT), Resident Assessment Instrument (RAI) Coordinators, Recreation Assistant (RA), registered staff (RN/RPN), personal support workers (PSWs) and residents.

During the course of the inspection, the inspectors conducted observations of resident home areas, staff to resident interactions, resident to resident interactions, reviewed clinical health, treatment and medication administration records, staffing schedules and the home's staffing plans, internal investigation notes and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Snack Observation
Sufficient Staffing

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

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_808535_0018	210
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2019_808535_0017	535
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2019_808535_0017	535
O.Reg 79/10 s. 36.	CO #002	2019_808535_0018	535
O.Reg 79/10 s. 53. (4)	CO #003	2019_808535_0017	500
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #004	2019_808535_0018	210
O.Reg 79/10 s. 73. (1)	CO #003	2019_808535_0018	500

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #024 so that their assessments are integrated, consistent with and complement each other.

A complaint was submitted to the MLTC regarding resident #024 who had to go for a community appointment. The home informed the family one day before the appointment that it was not safe for the resident to be transferred to the appointment using a mobility device.

According to the Physiotherapist, when there is a change in the resident's transfer status or their mobility device, the resident should be assessed for safety, and a referral should be sent to PT for an assessment. Up to the day before the community appointment, there was no referral sent to PT for assessment of the transfer status of resident #024.

Source: observation, review of resident #024’s clinical record, interview with resident #024, family member, PT and other staff. [s. 6. (4) (a)]

Issued on this 10th day of November, 2020

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

Original report signed by the inspector.