Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 4, 2019	2019_723606_0014	024837-18, 026059-18, 002384-19, 002385-19, 003523-19, 003894-19, 007774-19, 009212-19	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

JANET GROUX (606)

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): June 14, 17, 18, 19, 20, 21, 25, 27, and 28, 2019.

The following Critical Incident System (CIS) intakes were inspected:
Log #024837-18 regarding a resident fall resulting in a serious injury, log #026059-18 regarding a resident to resident altercation resulting in a minor injury, log #003523-19 an allegation of staff to resident abuse resulting in a serious injury, log #003894-19 an allegation of staff to resident abuse resulting in emotional distress, log #007774-19 regarding an allegation of improper care resulting in a change in a resident's condition and log #009212-19 regarding a serious injury of unknown cause.

The following Follow Up (FU) intakes were inspected:
Log # 002384-19 Order (CO) #001 s. 19(1) of the Long Term Care Homes Act (LTCHA) and log #002385-19 CO #002 s. 54(b) of Ontario Regulation 79/10.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Associate Director of Care (ADOC), Physiotherapist (PT), Medical Director/Physician, Third Party Legal Counsel, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Substitute Decision Makers (SDM) and residents.

During the course of the inspection, the inspector(s) conducted observations of resident care, residents and staff interactions, completed interviews and reviewed residents' clinical records including progress notes, assessments, physician orders, plan of care, reviewed relevant home's investigation records, home's meeting minutes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_723606_0025	606
O.Reg 79/10 s. 54.	CO #002	2018_723606_0025	606

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 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

A Critical Incident System (CIS) reported resident #001 had a significant change in their condition resulting in a serious injury. A second CIS reported that resident#001 told a service provider that a staff action caused their injury.

Resident #001's progress notes stated resident #001 was discovered with a altered skin integrity impairment and had complained of pain. The progress notes stated that when an identified service provider asked the resident how they sustained the injury, the resident told them that a staff action caused it.

The home's investigations into the two incidents were unable to conclude the cause of resident #001's injury. However, during the investigation, it was revealed that resident #001 was not provided care according to the resident's plan of care.

PSW #120 and #122 stated that they did not provide care as specified in resident #001's plan of care.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A) A CIS reported resident #003 had a fall resulting in a serious injury.

Resident #003's progress notes stated that the resident fell. The resident was assessed with a change in their condition and that their condition worsened hours later. The resident was further assessed and diagnosed with an identified medical condition.

Resident #003's progress notes stated that the resident was identified at a risk level for falling and had fallen an identified number of times during a specific time period. The resident had an identified responsive behaviour and had been observed displaying the identified responsive behaviour in several areas of the unit. The progress notes and identified assessments stated that staff were to continue to implement the interventions in the plan of care and no further changes to the plan of care were made.

Resident #003's plan of care identified the resident to be a risk for falls related to their perception of their needs, identified medical problems, responsive behaviours and specific treatment regime. The plan of care directed staff to ensure the staff provided a number of identified interventions.

Review of resident #003's plan of care did not include any additional revisions or additional interventions to manage the resident's risk for further falls after the resident fell during an identified date.

Personal Support Worker (PSW) #107, Registered Practical Nurse (RPN) #111, and Physiotherapist (PT) stated that resident #003 was at risk of falling because the resident had an identified responsive behaviour. They acknowledged that there were no further revisions or additional interventions put in place to manage the resident from falling.

B) Resident #011's progress notes stated that the resident had fallen a number of times during an identified month due to an identified action.

Resident #011's plan of care identified the resident at a risk level of falling related to their physical and psychological condition and staff were directed to initiate a number of specific interventions. However, the plan of care did not show additional revisions and/or interventions to manage and prevent resident #011's risks for further falls after the resident fell a number of times during an identified period.

PSW #114 stated that when interventions in the plan of care were no longer effective, the charge nurse was informed and the resident's plan of care was reassessed to find a better solution.

The licensee has failed to ensure that different approaches were considered in resident #003 and #011's revision of the plan of care. [s. 6. (11) (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 there is a written plan of care for each resident that sets out, (a) the planned care for the resident; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan; and to ensure that when a resident is reassessed and the plan of care reviewed and revised, (b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident is discharged from the home.

A CIS reported an allegation of staff to resident abuse.

Resident #002's discharge files were not available for review. The Executive Director (ED) stated that the home was unable to locate resident #002's discharge files.

Issued on this 5th day of July, 2019

[redacted]

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

Original report signed by the inspector.