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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 26, 2014	2014_163109_0008	T-627-13	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), MATTHEW CHIU (565)

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): March 6, 7, 10 ,11, 2014.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered nursing staff, Personal Support Workers (PSW)

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, record review of identified residents health record, review of falls prevention policies and procedures

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

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.) 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. 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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care regarding the use of mechanical lift to transfer resident was provided to the resident as specified in the plan.

Record review of the current care plan stated resident #8 requires extensive assistance with 2 staffs to transfer from bed to chair using a total lift and full sling. The use of the standing lift and half sling with 2-person assist is required for toileting transfer for resident #8.

Staff interview revealed that an identified staff member has never used a total lift for resident #8 for any transfers. The staff member stated that she/he has only used the standing lift with 2-person assist for transferring because the resident can hold onto the standing lift as required during transfer. On March 11, 2014, the identified staff member stated that she/he transferred the resident from the bed to the wheelchair that morning using a standing lift instead of the total lift with full sling. [s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care related to bed rail use was provided to the resident as specified in the plan.

Record review identified that the use of bed rails was not indicated for this resident. On March 10, 2014, resident #8 was observed lying on the bed with full length bed rails in up position on both sides of the bed.

Interview with staff members confirmed that no bed rail should be used when the resident is lying in bed. [s. 6. (7)]

3. The licensee failed to ensure that the staff who provide direct care to a resident is kept aware of the contents of the plan of care related to checking resident hourly for safety.
Record review of the current care plan revealed that resident #8 is to be checked every hour for safety during identified periods when risk for falls is increased.

Interview with staff revealed that an identified staff member was not aware of the hourly safety checks for resident #8. [s. 6. (8)]

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 ensure that the care set out in the plan of care regarding the use of mechanical lift is provided to resident #8 as specified in the plan, and to ensure that the staff who provide direct care to resident #8 are kept aware of the contents of the plan of care, to be implemented voluntarily.

Issued on this 26th day of March, 2014

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