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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 14, 2017	2017_420643_0015	007683-17, 009618-17	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

ADAM DICKEY (643)

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): August 16, 17, 18 and 24, 2017.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with The Director of Resident Care (DOC), Associate Director of Resident Care (ADOC), Registered Nurses (RN), Registered
Practical Nurses (RPN), Personal Support Workers (PSW), residents, family members and
Substitute Decision Makers (SDM).

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident had occurred shall immediately report the suspicion and the information upon which it is based to the Director.

A complaint was submitted to the Ministry of Health and Long-Term Care related to an injury with unknown origin sustained by resident #003.

Review of resident #003’s progress notes and interview with RPN #105 revealed an incident of injury with unknown cause was discovered on an identified date. According to the progress note resident #003 complained that staff were mad at him/her and had sustained an identified injury as a result of staff members bumping a specified area of his/her body. In an interview RPN #105 stated that this statement was considered an allegation of abuse of resident #003 and he/she reported this in an electronic mail communication to the DOC and ADOC.

Review of the Long-Term Care home Critical Incident reporting system website failed to reveal a Critical Incident System Report (CIR) related to the allegation of abuse from the above mentioned identified date.

In an interview, the DOC stated that the expectation of the home is that allegations of abuse of a resident should immediately be reported to the MOHLTC. The DOC additionally stated that rough treatment of a resident during care would be considered a form of resident abuse. The DOC further stated that resident #003's statement was considered an allegation of abuse. The DOC stated that an investigation into the allegation had been carried out by the home, however could not provide documentation of the investigation. The DOC acknowledged that the licensee had failed to immediately report suspected abuse of resident #003 and the information upon which it is based to the Director. [s. 24. (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 with ensuring that a person who has reasonable grounds to suspect abuse of a resident had occurred shall immediately report the suspicion and the information to the Director,, to be implemented voluntarily.

WN #2: 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:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response was made to a person making a verbal complaint indicating what the licensee has done to resolve the complaint.

A complaint was received by the MOHLTC from a family member of resident #005 related to skin and wound care, neglect, and the home's management of complaints. The complaint stated that the complaint was discussed with the DOC who told the complainant he/she would get back to the complainant but never did.

Review of the home's complaints management records failed to reveal a complaint from the family member of resident #005. Review of resident #005's progress notes revealed a complaint was made to RPN #105 on an identified date, by the resident's family member who was not the POA for the resident's care, regarding the resident's medical condition. The concern was followed up on by the home's nurse practitioner on the following day, noting that the condition was not worsening. No record of a response to the family member of resident #005 who made the complaint was found.

Review of the complaint letter submitted to the MOHLTC and interview with the DOC revealed that the family member of resident #005 had a telephone conversation about resident #005's care and and the DOC did not follow-up with the complainant to advise him/her of what was done to resolve the complaint. The DOC acknowledged that even though the family member was not the POA of resident #005 he/she should have provided a response to the complainant to advise him/her of the actions taken by the home to resolve the complaint. [s. 101. (1) 3.]

2. The licensee has failed to ensure that a documented record was kept in the home that includes: the nature of each verbal complaint, the date the complaint was received, actions taken to resolve the complaint, final resolution, dates communicating with the complainant, any response made by the complainant.

a. A complaint was received by the MOHLTC from a family member of resident #005 related to skin and wound care, neglect, and the home's management of complaints. The complaint revealed that resident #005's family member spoke with RPN #105 as well as the DOC regarding resident #005's skin condition.

Review of resident #005's progress notes revealed that a family member of the resident had concerns regarding resident #005's medical condition. Review of the home's complaints management records failed to reveal a complaint from the family member of resident #005.

In an interview, the DOC stated that he/she recalled discussing with resident #005's

family member's regarding their concerns but did not keep a record of the complaint. The DOC stated that as the family member was not the POA for resident #005's care that he/she did not record the complaint in the home's records.

b. A complaint was received by the MOHLTC from a family member of resident #003. The complaint stated that resident #003 had been cared for improperly resulting in pain. The complaint further stated that this concern was reported to the DOC on an identified date, but nothing was done about the concern.

Review of the home's complaints management binder failed to reveal any record of the complaint from resident #003's family member related to the complaint from the above mentioned date.

In an interview, the DOC stated that he/she recalled discussing the concerns that resident #003's family member had brought forward to the home. The DOC further stated that the concern was investigated by the home but no finding had been made through the investigation and had reported that to resident #003's family member. The DOC acknowledged that the licensee had failed to ensure that a documented record was kept in the home that includes: the nature of each verbal complaint, the date the complaint was received, actions taken to resolve the complaint, final resolution, dates communicating with the complainant, any response made by the complainant. [s. 101. (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 with ensuring that a response is made to a person making a verbal complaint indicating what the licensee has done to resolve the complaint; and
ensuring that a documented record is kept in the home that includes: the nature of each verbal complaint, the date the complaint was received, actions taken to resolve the complaint, final resolution, dates communicating with the complainant, any response made by the complainant,, to be implemented voluntarily.

Issued on this 21st day of September, 2017

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

Original report signed by the inspector.