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

**Hamilton District**
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

# Original Public Report

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| **Report Issue Date: April 29, 2024** | |
| **Inspection Number:** 2024-1265-0001 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident | |
| **Licensee:** The Central Canadian District of the Christian and Missionary Alliance in Canada | |
| **Long Term Care Home and City:** CAMA Woodlands Nursing Home, Burlington | |
| **Lead Inspector**<br>Jennifer Allen (706480) | **Inspector Digital Signature**<br>Jennifer L Allen Digitally signed by Jennifer L Allen<br>Date: 2024.05.01 13:05:24 -04'00' |
| **Additional Inspector(s)**<br>Olive Nenzeko (C205)<br>Stephanie Smith (740738) | |

# INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): **April 16, 18-19, 22-24, 2024.**

The following intake(s) were inspected:

- Intake: #00103671 - Critical incident (CI) related to Falls Prevention and Management
- Intake: #00110497 - Complaint related to concerns with Abuse and Neglect Prevention.

- Intake: #00111669 - Complaint related to concerns with Resident Care and Support Services.
- Intake: #00111897 - Critical incident (CI) related to Disease Outbreak.

The following intakes were completed in this inspection:
Intake #00109063 and Intake #00109570, were related to Disease Outbreak.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Documentation

NC #001 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 the provision of the care set out in the plan of care was documented for the residents.

**A. Rationale and Summary**
A resident's care record was missing documentation for their Activities of Daily

Living (ADLs) for a specified period of time.

The Director of Care (DOC) acknowledged that staff should complete documentation each shift and cited short staffing as a contributing factor for it not being completed.

**Sources:** Resident's clinical record, interview with DOC.
[740738]

**B. Rationale and Summary**
Another resident was noted to have missing ADL documentation for a different specified period.

Staff confirmed that ADL documentations were required for every shift and should be recorded at close to the time the care was provided as possible. The DOC stated that the staff should document the care provided in the computer system before the end of their shift and should have completed the documentation for the identified missing entries.

Failing to ensure that the provision of the resident care set out in the plan of care for the residents was documented increased the risk that care was not provided and potential miscommunication between staff.

**Sources**: Resident's health record and Interviews with the DOC and other staff.
[706480]

## WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (10) (b)**

Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was revised when the resident's care needs changed or care set out in the plan was no longer necessary.

**Rationale and Summary**
A resident's plan of care stated that specific items would not be available to the resident and would only be provided if the resident met certain criteria.

A registered staff member confirmed that the plan of care required updating as the resident was allowed to those specific items.

**Sources:** Resident's care plan, interview with a registered staff member.
[740738]

## COMPLIANCE ORDER CO #001 Plan of care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: FLTCA, 2021, s. 6 (7)**
Plan of care
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.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

The licensee must ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Specifically, the licensee must:
A)

- Ensure that all staff who work on designated home area are re-educated on a resident's plan of care related to safety measures and harm prevention.
- Maintain a record of the education provided, who provided the education, the date it occurred, and a sign-off sheet of all staff who completed the education.

B)

- Ensure that all staff are re-educated on the home's falls prevention program and the importance of adhering to falls interventions, including bed alarms, as outlined in the resident's plan of care.
- Maintain a record of the education content, who provided the education, when it was provided, and a sign-off sheet of all staff who completed the education.

**Grounds**

The licensee has failed to ensure that the care set out in the plan of care was provided to the residents as specified in the plan.

**A. Rationale and Summary**

A resident's plan of care indicated that they were not to receive specific items. On a specified day, the resident was transferred to hospital from an injury acquired from that specific item.

A registered staff member confirmed that the resident sustained an injury from

that specific item.

Failure to ensure that the resident was not provided that specific item as per their plan of care led to actual harm to the resident.

**Sources:** Resident's progress notes, interview with staff.
[740738]

**B. Rationale and Summary**

Another resident sustained a fall resulting in an injury.

The resident's care plan identified that the resident was at high risk for falling, and falls interventions included the use of a specific device.

A staff member acknowledged that the resident did not have the device in place at the time of the fall, but that one was put in place after the occurrence.

Failure to implement the resident's falls intervention increased the resident's risk of falling.

**Sources:** Resident's clinical record; Interview with staff.
[C205]

**This order must be complied with by July 5, 2024.**

## 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

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.