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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 15, 2015	2015_157210_0015	T-1199-14	Complaint

Licensee/Titulaire de permis

WOODS PARK CARE CENTRE INC.
110 LILLIAN CRESCENT BARRIE ON L4N 5H7

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

WOODS PARK CARE CENTRE
110 LILLIAN CRESCENT BARRIE ON L4N 5H7

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

SLAVICA VUCKO (210)

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): April 28, 29 and 30, 2015.

During the course of the inspection, the inspector(s) spoke with registered staff, personal support workers, director of care (DOC), assistant director of care (ADOC), recreation assistants, director of resident and family services, care coordinator, convalescent care coordinator, social worker (SW), a family member, reviewed clinical record and continence product list.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 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. (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. (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 plan of care set out clear directions to staff and others who provide direct care to the resident.

Review of the written plan of care for resident #1, who was admitted on an identified date, revealed there was no section for activities and recreation. Review of the recreation admission assessment indicated the resident was interested in entertainment, church services, walking and watching TV.

Interview with the director of resident and family services indicated whenever a new resident is admitted to the home he/she is assessed for interest in activities, it is documented in the written plan of care, the interest and involvement in activities is assessed on an on-going bases, and participation is documented.

Review of the written plan of care of resident #1 and interview with the director of resident and family services confirmed that the written plan of care did not set out clear direction to staff and others who provide direct care to the resident in regards to activities and recreation programs. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was 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 the community care access center (CCAC) admission documents, minimal data set (MDS) assessment, section L-continence assessment, for resident #1 indicated the resident was occasionally incontinent with incontinent episodes two or more times a week but not daily.

Review of the written plan of care indicated staff are to place a toileting assistive device within the resident's reach. There is no mention of the resident's continence status or use of incontinent product.

Interview with an identified PSW revealed the resident uses an incontinent product at night.

Review of the continence record for the period of two months since admission, revealed that the resident was frequently incontinent.

Interview with a registered nursing staff indicated all incontinent residents get assessed for continence at admission and change in continence status and this is documented in the continence assessment form that is located in the electronic documentation record, the assessments tab, and the written plan of care is updated.

Review of the electronic documentation record, the section for continence assessment and interview with an identified PSW and registered nursing staff confirmed the resident was not reassessed and the care plan was not reviewed when the resident became frequently incontinent. [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 to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, the resident was 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. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any;
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and
(c) a record is kept of the date, the participants and the results of the conferences.

Record review revealed resident #1, was admitted to the home on an identified date, and the care conference was held two months and three days after the admission.

Interview with the convalescent care coordinator (CCC) indicated that care conferences for convalescent care unit are usually held between 30-45 days of admission or shortly after the resident's visit to an outpatient clinic typically scheduled around 45 days after admission.

Record review and interview with an identified registered nursing staff confirmed that a care conference of the interdisciplinary team was not held within six weeks following the resident #1's admission. [s. 27. (1)]

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 a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her SDM, if any, within six weeks of the admission of the resident, the resident, their SDM, if any, and any other person that either of them may direct is invited to participate in these care conferences, and a record is kept of the date, the participants, and the results of the conferences, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, are documented.

Review of resident #1's recreation and activities flow sheets for an identified period of two months, indicated, he/she participated in activities as follows:

*four times in group activities and twice in one-to-one activities during two weeks since admission,
*four times in group activities and three times in one-to-one activities for a period of one month, and
*no group activity and three times in one-to one activities during the last month before discharge.

Interview with an identified recreation assistant indicated the expectation is the resident's participation in activities should be documented in the activities record and should identify whether the activity was active, passive or refused.

Review of the policy, programs assessment, policy number X-F-20.00, leisure and well-being, revised September 2013, indicated the role of the recreation staff is to complete a care plan within 21 days of admission, complete documentation for each resident at least quarterly or at anytime there is significant change in the resident, or it is no longer effective, and the resident's name is added to the attendance tracking form within 24 hours of admission.

Interview with the director of resident and family services indicated if a resident's level of participation in activities changes the expectation of the recreation assistant is to communicate the change with registered nursing staff, document and evaluate the care plan.

Interview with an identified recreation assistant and the director of resident and family services confirmed no documentation of the activity participation of resident #1 as active, passive or refused. Furthermore, there is no documentation of the decreased participation in group activities during the period of 26 days before the resident discharge. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, are documented, any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Review of the CCAC pre-admission documents for resident #1 indicated the resident was occasionally incontinent having incontinent episodes two or more times a week but not daily, and he/she used pads or briefs to protect against wetness. The resident was admitted in the home on an identified date and resided in the home for two months and three days till discharge.

Review of the written plan of care indicated the resident was unable to control urination that resulted in frequent voiding. The goal of this focus was the resident to be clean, dry and odor free. The interventions listed included staff to place a toileting assistive device within the resident's reach, note any changes in the amount, frequency, color or odor, and report any abnormalities to registered staff.

Interview with an identified PSW indicated the resident was continent during the day and used the toilet, but incontinent at night, and used an incontinent product with a toileting assistive device within reach. According to the identified PSW the resident had occasional incontinent episodes during the day.

Review of the incontinence flow sheets for a period of one month before the discharge indicated the resident was frequently incontinent throughout day and night.

Interview with the continence care program leader indicated he/she is responsible for arranging incontinence care products for residents who are incontinent according to assessments for appropriate use of an incontinent product but resident #1 was not on the continence product list.

Interview with the convalescent care coordinator indicated continence assessment is performed to long-stay residents in the long term facility and documented under the assessments tab in the electronic record but the practice is not the same for the short-stay residents in the convalescent care unit, and continence assessment is not performed for convalescent care residents.

During a review of the continence assessment records the inspector was not able to locate a continence assessment form for resident #1 and the convalescent care coordinator confirmed that there was no continence assessment performed.

Record review and interview with registered nursing staff and the continence care program leader confirmed resident #1 did not receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using the clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

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 each resident who is incontinent received an assessment that: includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and a response is provided within 10 business days of receipt of the complaint.

Review of the progress notes for resident #1 indicated on an identified date, a family member of the resident approached a registered nursing staff to express concern about the resident's adjustment in the convalescent care unit and discharge home. According to the progress notes the family member described the resident as being rude and snippy at staff and he/she was concerned the resident's spouse would not be able to look after

him/her at home related to his/her attitude and personality.
Interview with the approached registered nursing staff indicated he/she sent a referral to the social worker on the same day when he/she received the complaint from the family member.

Interview with the social worker indicated he/she works only two hours a week in the home and he/she saw the resident one week after receiving the referral. The social worker was not able to explain what was the expectation from his/her assessment, but he/she explained that he/she tried to talk to the resident, and it was very difficult to gain trust in the resident or find out more about potential issues.

Interview with an identified registered staff indicated one and a half months after the admission he/she had noticed a new responsive behaviour of the resident and documented it in progress notes. The behavioural progress note describes the resident as "upset at the PSW for not making his/her bed and resident was seen coming out of his room and throwing his/her clothes on to the floor". The interventions implemented were documented as not effective. The registered staff indicated besides the documentation he/she reported the incident to the convalescent care coordinator.

Interview with the associate director of care revealed that when there is a complaint (either verbal or written) by a family member to staff, the expectation is management should be notified, the complaint should be documented in the progress notes, and 24 hours shift report in order for the complaint to be reviewed and dealt with. He/she further stated that until the incident with resident #1, management practice was to review the progress notes for all complaints raised by family members but this practice applied only to long term care residents and not for residents in the convalescent care program. After the incident involving resident #1 the home made adjustments to the practice and started checking the progress notes for potential complaints by convalescent care residents or their family members.

Interview with the associate director of care (ADOC) indicated all complaints that are not resolved in 24 hours are recorded by management staff in an electronic complaints log that is kept on the shared drive. He/she confirmed that the verbal complaint by the family member of resident #1 on an identified date, had not been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint. [s. 101. (1) 1.]

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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, to be implemented voluntarily.

Issued on this 19th day of May, 2015

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

Original report signed by the inspector.