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**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

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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 |
|---|---|---|---|
| Feb 10, 2014 | 2014_312503_0003 | T-272-13 | 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**

LAURA BROWN-HUESKEN (503)

**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): January 20, 21, 22, 2014**

**During the course of the inspection, the inspector(s) spoke with Resident, Personal Support Workers, Laundry staff, Food Services Workers, Registered Nursing staff, Dietary Manager and Support Services Manager.**

**During the course of the inspection, the inspector(s) observed meal and snack services and provision of care to residents, reviewed clinical records, toured Prittie House area common areas, servery, dining room and residents' rooms, toured kitchen, inspected residents' closets/wardrobes, reviewed resident council minutes and family council minutes, and reviewed policies related to meal service, snack service and laundry service.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Nutrition and Hydration**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 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.<br><br>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. (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 the care set out in the plan of care is provided to the resident as specified in the plan.

During the lunch meal service on January 20, 2014, a Personal Support Worker (PSW) was observed to ask Resident 001 whether the resident would like sugar in the coffee. Resident 001 was unable to answer the question. Resident 001 was served coffee with 1 sugar and milk. Resident 001 consumed only sips of the coffee during the meal. The home area's diet list, located in the servery, notes Resident 001's preference to have coffee with specific ingredients added at all meals, not the 1 sugar and milk which were added. Resident 001's written plan of care also instructs staff to provide the resident coffee with specific ingredients at all meals. [s. 6. (7)]

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the home's Snack and Nourishment Service policy was complied with.

The home's Snack and Nourishment Service policy RESI-05-02-03, version November 2013 instructs staff to ensure special labeled items, supplements and nourishments are not left at the bedside unless otherwise indicated by the resident/family/substitute decision maker and noted in the plan of care. On January 21, 2014 Resident 001 was observed asleep in bed with a labeled afternoon nourishment drink on the bedside table. Resident 001's written plan of care did not indicate an exception to this policy. In an interview with the Dietary Manager it was confirmed that the labeled nourishment drink should have been returned to the fridge if the resident was sleeping and that the aforementioned policy had not been complied with. [s. 8. (1)]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

During the lunch meal service observation on January 22, 2014 the posted menu indicated a choice of whole wheat vegetable lasagna, texas garlic toast, and green peas or steak and mushroom pot pie and mixed green salad. Resident 003 was observed to be served the lasagna and peas, but not the texas garlic toast. Interviews with PSW and Food Services Worker (FSW) confirmed that Resident 003 was not served a texas garlic toast. In an interview with the Registered Dietitian it was confirmed that the resident's written plan of care and the therapeutic spreadsheet for the meal indicated that the garlic toast was to be offered to Resident 003. An interview with the Dietary Manager indicated that FSWs are to serve residents according to the residents' diet order and corresponding meal items outlined in the therapeutic spreadsheet. [s. 71. (4)]

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control**
**Specifically failed to comply with the following:**

**s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that immediate action is taken to deal with pests.

Progress notes and communication/pest spotting book for the contracted pest control company Orkin, located in the second floor nurses station, indicates that a cockroach was spotted in the room of Resident 001 on December 8, 2013. Review of Orkin service reports from December 10, 2013, December 19, 2013 and January 14, 2014 do not reveal that area was inspected or that treatment was applied to the area where the cockroach was reported. In an interview with the Support Services Manager it was confirmed that no action had been taken with respect to this cockroach sighting. [s. 88. (2)]

**Issued on this 10th day of February, 2014**

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

L Brown-Huesken.