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

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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
Sep 16, 2014	2014_168202_0018	T-1146-14	Complaint

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

Long-Term Care Home/Foyer de soins de longue durée

THE WOODHAVEN
380 Church Street, MARKHAM, ON, L6B-1E1

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

VALERIE JOHNSTON (202)

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): September 09, 10, 11, 2014.

During the course of the inspection, the inspector(s) spoke with the administrator, assistant director of care(ADOC), resident care coordinator, registered nursing staff, personal support workers, resident.

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, reviewed the home's policies related to fall's prevention.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Personal Support Services

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).

Findings/Faits saillants :

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

A review of the clinical records for an identified period of time for resident #01, indicated that on an identified date, the resident was found on the floor in his/her room. The resident complained of pain and was sent to hospital for further assessment. The resident returned to the home nine days later with multiple diagnoses. On an identified date, annual blood work had been scheduled for the resident, however, the progress notes indicated that the resident had refused. Staff interviews indicated that the resident often refuses blood work testing, however, when a resident refuses, the blood work is rescheduled for the following week and each week thereafter until results are obtained. An interview with the ADOC confirmed that the annual blood work scheduled for resident #01 on the identified date, was missed and not provided to the resident as specified in the plan of care. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #01's plan of care identified the resident as high risk for falls, uses a wheelchair for mobility, will attempt to self transfer and requires staff assistance for transferring. The home's falls prevention policy, LTCE-CNS-G-10, revised January 2013, directs registered staff to document an 'Occurrence Note' in the progress notes in the event of a resident fall. Registered staff interviews indicated that the required 'Occurrence Note' is considered a clinically appropriate assessment instrument that is specifically designed for falls. A review of resident #01's clinical records for an identified period of time, indicated that the resident had a fall on three identified dates, without injury. The ADOC confirmed in an interview that resident #01 had not been assessed using a clinically appropriate assessment instrument specifically designed for falls for the above mentioned three falls. [s. 49. (2)]

Issued on this 17th day of September, 2014

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