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

Original Public Report

Report Issue Date: March 30, 2023	
Inspection Number: 2023-1333-0002	
Inspection Type: Critical Incident System	
Licensee: West Park Healthcare Centre	
Long Term Care Home and City: West Park Long Term Care Centre, Toronto	
Lead Inspector JulieAnn Hing (649)	**Inspector Digital Signature** Julie ann Hing Digitally signed by Julie ann Hing Date: 2023.04.13 10:21:32 -04'00'
Additional Inspector(s) Reji Sivamangalam (739633) Yannis Wong (000707) was present during this inspection.	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 24, 27, 28, March 1, 2, 3, 6, and 8, 2023.

The following intake(s) were inspected:

- Intake: #00002759, Critical Incident (CI) #2848-000013-21 related to a fracture of unknown cause.
- Intake: #00014794, CI #2848-000025-22 related to falls prevention and management.
- Intake: #00015033, CI #2848-000026-22 related to resident to resident physical abuse.
- Intake #00015474, CI #2848_000027_22 related to improper treatment.
- Intake: #00016823, CI #2848-000029-22 were completed during this inspected related to an injury with a significant change in condition.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours

Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that their hand hygiene program was implemented in accordance with any standard issued by the Director.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 stated that the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary:

On February 27, 2023, on an identified home area, there were expired hand sanitizer products found on three wall-mounted units; two hand sanitizer products were found on the screening station and one on the testing area for Rapid Antigen Test.

The Infection Prevention and Control (IPAC) Manager acknowledged that the expired products should have been replaced and might not be effective.

There was a risk of infection transmission when expired products were used for hand hygiene.

Sources: Observations and interview with Housekeeper, Screener and IPAC Manager. [739633]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that staff collaborated in resident's assessment followed by physician's referral to Behavioral Support Ontario (BSO).

Rationale and Summary:
As a result of a resident’s fall, the physician requested a BSO assessment. The home's Responsive Behavior Manager verified that they did not receive a referral, and an assessment was not completed

related to the physician's referral. The Director of Care (DOC) confirmed that staff were expected to send a referral to the Responsive Behavior Manager after the physician's request, and a referral was not made.

There was a risk when the BSO assessment was not completed related to resident's fall.

Sources: Resident's clinical records, interview with the Physician, Responsive Behavior Manager and DOC. [739633]

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 131 (2)

The licensee has failed to ensure that medication was given to the resident as prescribed by the physician.

Rationale and Summary:
The resident sustained a fall and was experiencing pain. As a result, the physician ordered a change in their pain medication. The resident continued receiving the previous dose of pain medication for a number of days, despite the physician's order for a change in the resident's pain medication. The Registered Practical Nurse (RPN) and DOC acknowledged that the pain medication should have been administered as per the physician's order and that the resident was at risk of pain not being managed.

Sources: The physician's order, Medication Administration Records (MAR), resident's assessments and progress notes, interview with RPN and DOC. [739633]

WRITTEN NOTIFICATION: Medication management system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to comply with the home's policies, developed for medication management system.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that the home's receiving medications policy related to receipt of medication, information security policy related to authentication of user, and accurate administration and documentation of medications was complied with.

Rationale and Summary:

(i) Specifically, staff did not comply with the home's receiving medications policy that directed staff to sign the shipping report for residents' strip pack medications.

Review of Care Medical pharmacy daily shipping report with the resident's medications indicated it had not been signed by staff as was directed in the above policy.

A RPN advised that the daily shipping report should have been signed by the nurse.

Staff failure to sign the shipping report for receipt of the resident's medication to put the resident at risk for medication discrepancy.

Sources: Review of Care Medical Corporation shipping report, printed at 1605 hours, home's Receiving Medications (policy #4-11, last revised September 2019), interviews with RPN, and other relevant staff.

Rationale and Summary:
(ii) Specifically, staff did not comply with the home's medication management policy that directed staff to ensure that medications were not prepared in advance (pre-poured), and immediately document all medications administered on the MAR.

The home submitted a CI report related to an incident of resident to resident, physical abuse, where the resident sustained an injury.

Residents on different home areas on different days had all their medications administered and/or documented within a period of two to 12 minutes.

A RPN admitted to pre-pouring residents' medications in advance.

A RN advised that when the medication cart computer was not working due to internet issues they would give four or five residents' medications at the same time, and then sign for them all at once on the desktop computer. When there were no issues with the medication cart computer or no internet issues they gave medication at the resident's room entrance and may not sign immediately, instead move to the next resident and administer medication and then and sign for everything.

A RN acknowledged that they had administered residents' medications but had not immediately signed for the administration and may see this practice on other days.

The home was unable to provide any evidence of any internet issues affecting medication administration on the above-mentioned dates.

Failure of registered staff to sign for medications at the time of administration put the resident at risk for medication errors.

Sources: Review of home's medication admin audit report for November 2022 and February 2023 for several home areas, home's policy titled medication management (policy #RC-16-01-07, last reviewed

January 2022), interviews with RPN, RNs, and other relevant staff. [649]

WRITTEN NOTIFICATION: Medication management system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary:
A resident returned to the Long-Term Care Home after an external leave of absence. They had medications scheduled for two separate administration times. Their medication audit report indicated that the scheduled medications were administered and documented all at the same time.

A RPN acknowledged that the physician's orders were not followed.

Staff failure to administer and document medications at scheduled times put the resident at risk for future responsive behaviors.

Sources: CI #2848-000026-22, review of resident's medication admin audit report, interviews with RPN and other relevant staff. [649]

COMPLIANCE ORDER CO #001 Prevention of abuse and neglect

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 24 (1) [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:
(i) Ensure residents visiting the hairdresser are protected from injury.
(ii) Ensure that the resident is protected from abuse.
(iii) The plan should include identified staff roles and responsibilities, and a timeline is to be established for the implementation of each component steps (i) through (ii) within the compliance due date.

Please submit the written plan for achieving compliance for inspection #2023-1333-0002 to JulieAnn Hing (649), LTC Homes Inspector, MLTC, by email to torontodistrict.mltc@ontario.ca by April 13, 2023. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to ensure that two residents were protected from abuse.

(i) Section 2 (1) of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary:
The home reported that a resident sustained injuries after a visit to the hairdresser.

Staff interviews indicated that the resident sustained injuries after a scheduled visit to the hairdresser.

Sources: Review of CI report #2848-000027-22, resident's clinical record, home's investigation notes, and interviews with RPN, and DOC. [649]

(ii) Section 2 (1) of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident ("mauvais traitements d'ordre physique").

Rationale and Summary:
A resident had a physical interaction with another co-resident, despite an intervention from staff. During the physical interaction, one of the residents sustained an injury.

A PSW who witnessed the above interaction between the two residents confirmed what had occurred between the two residents.

Sources: Review of CI #2848-000025-22, home's investigation notes, review of two residents' clinical records, interviews with PSW, and other relevant staff.

This order must be complied with by May 11, 2023

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.