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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 17, 2012	2012_102116_0041	T2128-12	Other

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

SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): November 19, 20,26,28, 30 & December 3, 2012

Log#- T2128-12

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care, Assistant Director of Care, Resident Care Coordinator, Residents, Registered staff and direct care staff members.

During the course of the inspection, the inspector(s) reviewed the health record of residents, reviewed the homes responsive behaviour policy and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #1 as specified in the plan.

- Resident #1 was admitted to the home with verbal and physical aggression. Over a specified period there have been multiple incidents of verbal and physical aggression displayed by the resident towards residents and staff which have resulted in injury.
- Through interviews with staff members and review of resident's health records the following was identified: On a specified date, resident #1 was observed to be standing over resident #2 who was on the floor. Resident #1 was yelling at Resident #2. Resident #2 was bleeding from the nares. The resident's eyes were open but resident #2 was not responding to verbal stimuli. Resident #2 was taken to the hospital for assessment of sustained injuries. Resident #2 passed away two days after the incident [s. 6. (7)].

2. A referral to specialized resources was initiated but not followed through with for resident #1 who experienced an increase in verbal and physical aggression [s. 6. (7)].

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 care set out in the plan of care is provided to resident #1, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours require heightened monitoring because those behaviours pose a potential risk to the resident or others.

- Resident #1 exhibits verbal and physical aggression towards residents and staff. Incidents of physical aggression involving Resident #1 have resulted in injuries towards co-residents on the unit. Resident #1 resides on a 20 bed secured unit that has resident's which have a diagnosis of dementia accompanied with/without responsive behaviours that require monitoring. Resident #3 and Resident #4 are documented to exhibit physical behaviours.
- The unit is regularly staffed by a Registered Practical Nurse (RPN) for the night shift. On a specified date, the scheduled RPN for the night shift was unavailable resulting in the home staffing the unit with a personal support worker (PSW).
- On a specified date, Resident #2 was found in the hallway of a resident care unit lying on the floor with blood coming from the nares. Resident #1 was observed standing over Resident #2 yelling at Resident #2. Resident #2 sustained injuries and passed away in the home two days later.
- Throughout interviews held with staff members assigned on the specified date it was confirmed that advise was not provided at the beginning of the shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others [s. 55. (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 all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training on the duty under section 24 to make mandatory reports [s. 76. (2) 4.].

2. The licensee failed to ensure that a Registered staff member received training on mandatory reporting under section 24 of the Act before performing duties, as confirmed through review of training records provided and interview with staff member [s. 76. (2) 4.].

3. The licensee failed to ensure that all staff who provide direct care to residents received training related to mental health issues, including caring for persons with dementia and behaviour management, as confirmed through a review of training records and interviews with staff.

- A Registered staff member employed by the home stated to the inspector that training on behaviour management was not provided. Two PSW's reported to the inspector that they had not received retraining in techniques and approaches related to mental health issues and training in techniques and approaches related to responsive behaviours as required in the regulations (O.Reg. 79/10, s. 221 (3). [s. 76. (7) 3.]

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 all staff at the home have received training and retraining as required by this section, to be implemented voluntarily.

Issued on this 7th day of January, 2013

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