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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Public Report

Report Issue Date: March 3, 2025
Inspection Number: 2025-1333-0001
Inspection Type: 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): February 25-27, 2025 and March 3, 2025
The inspection occurred offsite on the following date(s): February 28, 2025

The following Critical Incident (CI) intakes were inspected:
Intake: #00137223 – [CI: #2848-000004-25] – related to infectious disease outbreak
Intake: #00135950 – [CI: #2848-000031-24] – related to allegation of neglect of a resident
Intake: #00136768 – [CI: #2848-000002-25] – related to a fall resulting in injury

The following Critical Incident (CI) intake was completed:
Intake: #00135094 - [CI: #2848-000029-24] – related to infectious disease outbreak

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control

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 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure the provision of care set out in the plan of care was documented for a resident on 14 shifts in March 2024.

Sources: Resident's clinical records.

WRITTEN NOTIFICATION: Pain management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure that a resident was monitored for their response to, and the effectiveness of, their pain management strategies. On a specified date, a resident sustained a fall with injury. A Registered Nurse (RN) documented the

resident had a Pain Assessment in Advanced Dementia (PAINAD) scale score of five out of ten, and administered the resident's scheduled pain medication. An Assistant Director of Care (ADOC) acknowledged there was no follow up pain assessment conducted.

Sources: Resident's clinical records; and interview with ADOC.