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
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Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
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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
Nov 30, 2012	2012_174189_0010	T-578-12, T-855-12, T-3005-11	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

NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): November 19, 20, 21, 22, 2012

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Registered Staff, Personal Support Workers

During the course of the inspection, the inspector(s) Reviewed health care records, reviewed training materials, reviewed Lifts and Transfer Policy

The following LOGs were inspected as part of this inspection:
T-3005-11, T-578-12, T-855-12

The following Inspection Protocols were used during this inspection:
Personal Support Services

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.) 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Plan of care for resident #1 states resident requires two staff to transfer via ceiling lift or mechanical lift. Resident #1 is non weight bearing and at risk for falls related to inability to transfer self.

On December 20, 2011, a Personal Support Worker(PSW) transferred the resident manually from bed to wheelchair without the use of a mechanical lift and without a second person assisting. The resident sustained a undisplaced fracture of the left leg.

Resident informed inspector that on the morning on December 20, 2011, the PSW manually lifted him/her from the bed to the wheelchair, and during that transfer his/her left leg hit against the foot rest and went backwards. Resident reported to inspector that he/she is unable to transfer self and that the usual method of transfer is with the use of a mechanical lift and second person assisting.

Resident #1 also informed inspector that on occasions he/she is transferred with a ceiling lift by staff without a second person assisting.

Staff interviews confirmed that an identified PSW transferred the resident from bed to wheelchair using the ceiling lift without a second person assisting on multiple occasions. [s. 36.]

2. On March 9, 2012, resident #3 sustained a serious injury when a Personal Support Worker (PSW) transferred the resident from his/her wheelchair to the toilet and left the resident unattended on the toilet. The resident fell from the toilet and sustained a fractured skull. [s. 36.]

3. On April 15, 2012, resident #2 was transferred by a PSW with a mechanical lift. The PSW did not apply the sling correctly resulting in resident's legs dangling and spread wide apart during transfer. Staff interview confirmed that resident was not positioned properly in the mechanical lift and that resident complained of pain following the transfer. [s. 36.]

4. [this finding was combined with finding #1] [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for resident #4 provides clear directions to staff and others who provide direct care to the resident.

Staff interviews revealed that resident #4 is transferred by ceiling/hoyer lift. The lift log in the resident room indicated that the resident requires a full hoyer mechanical lift.

The written plan of care for resident #4 states the resident requires two staff to transfer resident via mechanical standing lift from bed to chair for safety. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care is provided to resident #3 as specified in the plan.

Plan of care for resident #3 states resident is High Risk for falls, unsteady gait, and frequent falling related to disease process. Resident's memory loss affects his/her safety and may fall if he/she gets up.

On March 9, 2012. a Personal Support Worker (PSW) transferred the resident from his/her wheelchair to the toilet and left the resident unattended. The resident fell from the toilet and sustained a fractured skull.

Staff interviews confirmed that the resident is wheelchair bound with limited mobility and that the resident was not to be left unattended. [s. 6. (7)]

3. The licensee failed to ensure that the care set out in the plan of care is provided to resident #1 as specified in the plan.

Plan of care for resident #1 states resident requires two staff to transfer via ceiling lift or mechanical lift. Resident is non weight bearing and at risk for falls related to inability to transfer self.

On December 20, 2011, a Personal Support Worker(PSW) transferred the resident manually from bed to wheelchair without the use of a mechanical lift and without a second person assisting. The resident sustained a undisplaced fracture of the left leg.

Resident informed inspector that on the morning on December 20, 2011, the PSW manually lifted him/her from the bed to the wheelchair, and during that transfer his/her left leg hit against the foot rest and went backwards. Resident reported to inspector

that he/she is unable to transfer self and that the usual method of transfer is with the use of a mechanical lift and second person assisting.

Resident #1 also informed inspector that on occasions he/she is transferred with a ceiling lift by staff without a second person assisting.

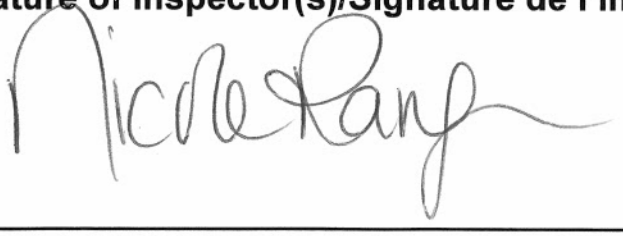
Staff interviews confirmed that an identified PSW transferred the resident from bed to wheelchair using the ceiling lift without a second person assisting on multiple occasions. [s. 6. (7)]

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 written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident; and the licensee ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 17th day of December, 2012

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



Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NICOLE RANGER (189)
Inspection No. / No de l'inspection :	2012_174189_0010
Log No. / Registre no:	T-578-12, T-855-12, T-3005-11
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 30, 2012
Licensee / Titulaire de permis :	WEST PARK HEALTHCARE CENTRE 82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5
LTC Home / Foyer de SLD :	WEST PARK LONG TERM CARE CENTRE 82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~TRISH TALABIS~~ Josée Goulet-Kack NR

To WEST PARK HEALTHCARE CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning techniques when assisting resident #1 and resident #3. Please submit plan to Nicole.Ranger@ontario.ca by December 10, 2012

Grounds / Motifs :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Plan of care for resident #1 states resident requires two staff to transfer via ceiling lift or mechanical lift. Resident is non weight bearing and at risk for falls related to inability to transfer self.

On December 20, 2011, a Personal Support Worker(PSW) transferred the resident manually from bed to wheelchair without the use of a mechanical lift and without a second person assisting. The resident sustained a undisplaced fracture of the left leg.

Resident informed inspector that on the morning on December 20, 2011, the PSW manually lifted him/her from the bed to the wheelchair, and during that transfer his/her left leg hit against the foot rest and went backwards. Resident reported to inspector that he/she is unable to transfer self and that the usual method of transfer is with the use of a mechanical lift and second person assisting.

Resident #1 also informed inspector that on occasions he/she is transferred with a ceiling lift by staff without a second person assisting.

Staff interviews confirmed that an identified PSW transferred the resident from bed to wheelchair using the ceiling lift without a second person assisting on multiple occasions.
(189)

2. On March 9, 2012, resident #3 sustained a serious injury when a Personal Support Worker (PSW) transferred the resident from his/her wheelchair to the toilet and left the resident unattended on the toilet. The resident fell from the toilet and sustained a fractured skull. (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 25, 2013

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30th day of November, 2012

Signature of Inspector / Signature de l'inspecteur : Nicole Ranger

Name of Inspector / Nom de l'inspecteur : NICOLE RANGER

Service Area Office / Bureau régional de services : Toronto Service Area Office