Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Central West District**
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# Original Public Report

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| **Report Issue Date:** September 26, 2024 |
| **Inspection Number:** 2024-1307-0003 |
| **Inspection Type:**<br>Critical Incident |
| **Licensee:** The Royale Development LP by its general partner, The Royale Development GP Corporation |
| **Long Term Care Home and City:** Woods Park Community & Retirement Living, Barrie |

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 17-20, 2024
The inspection occurred offsite on the following date: September 23, 2024

The following intake was inspected:

- Intake #00119702, related to allegations of improper care of a resident.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control

## INSPECTION RESULTS

## WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (4) (b)**
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff involved in a resident's care collaborated with each other in the development and implementation of the resident's plan of care related to nutritional and dietary risks.

**Rationale and Summary**

A resident was at nutritional risk.

During the resident's initial dietary assessment, specific interventions were to be implemented to minimize the resident's nutritional and dietary risks. However, some of these interventions were not communicated to the other members of the interdisciplinary team and as a result, were not implemented as required.

The Director of Care (DOC) said staff should have communicated the identified concerns to the appropriate team members.

Gaps in the collaboration between the multidisciplinary staff members regarding the resident's specific nutritional and dietary needs resulted in lack of appropriate interventions to minimize the resident's associated risks.

**Sources:** a resident's clinical records, the home's investigation notes and interviews with staff.

## WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (10) (b)**
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was re-assessed when their condition changed.

**Rationale and Summary**

A resident had a change in their condition and no immediate actions were taken to assess the resident, as required.

The following day, the resident was transferred to the hospital as their condition worsened.

The DOC said staff should have assessed the resident when the change in the resident's condition was noted and informed the other team members.

By not re-assessing the resident and communicating with the team members when the resident's condition changed, it delayed the implementation of appropriate interventions and increased the resident's risk for negative outcomes.

**Sources:** a critical incident report, a resident's clinical records, the home's investigation notes, complaint records, and interviews with staff.

## WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident received immediate treatment and interventions to promote healing and prevent infection of their areas of skin concerns.

**Rationale and Summary**

A resident was identified with multiple areas of skin concerns.

Staff did not implement immediate interventions to promote healing and prevent infection of these areas, as required.

The DOC said skin assessments and interventions should have been initiated as soon as staff noted the areas of skin concerns.

Not implementing immediate interventions to promote healing and prevent infection of the resident's affected skin areas, may have contributed to the deterioration of these areas and increased the risk of infection.

**Sources:** a resident's clinical records, and interviews with staff.