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: January 24, 2024	
Inspection Number: 2023-1333-0007	
Inspection Type: Critical Incident	
Licensee: West Park Healthcare Centre	
Long Term Care Home and City: West Park Long Term Care Centre, Toronto	
Lead Inspector Parimah Oormazdi (741672)	Inspector Digital Signature Parimah Oormazdi Digitally signed by Parimah Oormazdi Date: 2024.01.26 14:12:31 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 21-22, 2023 and January 2-5, and 8-9, 2024

The following intakes were inspected during this Critical Incident (CI) Inspection:

- Intake: #00094338 / CI #2848-000006-23 was related to resident to resident physical abuse
- Intake: #00102684 / CI #2848-000011-23 was related to fall prevention and management program

The following intake was completed in this Critical Incident (CI) inspection:

- Intake: #00095758 / CI #2848-000007-23 was related to unknown cause of injury

The following Inspection Protocols were used during this inspection:

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

Section 2 (1)(c) of Ontario Regulations 246 / 22 defines "Physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

Rationale and summary
A resident struck another resident multiple times. As a result, a co-resident sustained injuries and severe pain and was transferred to the hospital for further assessment.

A Registered Practical Nurse (RPN) indicated that the resident who struck the other resident had a history of responsive behaviours and supposed to have a staff member monitoring them closely as per the specialist recommendation. However,

that staff supervision was not provided at the time of the incident. An Associate Director of Care (ADOC) confirmed that the resident experienced physical abuse by a co-resident with responsive behaviours.

Failure to protect the resident from physical abuse, resulted in injuries and a transfer to the hospital.

Sources: Two residents' clinical records, interviews with a RPN and an ADOC, home's CI report.
[741672]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOUR

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that for a resident who was demonstrating responsive behaviours, strategies were implemented to respond to their behaviours.

Rationale and summary
An physical altercation occurred between two residents. As a result of this incident, one of the residents sustained injuries and severe pain and was transferred to hospital for further assessment. Prior to the incident, the resident with responsive behaviours had altercations with other residents and staff. A specialist assessed the resident and recommended to provide staff supervision for residents' safety, however the staff were not present at the time of incident.

A Personal Support Worker (PSW) and a RPN who arrived to the site of the incident indicated there was no supervision of the resident by staff. An ADOC confirmed that the a staff member should have stayed with the resident at all times to prevent altercations.

Failure to implement support for the resident with responsive behaviours as per the specialist recommendation, has put the other resident at risk of physical abuse and injuries.

Sources: Clinical records review of the two residents, interviews with a RPN, PSW and an ADOC.
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