Ontario

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

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: January 16, 2023	
Inspection Number: 2023-1412-0004	
Inspection Type: Critical Incident	
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP	
Long Term Care Home and City: Woodhall Park Community, Brampton	
Lead Inspector Gurvarinder Brar (000687)	**Inspector Digital Signature**
Additional Inspector(s) Alicia Campbell (741126)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 19-22, 2023

The following intake(s) were inspected:

- Intake: #00093929 related to Infection prevention and control
- Intake: #00095152 related to Food and nutrition
- Intake: #00097134 related to Fall prevention and management

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

Food, Nutrition and Hydration
Infection Prevention and Control

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings of NC

The licensee has failed to ensure that the Director was immediately informed, as much detail as is possible in the circumstances, when a confirmed parainfluenza outbreak was declared.

Rational and Summary

Public health declared a confirmed parainfluenza outbreak and the Licensee reported the outbreak to the Director four days late.

The Associate Director Care (ADOC) stated that the indicated outbreak declared by

public health should have been reported immediately, and confirmed it was reported four days late.

Failure of the home to immediately report the confirmed parainfluenza outbreak to the Director may have delayed the Director in responding to the incident.

Sources: CIS #2928-000022-23 and Interview with ADOC. [000687]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 4. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
ii. the long-term actions planned to correct the situation and prevent recurrence.

The licensee has failed to ensure that when they were required to submit a report to the Director regarding an incident under Ontario Regulation 115 (4) 4. that the report included an analysis and follow up action, including the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

Rationale and Summary
There was a medical emergency of a resident that required reporting to the Director. Follow up actions were not included in the report to the Director.

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Failure of the home to include follow up information in the report to the Director may have delayed the Director in responding to the incident.

Sources: CI #2928-000026-23, interview with ADOC. [741126]

WRITTEN NOTIFICATION: Emergency plans

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 3.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
3. Resources, supplies, personal protective equipment and equipment vital for the emergency response being set aside and readily available at the home including, without being limited to, hand hygiene products and cleaning supplies, as well as a process to ensure that the required resources, supplies, personal protective equipment and equipment have not expired.

The licensee has failed to ensure that the emergency plan for the emergency response being set aside and readily available at the home.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that emergency equipment vital for the emergency response being set aside and readily available at the home.

Specifically, staff did not comply with the policy “Code Blue - Medical Emergency, XVIII-H-10.00", which included that the nurse or designate should ensure that resuscitation equipment is replenished after an emergency.

Rationale and Summary
A resident had a medical emergency in the dining room. When the registered staff went to intervene, it was noticed that there was no resuscitation equipment in the dining room. Resuscitation equipment was collected from another unit and the resident was revived.

The ADOC indicated that the risk of not having emergency supplies available on the unit was a delayed response to the emergency.

Failure of the home to have all the required resuscitation equipment readily available in the designated location on the unit put resident at risk of receiving delayed care during a medical emergency.

Sources: Resident clinical records, homes investigation notes; Code Blue - Medical Emergency policy, XVIII-H-10.00; interviews with RN and ADOC. [741126]