Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Original Public Report

Report Issue Date: December 13, 2022

Inspection Number: 2022-1333-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: West Park Healthcare Centre

Long Term Care Home and City: West Park Long Term Care Centre, Toronto

Lead Inspector	**Inspector Digital Signature**
Matthew Chiu (565)	Matthew Chiu Digitally signed by Matthew Chiu Date: 2023.01.05 15:25:54 -05'00'

Additional Inspector(s)
Parimah Oormazdi (741672)
Ramesh Purushothaman (741150)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 15, 2022
November 16, 2022
November 17, 2022
November 21, 2022
November 22, 2022
November 23, 2022
November 24, 2022
November 25, 2022

The following intake(s) were inspected:

- Intakes: #00001380, #00002770, #00007704 related to significant change in residents' health status
- Intake: #00002322 related to resident's responsive behaviour
- Intake: #00004622 complaint related to allegation of abuse
- Intakes: #00011316, #00001449, #00001839, #00003254, #00003375, #00003550, #00005606 related to falls prevention and management

The following **Inspection Protocols** were used during this inspection:

Medication Management
Responsive Behaviours
Prevention of Abuse and Neglect
Infection Prevention and Control
Falls Prevention and Management
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that resident #003 was reassessed and the plan of care reviewed and revised at any other time when the resident's care needs changed, or care set out in the plan was no longer necessary.

Rationale and Summary:

The inspector observed that resident #003 was walking in a common area, sitting down on a couch, and getting up using a mobility aide without assistance from staff.

Resident #003 had multiple falls and sustained a significant injury in the last several months. As specified in the resident's plan of care, they required identified assistance for transfers and walking. Their falls prevention plan of care stated that specified interventions should be in place when the resident was in bed.

Staff interviews indicated resident #003's were assessed for transfer and walking after the above-mentioned injury. Since then, the resident's mobility had changed, and their care needs related to the assistance for transfers and walking, and their falls prevention were not the same as specified in their plan. Record review and staff interviews indicated the resident was at risk for falls. They were not reassessed, and their plan of care was not revised when their mobility and falls prevention care needs changed. The non-compliance caused a moderate risk to the resident's safety.

Sources: Resident's progress notes, care plan; observations; interviews with the Personal Support Worker (PSW), Registered Nurse (RN), and Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator. [565]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in resident #006's plan of care was provided to the resident as specified in the plan.

Rationale and Summary:

Resident #006 had a diagnosis of a health condition. Their current written care plan stated the resident required an intervention to be implemented on all shifts to ensure their safety.

Two observations on separate days indicated that the intervention was not provided to the resident when the resident was in their room.

A Registered Practical Nurse (RPN) stated that during the above-mentioned observations, the intervention should have been provided to the resident to ensure their safety. Leaving the resident in their room without the intervention increased the risk of resident #006's safety.

Sources: Resident's care plan; observations; interviews with the RPN, RN, Behavioural Supports Ontario (BSO) Manager and DOC. [741150]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the infection prevention and control (IPAC) standard for long-term care home issued, April 2022, by the Director was implemented in accordance with the standard:

- 9.1, additional precaution (f), stated additional personal protective equipment (PPE) requirements including appropriate selection, application, removal and disposal. Specifically, the licensee failed to ensure that additional precautions were followed related to the appropriate application of N95 masks, removal and disposal of protective gown; and

- 10.4 (h), stated support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting. Specifically, the licensee failed to ensure that the staff support residents to perform hand hygiene using appropriate hand sanitizer that includes 70-90% Alcohol-Based Hand Rub (ABHR) prior to receiving meals.

Rationale and Summary:

(a) The home directed their staff to wear N95 masks when providing resident care as the local public health unit had declared a suspected and a confirmed respiratory outbreak in two different home areas.

During a meal service, the inspector observed that two PSWs were providing care to residents, as well as assisting them with feeding while their N95 masks were not covering their noses for approximately 45 minutes. One of the staff acknowledged that their N95 mask was not worn properly.

The home's policy #CRG-02, titled COVID-19 Universal PPE Strategy, revised on July 2022, and interview with the IPAC lead indicated that the mask should have been worn in a way that it covered both the nose and mouth.

By not wearing the N95 mask correctly and consistently, the risk of spreading the viruses among residents increases.

Sources: Policy #CRG-02 titled COVID-19 Universal PPE Strategy; dining observation; interviews with the PSW and IPAC lead. [741672]

(b) During a shift, a staff member was observed providing resident care in two resident rooms that were under droplet and contact precautions. When the staff came out of the first resident room, they removed their gown and placed it in one of the pouches of the clean caddy on the door. Subsequently, they re-entered the same room to provide resident care. After the care was completed, the staff went to provide resident care in the second resident room and then went back to the first resident room wearing the same gown.

The IPAC lead confirmed that the expectation was to remove the used gown before they came out of the resident’s room with droplet and contact precautions, and the gown should not be put back in the PPE caddy after it was worn.

Failure to appropriately doff and dispose of PPE increased the risk of transmission of infection.

Sources: Observation; home’s policy #IC-02-01-01, titled Routine Practices last reviewed January 2022; interviews with the staff and IPAC lead. [741150]

(c) During a dining observation, it was observed that staff did not provide alcohol-based hand rub to residents prior to serving meals; they provided alcohol free wet wipes to residents.

The home's policy #NC-03-01-01, titled Meal Service and Dining Experience, stated that staff to help residents sanitize their hands prior to and after meal service. Another home's policy #IC-02-01-08, titled Hand Hygiene, stated that hand hygiene may be performed either by using soap and running water, or with alcohol-based hand rub.

The IPAC lead confirmed that the wipes that were provided to residents prior to their meals did not contain any alcohol.

By not supporting residents to sanitize their hands with alcohol-based hand rub prior to serving meals increased the risk of transmission of infection.

Sources: Home's policies #IC-02-01-08 titled Hand Hygiene revised on April 2022, #NC-03-01-01 titled Meal Service and Dining Experience revised on January 2022; dining observation; interviews with the IPAC lead and Director of Care (DOC). [741672]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (15) 3.

The licensee has failed to ensure that the IPAC lead designated under this section worked regularly in that position on site at the home, with a licensed bed capacity of 200 beds, for at least 35 hours per week.

Rational and summary:

The Executive Director (ED) stated that the home had a licensed bed capacity of 200 beds and one of their Assistant Directors of Care (ADOCs) was also the home's designated IPAC Lead. This staff member worked 37.5 hours per week regularly in the home.

During an interview with the IPAC lead, who was also the ADOC, they indicated that they had not designated a minimum number of weekly hours for the IPAC lead position. The number of hours would vary from day to day based on their workload. They worked approximately four hours per day, 20 hours per week towards the IPAC duties. The rest of the work day was dedicated to the ADOC role.

The job description of the IPAC lead indicated that the IPAC lead who is also designated as ADOC is required to work 35 hours per week as IPAC lead and 2.5 hours per week as ADOC. There was no record that indicated IPAC lead hours were monitored and met the required minimum amount of time per week.

The non-compliance caused a risk of impact to the implementation of the home's IPAC program.

Sources: Home's IPAC lead job description; interviews with the IPAC lead and ED. [741672]

WRITTEN NOTIFICATION: BINDING ON LICENSEES

NC #05 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to carry out the COVID-19 asymptomatic screen testing requirements directive that applied to the long-term care home. Specifically, the licensee failed to ensure that staff who were assigned to conduct COVID-19 rapid antigen tests (RAT) followed the manufacturer's instructions.

Rationale and Summary:

The procedure card of the COVID-19 RAT device, brand name Rapid Response, which was used in the home to test visitors and staff prior to entering the home areas, indicated that the results of the test should be read 15 minutes after the drops of the extracted solution is applied on the test device.

The inspector observed that a general visitor was tested for COVID-19 via RAT upon entry to the home. They were allowed to enter the home areas within 10 minutes after the extracted solution drops were applied to the test device, and their test device was discarded as soon as they entered the home areas.

Two staff members, who were responsible for testing staff and visitors, were uncertain about the waiting time for reading the results of the test. The IPAC lead acknowledged that if the 15 minutes waiting time of the test was not followed, the COVID-19 RAT was not considered accurate.

By not following the manufacturer's instruction on the COVID-19 RAT procedure card, there was a risk that test results of those entering the home may not be considered accurate.

Sources: Rapid Response COVID-19 RAT procedure card; observation; interviews with the staff and IPAC lead. [741672]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC #06 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person, who had reasonable grounds to suspect abuse of a resident by anyone had occurred or might occur, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary:

During a shift, a visitor noticed an interaction between a staff member and a resident. Several days later, the visitor reported the incident to the DOC alleging abuse towards the resident. The home did not report the incident to the Director.

The DOC stated that the visitor reported the incident to them. They initiated an investigation of the alleged abuse as reported by the visitor, but did not report it to the Director.

Sources: Resident's progress notes, home's investigation records; interviews with the visitor and DOC. [741150]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #07 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (4) (a)

The licensee has failed to ensure that the staff and others involved in different aspects of care collaborated with each other in the behavioural assessment of resident #006 so that their assessments were integrated and consistent with and complemented each other.

Rationale and Summary:

Resident #006 exhibited moods and responsive behaviours, and a progress notes stated a BSO referral was completed by a registered staff in response to the resident's behaviours.

Interview with a RPN and review of resident's referral and assessment records indicated that no referral or subsequent assessment were completed. The RPN and BSO Manager stated that a BSO referral should have been initiated by creating a referral so that their behavioural assessment could have been initiated and integrated into the resident's plan of care.

Staff's failure to collaborate in the behavioural assessment for resident #006 caused a risk of behaviours not being managed effectively.

Sources: Resident's progress notes; interviews with the RPN, BSO Manager and DOC. [741150]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #08 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that resident #004's written plan of care related to their risk of a health condition set out the planned care for the resident.

Rational and summary:

The home submitted a CIS report when resident #004 had an episode of the health condition, and the report stated the action plans to prevent recurrence.

The resident's plan of care related to the health condition did not include some of the interventions specified in the action plans.

Observations and staff interview indicated resident #004 had difficulties in eating and swallowing. Their food and fluid intakes varied at different meals.

The physician indicated that resident #004, who was receiving a therapy and their oral intake varied sometimes, was at risk of the health condition.

The ADOC acknowledged that interventions related to the risk of the health condition should have been set out in the resident's written plan of care, so that staff would be aware and implement them.

Failure to set out interventions related to the risk of the health condition in the resident's plan of care increased the risk of reoccurrence of the condition.

Sources: CIS report, resident's care plan, electronic medication administration records (eMAR), progress notes, home's policy; observation; interviews with the physician and ADOC. [741672]

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #09 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

The licensee has failed to ensure that resident #007's right to be afforded privacy in treatment and in caring for their personal needs, was fully respected and promoted by a nurse.

Rationale and summary:

It was observed that a nurse was assisting resident #007 in a common area. Parts of the resident's body were exposed during the treatment. Co-residents and staff members were in the same area when it occurred.

A Nurse Practitioner (NP) stated that the nurse's practice was not acceptable in any circumstance as the treatment must be done in the resident's room to maintain privacy.

A RPN stated that the nurse was called to provide the treatment for resident #007. The RPN confirmed that the nurse's practice was not appropriate, and they should have taken the resident to their room for the treatment.

Sources: Observation; resident #007's progress notes; interviews with the RPN and NP. [741672]

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