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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: June 9, 2023	
Inspection Number: 2023-1333-0004	
Inspection Type: Follow up Critical Incident System	
Licensee: West Park Healthcare Centre	
Long Term Care Home and City: West Park Long Term Care Centre, Toronto	
Lead Inspector JulieAnn Hing (649)	**Inspector Digital Signature** Julie ann Hing Digitally signed by Julie ann Hing Date: 2023.06.16 10:04:51 -04'00'
Additional Inspector(s) Lisa Salonen Mackay (000761)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 25, 26, 30, and 31, 2023.

The following intake(s) were inspected:

- Intake: #00084813 - Follow up inspection related to duty to protect.
- Intake: #00020941, Critical Incident (CI) #2848-000002-23 related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #001 from Inspection #2023-1333-0002 related to FLTCA, 2021, s. 24 (1) inspected by Julie Ann Hing (649).

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 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 a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary
The resident sustained a fall that resulted in an injury. The following day the Physiotherapist (PT) assessed the resident and recommended use of a specific device. The PT's recommendation was not immediately updated in the resident's written care plan.

Four days later, the resident sustained another fall that resulted in an injury and subsequent transfer to hospital. The staff who discovered the resident's fall was not aware of the specific device.

A Registered Practical Nurse (RPN) stated that the resident always had the specific device. According to the resident's written care plan, the specific device had been resolved, and reinitiated several months after the above mentioned falls.

Failure to update and revise the resident's plan of care put them at risk of subsequent falls and injury.

Sources: Review of the resident's clinical record, CI #2848-000002-23, interviews with AA, RPN, and other relevant staff. [000761]

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with Compliance Order (CO) #001 issued on March 30, 2023, under

inspection report #2023_1333_0002 with a compliance due date of May 11, 2023.

The home failed to comply with their compliance plan which had indicated that all hair dryers will be added to a preventive maintenance program, and inspected.

Rationale and Summary
Upon follow-up the home was found to be non-compliant with their compliance plan which indicated that all hair dryers will be added to a preventative maintenance program and inspected. The home's record indicated that preventative maintenance and inspection was only completed on one out of three hair dryers in the home.

The Environmental Service Manager (ESM) acknowledged that the record of preventative maintenance was only available for one hair dryer. There was no record of preventative maintenance for the other two hair dryers.

The Director of Care (DOC) and ESM both acknowledged that preventative maintenance was not completed for the other two hair dryers since they were unable to provide any documentation to support this action.

The home failed to comply with this part of their compliance plan during inspection 2023_1333_0004 and put residents at risk for further harm.

Sources: Review of home's equipment records, home's compliance plan, interviews with ESM, DOC, and other relevant staff. [649]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021, s.24 (1)
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
-Order #001 of Inspection #2023_1333_0002, FLTCA, 2021, s. 24 (1)

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002