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 1, 2021	2021_526645_0004	022507-20	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

DEREGE GEDA (645)

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 1, 2, 3, 4, 5, 8, 9, 10, 11 and 12, 2021.

This inspection was completed to inspect upon intake log# 022507-20, for Critical Incident System (CIS) report number 2848-000029-20, related to Prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOC), Infection Prevention and Control (IPAC) Lead, Registered Nurses(RN), Registered Practical Nurses (RPN), Dietary Aides, Housekeeping staffs, Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector observed the provision of care, services and supplies; reviewed records including but not limited to relevant training records, policies and procedures, line listings, residents' clinical health records, and staff schedules.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was not neglected by the licensee or staff.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 ”neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

A Critical Incident System(CIS) report was submitted to the Ministry of Long Term Care (MLTC) related to an incident that caused an injury to resident #001 for which the resident was taken to hospital. Resident #001 had an identified type of illness and symptoms that required frequent monitoring.

On an identified date, resident #001 was unwell, and RN #100 called the physician and an order was obtained to hold the resident’s medication and monitor them frequently. A few hours later, the resident's health condition declined and was transferred to hospital. The resident was not monitored, and their vital signs were not checked.

Inspector #645 reviewed resident #002’s and #003’s clinical records to increase the resident sample size due to identified noncompliance.

On an identified date, resident #002 was unwell, their medication was held, and required frequent monitoring of their vital signs. The records did not indicate if the resident was monitored and their vital signs were checked as needed.

RN #100 confirmed that they did not check resident #001’s vital signs when they were ill. They also indicated that when resident #002 was unwell on the identified date, the required frequent monitoring were not completed. They indicated that it was the expectation of the home that registered staff assess resident's health condition and monitor their vital signs frequently.

The DOC indicated that it was the expectation of the home that registered staff check and recheck residents’ health conditions and monitor their vital signs.

Sources: residents #001's, #002's and #003's plan of care and progress notes, incident investigation records, and interviews with registered staff and the DOC. [s. 19. (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 residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

During the inspection, Inspector #645 observed multiple staff members not wearing the appropriate personal protective equipment (PPE) on a COVID-19 outbreak unit. The COVID-19 outbreak signage posted on the unit's main entrance door directed staff members to wear mask and face shields when entering the unit, and to wear gloves and gowns when providing care to residents. The Inspector observed multiple staff members not wearing the appropriate PPE as follows :-

- On an identified date, housekeeping staff #102 and #103, were observed not wearing face shields on the unit. Housekeeping staff #102 was observed collecting garage bags, and housekeeping staff #103 was cleaning residents' room without wearing face shields.

- On the same day, two physiotherapy assistants (PTA) #104 and #105, were observed transferring and ambulating resident #002 in the hallway without wearing face shields.

- On an identified date, dietary aide #106 was observed delivering food trays for residents without wearing face shield and

- On the same day, housekeeping staff #107 was observed cleaning the unit hallway without wearing a face shield.

The above-mentioned staff members and ADOC #108 confirmed that it was the expectation of the home that staff members always wear face shields upon entering the unit and when on the unit.

Sources: observations, record reviews and staff interviews. [s. 229. (4)]

Issued on this 5th day of March, 2021

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

Original report signed by the inspector.