Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 16, 2013	2013_163189_0003	T-2191-12, T-36-13	Complaint

Licensee/Titulaire de permis

WEST PARK HEALTHCARE CENTRE
82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5

Long-Term Care Home/Foyer de soins de longue durée

WEST PARK LONG TERM CARE CENTRE
82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 17, 18, 22, 24, 2013

The following LOG's were inspected as part of this inspection and the findings are included in this report:
T-2191-12
T-2179-12
T-36-13

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Assistant Director of Care, Registered Staff, Physiotherapist, Personal Support Workers

During the course of the inspection, the inspector(s) Conducted walk through of resident and common areas
Reviewed health care records
Reviewed home's Falls management and Skin and Wound management policies

The following Inspection Protocols were used during this inspection:
Falls Prevention

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(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. 2007, c. 8, s. 6 (4).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other (a) in the assessment of the resident so that their assessment are integrated and are consistent with and complement each other.

The Personal Support Worker (PSW) reported to the inspector that on August 11, 2012, he/she had taken resident #2 to the washroom to use the toilet. The resident was on the toilet and he/she stepped outside the washroom to get the resident's wheelchair. The resident was left unattended on the toilet and fell.

The Physiotherapist reported to the inspector that while the resident was in the physiotherapy room around August 14, 2012, the resident complained of pain to his/her right leg and the Physiotherapist assessed the resident's leg to be very swollen and the resident unable to stand. The Physiotherapist reported that he/she notified the registered staff on the multi-disciplinary notes that the resident requires immediate assessment by the physician.

There is no indication that the resident was assessed by the registered staff or the physician related to the Physiotherapist assessment of August 14, 2012. The resident went out on a Leave of Absence with his/her spouse on August 17, 2012. The spouse called the home on August 17, 2012 and reported to the registered staff that the resident was in excruciating pain and will be transferred to the hospital for assessment. The resident was taken to hospital and was diagnosed with a fracture of the right hip. [s. 6. (4) (a)]

2. The licensee failed to ensure that the care set out in the plan of care is provided to resident # 1 as specified in the plan.

The plan of care for resident # 1 states that the resident requires 2 staff to use the ceiling lift while transferring the resident. The second staff member is to provide physical help and constant supervision. Resident #1 was not transferred with 2 direct care staff as required.

During an interview with resident #1 on April 18, 2013, the resident reported to the inspector that he/she was transferred on April 16, 2013 with a ceiling lift by identified PSW#1 while the housekeeping aide stood in the room and observed the PSW transfer the resident. The resident reported that the housekeeping aide has observed

such transfers on multiple occasions.

The housekeeping aide does not provide physical assistance as required in resident #1 plan of care. The housekeeping aide role does not include provision of direct care to residents.

The housekeeping aide was interviewed on April 18, 2013. He/she reported that on April 16, 2013, he/she stood and observed PSW # 1 transfer resident # 1 with a mechanical lift unassisted.

Interviews with both PSW # 1 and housekeeping aide confirms that PSW # 1 transferred resident # 1 unassisted with the ceiling lift while the housekeeping aide stood and observed on multiple occasions. [s. 6. (7)]

3. The licensee failed to ensure that the care set out in the plan of care is provided to resident # 5 as specified in the plan.

Plan of care for resident #5 states resident requires two staff to transfer for total assistance via mechanical lift. The resident is non weight bearing.

The housekeeping aide was interviewed on April 18, 2013. He/She reported that earlier in the day, he/she stood and observed PSW # 1 transfer resident # 5 with a mechanical lift unassisted.

Interviews with both PSW # 1 and housekeeping aide confirms that PSW # 1 transferred resident # 5 unassisted with the mechanical lift while the housekeeping aide stood and observed on multiple occasions. [s. 6. (7)]

4. The licensee failed to ensure that the care set out in the plan of care is provided to resident # 2 as specified in the plan.

Plan of care for resident #2 states resident is to be transferred to the toilet after meals and as needed (PRN) by hoyer lift. Resident is totally dependent for all aspects of toileting activity and is non weight bearing. Resident #2 was not transferred by hoyer lift as required.

The PSW reported to the inspector that on August 11, 2012, he/she wheeled the

resident into the washroom to use the toilet. The resident held onto the hand rail and was transferred by the PSW to the toilet. While the resident was on the toilet, he/she stepped outside the washroom to get the resident's wheelchair. The resident was left unattended on the toilet and fell. The resident was diagnosed with a fracture of the right hip on August 17, 2012. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan of care, and to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

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1. The licensee failed to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered staff (iii) upon any return of the resident from an absence of greater than 24 hours.

On June 8, 2012, registered staff completed a Braden Skin Assessment and identified resident #2 as moderate risk for skin breakdown.

Between June 2012 and September 2012, resident #2 went out on three Leaves of Absence (LOA) with his/her spouse for the weekend. Upon return from his/her LOA, the resident did not receive a skin assessment by a registered staff as required. [s. 50. (2) (a) (iii)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments.

On August 15, 2012, during resident #2's scheduled shower, the PSW identified the resident having skin breakdown to his/her coccyx area. PSW reported to the inspector that he/she completed the Head to Toe Skin assessment documentation on that day and noted the area of redness to the resident's coccyx. PSW states that this was reported to the registered staff.

Interview with the registered staff confirmed that the PSW reported the skin breakdown to him/her, but the registered staff did not conduct a skin assessment. The resident was admitted to the hospital on August 17, 2012 and came back to the home on August 20, 2012 with a Stage 3 pressure ulcer to his/her coccyx. [s. 50. (2) (b) (i)]

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Issued on this 17th day of May, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs