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

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| **Report Issue Date:** August 4 2023 | |
| **Inspection Number:** 2023-1333-0005 | |
| **Inspection Type:**<br>Follow up<br>Critical Incident System | |
| **Licensee:** West Park Healthcare Centre | |
| **Long Term Care Home and City:** West Park Long Term Care Centre, Toronto | |
| **Lead Inspector**<br>Michael Chan (000708) | **Inspector Digital Signature**<br>Michael K Chan Digitally signed by Michael K Chan Date: 2023.08.11 16:49:05 -04'00' |
| **Additional Inspector(s)**<br>Henry Chong (740836) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 31, 2023, and August 1, 2, 2023.

The following intake(s) were inspected in the Critical Incident System (CIS) Inspection:

- Intake: #00087452 - related to an injury of unknown cause of a resident

The following intake(s) were inspected in the Follow-Up Inspection:

- Intake: #00089787 - a follow-up intake related to a previously issued Compliance Order

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1333-0002 related to FLTCA, 2021, s. 24 (1) inspected by Henry Chong (740836)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Transferring and Positioning Techniques

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that a staff used safe transferring techniques when assisting a resident.

**Rationale and Summary**

A resident was sent to the hospital for further assessment. The resident had sustained an injury. The resident returned from the hospital and was assessed by the Physiotherapist (PT) and recommended the resident required a specified type of assist until their health status was confirmed. The staff confirmed the resident's health status, and the plan of care was updated. Documentation on the resident's clinical record indicated that the resident was not transferred according to the PT's assessment and their plan of care, and this was confirmed by staff. Staff and the home's management confirmed that not following the resident's care plan related to transfers could increase the risk for falls and further injury to the resident.

Failure to use safe transferring techniques when assisting the resident increased the risk for falls and further injury to the resident.

**Sources**: The home's investigation notes, interview with the home's staff, resident's clinical record.

[000708]

## NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Reinspection of outstanding CO #001, from inspection #2023-1333-0002 with Compliance Due Date May 11, 2023, which was originally followed up on during inspection #2023-1333-0004, which took place on May 25, 26, 30, and 31, 2023.

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.

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