

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

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

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

**Division des opérations relatives aux
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
Feb 16, 2021	2021_826606_0003	018496-20, 018755- 20, 020655-20, 022522-20, 023833- 20, 025645-20	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), AMANDA COULTER (694)

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): January 12-15, 18-20, 2021.

The following Critical Incident (CI) intakes were inspected:

Log # 025645-20 regarding missing medications.

Log #023833-20, log #018496-20, regarding allegations resident abuse.

Log #018755-20, log #020655-20, and log #022522-20 regarding resident falls resulting in injuries.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Director of Resident Programs (DRP), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Behavioural Support of Ontario (BSO) Lead, Personal Support Workers (PSW), and residents.

The inspector also observed staff and resident interactions, provision of care, reviewed residents' health records, and other relevant documents.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Pain

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)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: 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 an allegation of abuse reported by a resident was immediately reported to the Director.

A resident alleged that a staff member was forceful during care. The incident was not reported to the Director.

Sources: Critical Incident (CI) report, observations, resident's progress notes, head to toe assessment, and interviews with a resident and staff. [s. 24. (1)]

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 an allegation of a resident by anyone is immediately reported to the Director, to be implemented voluntarily.

**WN #2: 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. (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,**
- (a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
 - (b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
 - (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care in relation to transfers was reviewed and revised after the resident suffered an injury.

A Personal Support Worker (PSW) observed a resident in pain when they were transferred with a lift. The resident continued to be transferred with the lift the following day and reported pain during the transfers.

A Registered Practical Nurse (RPN) assessed the resident and identified that the resident's pain was caused by transfers with a lift.

The resident's plan of care was not updated with alternative transfer methods, to address the resident's pain.

Sources: resident's progress notes, head to toe assessment, care plan, and interviews with staff. [s. 6. (10) (b)]

Issued on this 1st day of March, 2021

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

Original report signed by the inspector.