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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 2, 2016	2016_377502_0003	031805-15	Complaint

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
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

JULIENNE NGONLOGA (502)

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): January 27, 28, February 1, and 5, 2016.

This complaint inspection is related to a complaint regarding allegations of neglect to a resident. It will be inspected concurrently with a critical incident the home submitted related to staff to an injury in respect of which a person is taken to hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Coordinator (RCC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist (PT), Physiotherapist Assistants (PTAs) and residents, substitute decision-maker (SDM).

The inspector observed the provision of care, staff to resident interactions; reviewed resident's health records, staffing schedules, staff training records, home's record and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

Review of resident #001's progress notes confirmed the resident had an identified medical procedure on a specified date as result of a fall sustained a day before. Review of Physiotherapist (PT) assessment with an identified date, revealed staff #109 has made recommendations related to resident #001's transfer and mobility.

Interviews with staff #100, staff #101, staff #109 and staff #115 confirmed resident #001's transfer and mobility was changed until an identified date, when he/she was transferred to the hospital.

Review of resident #001's plan of care gives no indication of the PT's recommendations.

Interview with staff #114 and staff #115 confirmed the plan of care was not reviewed and revised to include the above mentioned PT's recommendations. [s. 6. (10) (b)]

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 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 the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Review of the home's policy titled "Palliative, Pain and Symptom Control" #LTC-CA-WQ-200-05-04, and revised on November 2014, revealed the following:
- Pain assessment will be completed quarterly and frequently if a resident experiences more pain or new pain.
- Registered staff are to follow up verbal reports from care staff by assessing the resident for new or an exacerbation of current pain by using a numerical score of the pain for cognitively well resident.

Review of resident #001's progress notes for an identified period of time, revealed the resident had multiple medical procedures on specified dates. Further review of the progress notes confirmed on multiple occasions, resident #001 had complaint of pain.

Review of resident #001's pain assessment records gives no indication that the resident was assessed on specified dates when he/she had complaint of pain, as indicated in the above policy.

Interviews with staff #105, staff #106, and staff #114 confirmed resident #001 was not more frequently assessed for pain and the pain scale was not used when resident #001 had experienced more pain. [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): An injury in respect of which a person is taken to hospital.

Review of resident #001's progress notes confirmed on specified date and time, resident #001 had symptoms for an identified medical condition. Staff suspected a specified injury and the resident was transferred to the hospital the same day. Resident #001 was diagnosed with an identified medical condition.

Review of the critical incident report, revealed the above mentioned incident was reported to the Director on a specified date.

Interview with staff #114 confirmed the above incidents were not reported to the Director until an identified date, two business days after the incident occurred. [s. 107. (3) 4.]

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Issued on this 11th day of March, 2016

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

Original report signed by the inspector.