Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
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Original Public Report

Report Issue Date: April 24, 2024	
Inspection Number: 2024-1333-0001	
Inspection Type: Critical Incident	
Licensee: West Park Healthcare Centre	
Long Term Care Home and City: West Park Long Term Care Centre, Toronto	
Lead Inspector Adelfa Robles (723)	**Inspector Digital Signature**
Additional Inspector(s) Lisa Salonen Mackay (000761)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 9-12 and 15-18, 2024

The following intake(s) were inspected:

- Intake: #00103463/Critical Incident (CI) #2848-000012-23 related to COVID-19 outbreak
- Intake: #00103615/CI #2848-000014-23; Intake: #00106215/CI #2848-000002-24; Intake: #00103594/CI #2848-000013-23, see intake #00103615 – were all related to alleged resident neglect
- Intake: #00109668/CI #2848-000007-24 – related to alleged staff to resident physical abuse
- Intake: #00107915/CI #2848-000005-24 – related to a fall with injury

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
ii. give or refuse consent to any treatment, care or services for which their consent is required by law and to be informed of the consequences of giving or refusing consent,

The licensee has failed to ensure that a resident's right to consent for treatment was respected.

Rationale and Summary:

A CI report submitted by the home indicated a resident raised their voice when asking a staff to leave their room. The home's investigation notes indicated the resident refused to change the orientation of their equipment when the staff intended to provide them with care.

The resident stated they refused care and raised their voice asking staff to leave but the staff continued to provide care. Another staff stated the resident reported that they refused care, but the staff continued providing care. The staff stated they completed to provide care to the resident.

The home stated that the staff should have asked and waited to receive consent from the resident and that staff were expected to stop and reapproach residents who refused care.

Providing care to a resident in spite of their refusal violated the resident's bill of rights as it was related to consent.

Sources: Home's investigation notes, CI report #2848-000007-24 and staff interviews.

[723]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The Licensee has failed to ensure that continence care provided to a resident was documented.

Rationale and Summary:

The home submitted a CI report related to a care concern of a resident resulting to hospitalization.

Review of a resident's clinical records at a specified time revealed no staff sign off to indicate if care was provided. Staff stated they were expected to document care as provided. The staff assigned to the resident at a specified time stated they provided care to the resident as per their routine but failed to document. The home stated that based on their investigation, the staff provided care, but it was not documented.

There was a potential that follow up care would be missed when staff failed to document care as provided in the resident's plan of care.

SOURCES: A resident's clinical records and staff interviews.

[723]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the

information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that The Director was informed immediately when an alleged staff to resident abuse was reported to the home.

Rationale and Summary:

A CI report submitted by the home indicated an alleged staff to resident abuse. The home initiated an investigation, and the director was informed two days after it was reported to the home.

A staff stated they informed the home about the alleged staff to resident abuse. The home stated that allegation of abuse and neglect should have been reported to The Director immediately.

Failure of the home to inform The Director immediately of any allegation of abuse did not place the resident at risk.

Sources: Home's investigation notes, CI Report #2848-000007-24 and staff interviews.

[723]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours

s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to ensure that written strategies were in place to prevent, minimize and respond to a resident's responsive behaviours.

Rationale and Summary:
A resident was observed with escalating responsive behaviours. Review of the resident's plan of care did not include any focus on responsive behaviours.

The home's policy indicated that a plan of care should be developed to address the risk of any identified behaviours and provide interventions and strategies to manage the behaviours.

Staff interviews indicated that the resident had responsive behaviours. The home stated that all responsive behaviours should be included in a resident's plan of care.

Failure to ensure that a resident's triggers and written approaches to care were developed increased the risk of ineffectively managed responsive behaviours.

Source: Responsive Behaviour Policy (revised March 2023), a resident's clinical records and staff interviews.

[000761]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement a protocol issued by The Director with respect to infection prevention and control.

The license has failed to ensure Personal Protective Equipment (PPE) was used in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard) as required by Additional Precaution 9.1(f) under the IPAC Standard.

Rationale and Summary:
During a COVID-19 outbreak, a staff was observed going to a resident's room with no gown, wearing a surgical mask under a N95 mask. Signage on residents' room entrance indicated the resident was on enhanced IPAC precautions. The staff acknowledged that the room they entered required additional IPAC precautions and confirmed they entered the room without donning the required PPE.

The home confirmed that when entering the room of a resident on enhanced IPAC precautions, all staff were expected to wear full PPE. The home also stated that wearing a surgical mask under a N95 mask and not wearing a gown prior to

entering a resident's room on enhanced IPAC precautions did not meet expectations.

Failure to follow enhanced IPAC precautions increases the risk of infection transmission.

Source: Observations in the home, IPAC Standards and staff interviews.

[000761]