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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 7, 2018	2018_745690_0014	003235-18, 003367-18, 006299-18, 016561-18, 020628-18, 022296-18	Critical Incident System

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

TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 19-23, 2018

The following intakes were inspected during this Critical Incident Inspection:
-Two logs which were related to critical incidents the home submitted to the Director regarding respiratory outbreaks; and
-Four logs were related to critical incidents the home submitted to the Director regarding falls with injuries.

Complaint inspection #2018_745690_0013 and Other inspection #2018_745690_0015 were conducted concurrently with this Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreation Therapists, Physical Therapy Assistants, residents, family members and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector(s) conducted observations in resident home areas, observation of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
1 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	Légende 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

A Critical Incident (CI) report was submitted to the Director on an identified date, for an incident that occurred three days prior, in which resident #004 sustained an injury after an unwitnessed fall subsequent to exhibiting an identified responsive behaviour in an identified area. The CI report further indicated that resident #004 had a history of an identified responsive behaviour and that staff were monitoring resident #004 due to increasing responsive behaviours.

A review of resident #004's health records revealed a document from an external agency, on an identified date. The document indicated that resident #004 was referred to the external agency to assist with interventions for identified responsive behaviours. A further review of resident #004's health record revealed an additional document from the external agency that included identified recommendations to assist with managing the identified responsive behaviours. Inspector #690 reviewed a document from the external agency indicating that resident #004 was discharged from their services and recommended that staff continue with the previous recommended interventions.

A review of resident's electronic progress notes revealed five documented incidents of resident #004 exhibiting identified responsive behaviours towards other residents and staff during a specific time period.

In an interview with Inspector #690, Personal Support Worker (PSW) #119 indicated that the resident had on-going identified responsive behaviours. They further described that previous interventions in place were not effective with managing resident #004's responsive behaviours. PSW #119 indicated that they would access the kardex to find information on resident #004's responsive behaviours and the interventions that were in place. Together Inspector #690 and PSW #119 reviewed resident #004's kardex. PSW #119 identified that the kardex had a focus and interventions for one of the identified responsive behaviours but the kardex did not have a focus or interventions related to the other identified responsive behaviours.

In an interview with Inspector #690, Registered Practical Nurse (RPN) #115 indicated that resident #004 had on-going identified responsive behaviours towards staff and other residents. RPN #115 indicated that PSW staff would access the kardex and that Registered staff would access the electronic care plan to find information on resident #004's responsive behaviours and what interventions were in place to manage the behaviours. Together Inspector #690 and RPN #115 reviewed resident #004's care plan. RPN #115 identified that there were no interventions on the care plan to address a specified responsive behaviour towards staff and other residents and that the strategies to assist with managing the other identified responsive behaviours were ineffective with resident #004. RPN #115 further indicated that there were no new interventions put in place since the external agency had discharged resident #004 from their service, and that there should have been.

In an interview with Inspector #690, the Director of Care (DOC) indicated that resident #004 had on-going responsive behaviours and that the interventions that were in place were ineffective and that resident #004 continued to be a risk to staff and co-residents. The DOC further indicated that the strategies and interventions should have been re-assessed and revised at minimum of every three months, when there was a change in status or the interventions were no longer effective. The DOC identified that there had not been any new interventions or any re-referrals done to manage resident #004's identified responsive behaviours and that there should have been. [s. 53. (4) (b)]

2. A CI report was submitted to the Director for an incident that occurred on an identified date, in which resident #005 fell and sustained an injury. A further review of the CI report revealed that resident #005 had been brought to an identified area of the home by staff and was left unattended. Resident #005 exhibited a specified responsive behaviour, which caused resident #005 to fall and sustain an injury.

A review of resident #005's progress notes revealed four documented incidences of resident #005 exhibiting the specified responsive behaviour during a specific time period prior to the above mentioned incident.

Resident #005's care plan that was in place prior to the incident, had indicated a focus for ineffective coping related to an identified responsive behaviour. The care plan included identified interventions for the ineffective coping. Inspector #690 could not find any focus for the other responsive behaviour or any other interventions to manage the other responsive behaviour. Inspector #690 reviewed the kardex and could not locate any focus or interventions related to any responsive behaviours.

In an interview with Inspector #690, PSW #111 indicated that resident #005 had a history of an identified responsive behaviour prior to the day of the incident. PSW #111 indicated that they would access the kardex to find information on a resident's responsive behaviours. Together PSW #111 and Inspector #690 reviewed resident #005's kardex and could not locate any information related to resident #005's identified responsive behaviours. PSW #111 indicated that the identified responsive behaviours should have been on the kardex.

In an interview with Inspector #690, Registered Nurse (RN) #118 could not recall if resident #005 had an identified behaviour at the time of the incident. RN #118 reviewed resident #005's kardex with Inspector #690 and identified that there were no behaviours identified or any interventions to manage resident #005's responsive behaviours on the kardex. RN #118 indicated that PSW staff accessed the kardex to find information on a resident's responsive behaviours. RN #118 indicated that Registered staff would access the care plan to find information on a resident's responsive behaviours. RN #118 reviewed the care plan for resident #005 that was in place at the time of the above mentioned incident, and identified there was no focus or interventions related to the identified responsive behaviour and that there should have been.

In an interview with Inspector #690, the DOC reviewed resident #005's kardex and care plan that was in place at the time of the incident, and identified that there were no interventions or strategies to address resident #005's identified responsive behaviours and that there should have been. [s. 53. (4) (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 strategies are developed and implemented to respond to the resident demonstrating responsive behaviours, where possible, to be implemented voluntarily.

Issued on this 19th day of December, 2018

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

Original report signed by the inspector.