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 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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

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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
Jan 18, 2019	2018_728696_0012	021839-17, 022584-17, 024679-17, 000449-18, 011560-18, 012766-18, 019868-18	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Woodhall Park Care Community
10260 Kennedy Road North BRAMPTON ON L6Z 4N7

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

ZINNIA SHARMA (696)

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): December 4, 5, 6, 12, 14, 17, 18, 19, 20, and 21, 2018.

During the course of the inspection, the following Critical Incident (CI) intakes were inspected:

Log #021839-17 related to improper/incompetent treatment of a resident that resulted in harm to a resident.
Log #022584-17 related to improper/incompetent treatment of a resident that resulted in risk to a resident.
Log #024679-17 related to fall with injury.
Log #000449-18 related to incident with injury.
Log #011560-18 related to significant change in resident's health status post hospitalization.
Log #012766-18 related to fall with injury.
Log #019868-18 related to fall with injury.

Please Note: Written Notifications and Voluntary Plan of Actions (VPCs) related to O. Reg. 79/10, s. 36, s. 30 (1) 4, and s. 50. (2) (b) (iv) were identified in this inspection for logs # 021839-17 and 000449-18 and have been issued in Inspection Report 2018_723606_0025.

During the course of the inspection, the inspector(s) spoke with residents, personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), Associate Director of Care (ADOC), Director of Care (DOC), and Executive Director (ED).

During the course of this inspection, the inspector observed resident care, observed staff to resident interaction, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

4 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who had fallen, was assessed and a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #026 had a fall on a specific date. There clinical records were reviewed and there was no documentation or assessment to support that they were assessed post fall.

The ED acknowledged that resident #026 was not assessed and a post post-fall assessment was not conducted using a clinically appropriate assessment instrument, when the resident fell on that particular date. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #2: 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 that improper or incompetent treatment or care of a resident had occurred that resulted in harm or a risk of harm to the resident, had immediately reported the suspicion and the information upon which it was based to the Director.

On a specific date, a CI report was submitted to MOHLTC stating that improper or incompetent treatment or care of a resident had occurred that resulted in harm to resident #001.

The clinical records of resident #001 indicated that the incident took place on an earlier date and that registered staff and DOC were aware of the incident.

During an interview with DOC, they acknowledged that this incident was not reported to the Director immediately. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

On two occasions, the LTCH inspector observed resident #011 sleeping in their bed.

Resident #011's most current written plan of care was reviewed and did not include their sleep patterns and preferences.

PSW #112 and RPN #113 told the LTCH inspector that resident #011 usually woke up and went to bed during a specific time of the day.

RPN #113 reviewed resident #011's plan of care and acknowledged that it did not identify resident's sleep patterns and preferences. [s. 26. (3) 21.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the licensee determined that an injury to a resident had resulted in a significant change in the resident's health condition or remained unable to determine whether the injury had resulted in a significant change in the resident's health condition, informed the Director of the incident no later than three business days after the occurrence of the incident, and followed with the report required under subsection (4).

On a specific date, a CI report was submitted to the MOHLTC stating that an incident occurred that caused an injury to resident #012 for which they were taken to the hospital and which led to a significant change in the resident's health condition.

Resident #012's clinical record showed that the incident took place on an earlier date and they were transferred to the hospital immediately post incident.

PSWs #124 and #132 and RN #131 told the LTCH Inspector that this incident resulted in a significant change to resident #012's condition as it impacted their activities of daily living.

The ED stated that they were aware that such incidents needed to be reported no later than three business days after the occurrence of the incident. They acknowledged that this incident was not reported within the three business days.

The licensee has failed to ensure that an incident that resulted in a significant change in resident #012's health condition was reported to the Director no later than three business days after the occurrence of the incident, and followed with the report required under subsection (4). [s. 107. (3.1) (b)]

Issued on this 11th day of February, 2019

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

Original report signed by the inspector.