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
Aug 16, 2021	2021_833763_0014	021821-20, 007529-21, 008380-21, 010114-21	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)

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): July 6-9, 12-16, 19, and 20, 2021.

The following intakes related to falls were completed during this Critical Incident System (CIS) Inspection:

- Log #010114-21, CIS #2848-000011-21,
- Log #008380-21, CIS #2848-000010-21,
- Log #007529-21, CIS #2848-000007-21, and
- Log #021821-20, CIS #2848-000026-20.

PLEASE NOTE: A Written Notification and Compliance Order related to O. Reg. 79/10, s. 8. (1) (b) was identified in this inspection and has been issued in Inspection Report #2021_833763_0013, dated August 16, 2021, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Physiotherapist (PT), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), COVID-19 entrance screening staff, RAI Co-ordinators (RAI), environmental staff and residents.

During the course of this inspection, the inspector reviewed residents' clinical records and conducted observations, including staff-resident interactions, meal observations and resident care provisions.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for a resident.

The Ministry of Long-Term Care (MLTC) received a Critical Incident Report (CIS) report indicating that the resident fell after trying to self-transfer which resulted in significant injury.

Record review, observations and staff interviews indicated that the resident was at risk for falls and had several interventions in place to manage that risk. After their fall, they continued to self-transfer without asking for staff assistance on occasion and used an assistive device when they did mobilize.

The inspector observed the resident in their room sitting by their bed in an armchair. Their assistive device was placed within their reach but in front of a tripping hazard if the resident attempted to get up from their armchair. The staff who cared for the resident that day confirmed they left the resident in this position. Staff indicated that the resident had a history of self-transferring behaviours without calling for staff assistance and that they were left at risk with a tripping hazard in front of their assistive device.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan, assessments), CIS #2848-000011-21, staff interviews (PSW #108 and #109, RPN #114, and PT #118). [s. 5.]

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 in ensuring that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident regarding their use of a falls intervention.

The MLTC received a CIS report indicating that the resident fell after trying to self-transfer; the fall resulted in significant injury and a visit to the hospital. They were at risk for falls, required assistance for transfers and had several falls interventions included in their plan of care.

The inspector observed the resident's room and confirmed that the resident had a fall intervention in place to prevent injury from a fall. The resident's written care plan did not include this intervention.

Staff indicated that each resident's plan of care encompassed their written care plan, and if residents used an intervention to manage their falls risk, staff were expected to list this in the resident's written care plan to clearly indicate their care needs. The PT indicated that they were not aware that this intervention was in place when it was first implemented. Staff confirmed that not listing all falls interventions in the resident's written care plan made it unclear to others what interventions were in place to manage their falls risk.

Sources: resident clinical records (PointClickCare profile, progress notes, assessments, care plan), CIS report #2848-000011-21, home observations, staff interviews (PSW #108, RPN #114, and PT #118). [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to them as specified in the plan.

The MLTC received a CIS report indicating that the resident fell, which resulted in significant injury requiring surgical repair in hospital.

Record review and staff interviews indicated that the resident required an assistive device for locomotion prior to the fall but often forgot to use it. Staff were expected to always encourage the resident to use it. On the day of the incident, staff were busy assisting other residents and did not ensure the resident had the assistive device accessible to them at the time of the fall.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan, assessments), CIS #2848-000010-21, staff interviews (PSW #112 and #113, RPN #110, and ADOC #106). [s. 6. (7)]

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 in ensuring that the written plan of care sets out clear directions to staff and others who provide direct care to residents; and in ensuring that the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

Issued on this 16th day of August, 2021

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

Original report signed by the inspector.