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: November 8, 2024

Inspection Number: 2024-1333-0002

Inspection Type:
Complaint
Critical Incident

Licensee: West Park Healthcare Centre

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 23-25, and October 1-4, 7-9, 15-17, 2024.

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00125701/ CI #2848-000021-24 was related to fall prevention and management.
- Intake: #00125582/ CI #2848-000020-24 was related to alleged abuse.
- Intake: #00116370/ CI #2848-000010-24 was related to disease outbreak.

The following CI intakes were completed during this inspection:

- Intakes: #00116355/ CI #2848-000011-24, #00123180/ CI #2848-000017-24, and #00126053/ CI #2848-000022-24 were related to fall prevention and management
- Intakes: #00120900/ CI #2848-000015-24, and #00129191/ CI #2848-000027-24 were related to disease outbreak.

The following complaint intakes were inspected:

- Intake: #00120847 was related to allegations of abuse and care related concerns.

- Intakes: #00127583 and #00127534 were related to allegations of abuse, neglect, and care related concerns.

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

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

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
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;

The licensee failed to ensure that a resident's written plan of care included a certain type of intervention for their safety.

Rationale and Summary
A review of resident's progress notes indicated that the resident was placed on a certain type of intervention for safety after a fall. However, this intervention was not documented in the resident's plan of care.

During two separate observations, the resident did not have the specific interventions.

Interviews with a Personal Support Worker (PSW) and Registered Nurses (RN) revealed that the specific intervention was necessary to supervise the resident and prevent falls. The staff acknowledged that this intervention should have been included in the resident's plan of care.

A review of resident's plan of care at a later date, confirmed that Registered Practical Nurse (RPN) had included the specific intervention.

Sources: Observations, CIS report, resident's clinical records including progress notes, interviews with staff.

Date Remedy Implemented: October 3, 2024

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
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;

The licensee has failed to ensure that the written plan of care for a resident, set out the planned care for the resident related to bed linens.

Rationale and Summary
Review of a resident's progress notes indicated that staff were to provide a specific type of bed linens. However, the resident's plan of care did not include directions for the staff to provide the linens.

Staff reported the linens had been provided to the resident for several months, but was not included in the resident's plan of care. This led to some staff being unaware of the resident's needs.

Director of Care (DOC) acknowledged that this information should have been included in the plan of care when the arrangement was first implemented.

Failing to include the required type of bed linens in the resident's plan of care posed a potential risk to the resident, as staff were unaware of the specific arrangement for the resident's care.

Sources: Resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care

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.

The licensee has failed to ensure staff removed specified items for safety, as specified in a resident's plan of care.

Rationale and Summary
The resident had an identified safety risk, and staff were instructed to check for and remove specific items from the resident's room.

An observation showed two identified items were not removed from the resident's room.

A PSW stated that they had performed a room scan but could not recall seeing the above-mentioned items and acknowledged that they may have missed noting these items. A RN and RPN both agreed that ongoing room monitoring every shift was necessary for the resident's safety.

The DOC stated that the staff were to remove the specified items to ensure the resident's safety.

Failure to remove the specified items from the resident's room posed a potential risk to their safety.

Sources: Observations in the resident's room, review of resident's clinical records, and interviews with the resident and staff.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 4.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
4. Auditing of infection prevention and control practices in the home.

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Lead conducted required auditing of infection prevention and control practices in the home for the quarter from July to September 2024.

Specifically, in accordance with the IPAC Standard for Long-Term Care Homes, issued by the Director April 2022, section 7.3 (b) stated that the IPAC lead is responsible for ensuring that audits are performed, at least quarterly, to ensure that all staff can perform the IPAC skills required for their role.

Rationale and Summary
During an onsite inspection, the inspector reviewed multiple IPAC audits conducted from July to September 2024. The home was unable to provide hand hygiene audits or audits of selection and donning and doffing of Personal Protective Equipment (PPE) specifically for all Physiotherapy staff.

The Infection Prevention and Control (IPAC) lead confirmed that there were no documented records of these audits and stated that it was the responsibility of the Physiotherapist (PT) to complete them for their staff. The PT acknowledged that they observed their staff performing IPAC practices but did not document these observations for the period from July to September 2024.

By failing to complete the required IPAC audits, as outlined in the IPAC Standard, there was a risk that staff were not performing their IPAC duties properly.

Sources: Review of available audits and staff interviews.

WRITTEN NOTIFICATION: CMOH and MOH

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, issued by the Ministry of Health, effective April 2024, were followed in the home. In accordance with these recommendations masking was recommended for staff during respiratory outbreaks.

Rationale and Summary
An Acute Respiratory Infection (ARI) outbreak was declared in a resident home area. However, on a specific date, it was observed that a Personal Support Worker (PSW) was not wearing a mask while interacting with multiple residents, despite the requirement for all staff to wear masks when on the unit during the outbreak.

Associate Director of Care (ADOC) stated that staff were required to wear surgical

face masks while on the unit that was under outbreak.

Failure to implement universal masking in the outbreak areas, for respiratory outbreak placed residents at risk of exposure and prolonged outbreak.

Sources: Observation, Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (Ministry of Health, April 2024), and interviews with staff.