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

Public Report

Report Issue Date: June 25, 2025
Inspection Number: 2025-1333-0003
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 dates: June 20 and June-23-25, 2025.

The following intake was inspected:

-Intake #00147147 with Critical Incident #2848-000012-25 related to a resident injury of unknown cause.

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

Resident Care and Support Services

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 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that registered staff collaborated with direct care staff in the development of a resident's plan of care, so the plan's interventions were clear and consistent, regarding their refusal to use a safety device.

The resident required staff to apply a safety device at all times. Two Personal Support Workers (PSWs) reported to registered staff multiple times that the resident refused to use the safety device. A Registered Practical Nurse (RPN) was aware and did not update the plan of care related to the resident's refusal of the safety device.

Sources: Resident's clinical record, the home's investigation notes, interviews with a PSW, RPN, and Resident Assessment Instrument (RAI) Coordinator.

WRITTEN NOTIFICATION: Plan of care

NC #002 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 that a resident was provided with a safety device at all times as specified in their plan of care.

A RPN and PSW confirmed that the resident was not using the safety device when the resident was found with an injury.

Sources: Resident's clinical records, the home's investigation notes, and interview with a RPN.