Ontario

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
Apr 29, 2013	2013_162109_0019	T060-13	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

SUSAN SQUIRES (109)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 17, 18, 22, 23, 24, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, registered staff, personal support workers, residents, physiotherapist, volunteer coordinator/Activation manager

During the course of the inspection, the inspector(s) conducted a walk through of the care units, observed care activities, reviewed health records for identified residents, reviewed continence care and falls prevention policies, incontinence supplies

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Falls Prevention

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.
Record review revealed that resident # 11 was assessed as being at a high risk for falls. According to the falls management program, high risk residents have a "falling leaf" symbol posted on the bedroom door. The PSW staff stated to the inspector that the falling leaf symbol alerts them to who is at a high risk for falls. The PSW staff did not identify resident # 11 as being at a high risk for falls.
Resident # 11 does not have a falling leaf symbol posted on his/her door to alert staff of his/her risk of falling. The resident has sustained multiple falls since his admission to the home in September 2012. [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care sets out clear directions to the staff and others who provide direct care to the resident.
The plan of care for resident # 12 who is identified as being incontinent lacks clear direction for the direct care staff regarding the type and size of incontinent product to use. According the the home's updated continence lists (Resident Profile Worksheet) which identifies the size and type of continence care product to use on each of the incontinent residents, resident # 12 does not use an incontinence product. The plan of care does not identify the type and size of incontinent product to use on the resident. On April 23, 2013 the resident was wearing a medium brief because the PSW staff stated that the resident was incontinent. [s. 6. (1) (c)]

3. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan of care.
Resident # 11 has been identified to be at a high nutritional risk due to choking, aspiration and malnutrition. Resident has been losing weight over the past several months
In February 2013 resident had lost 12.1 % in 3 months
In November 10/12 resident had lost 5.9 % in one month and 14% in 3 months

The plan of care stated to provide resident with a nosey cup for soup and to ensure that the resident has 2 desserts at lunch and dinner.
On April 18, 2013 during the lunch meal, the resident was not provided with a nosey cup to eat his/her soup.
Resident # 11 was also not provided with a second dessert, [s. 6. (7)]

4. The licensee failed to ensure that the care set out in the plan of care is provided to

the resident as specified in the plan.
The plan of care for resident # 15, who is identified as being incontinent, states to provide a large brief. On April 23, 2013 the resident was wearing a medium sized brief instead of the large.
The plan of care for resident # 17 who is identified as being incontinent states to provide a day pad liner. On April 23 the resident was wearing a large brief instead of the liner.
The plan of care for resident # 20 states that she/he uses a large brief. On April 23 the resident was wearing a medium brief [s. 6. (7)]

5. The licensee failed to ensure that the plan of care is reviewed and revised at least every 6 months and at any other time when the resident's care needs change or care set out in the plan of care is no longer necessary.
Resident # 11 was identified as high risk for falls and had experienced several falls since his/her admission to the home in September, 2012. On February 26, 2013 the post falls analysis revealed that the resident was left unattended on the toilet and then fell. The falls analysis revealed that the resident should not be left alone when he is on the toilet.
The plan of care was not revised to reflect this analysis to ensure that the resident was safe from falls.
Resident # 11 has had 2 more falls since February 25, 2013. The PSW staff stated that he could be left sitting on the toilet. [s. 6. (10) (b)]

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 plan of care sets out clear directions to staff and other who provide direct care to the resident, 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 plan of care is revised when the resident's care needs change or the care set out in the plan is no longer necessary to ensure that the resident is safe from falls, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
Resident #11 assessed as being at a high risk for falls has sustained at least 12 falls since his/her admission in September 2012.

The homes post falls assessment tool was not completed until December 2012 and a second assessment was completed in March 2013. There was no post falls assessment conducted using a clinically appropriate assessment instrument for any of the other falls. [s. 49. (2)]

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 when a resident has fallen, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.
The following maintenance issues were observed during the walk through on April 17, 2013:
- In an identified resident room the closet/wardrobe door was broken off of the hinge and was hanging in an unsafe manner. Inspector spoke to resident # 14 who stated that the closet door door has been off hinges for over a week. The home corrected the broken door when Inspector pointed it out to the management.
- There were holes in the drywall in the doorway of a resident room.
- An identified resident room has extensive damage in the room. The flooring in the bathroom is damaged, the cabinet in the bathroom is torn off of the wall and there is wall damage in the room. [s. 15. (2) (c)]

Issued on this 1st day of May, 2013

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