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**

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**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 |
|---|---|---|---|
| Oct 18, 2019 | 2019_575214_0031 | 013265-19, 013598-19 | Complaint |

## Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

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

The Woodlands of Sunset
920 Pelham Street WELLAND ON L3C 1Y5

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

CATHY FEDIASH (214)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): September 30, October 3, 8, 9, 2019.**

**Please note: This inspection was conducted simultaneously with Critical Incident Inspection #2019_575214_0030 / 018747-19.**

**The following intakes were completed during this complaint inspection:**

**013265-19 - related to Personal Support Services; Safe and Secure Environment; Nursing and personal support services; Plan of care.**

**013598-19 - related to Registered Nurse staffing.**

**During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Resident Care (DRC); Associate Director of Resident Care (ADRC); Clinical Documentation Informatics (CDI) Coordinator; Registered Nurses (RN); Registered Practical Nurses (RPN); Personal Support Workers (PSW); physician and residents.**

**During the course of the inspection, the inspector (s) reviewed complaints; home's investigative notes; resident clinical records; staffing schedules; and observed residents during the provision of care.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Personal Support Services**
**Reporting and Complaints**
**Safe and Secure Home**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident in relation to their oral care.

A review of complaint log #013265-19, indicated that resident #001, was not receiving care in relation to a specified activity of daily living (ADL).

A review of the most current Resident Assessment Protocol (RAP), that was specific to this activity of daily living, indicated that the resident was assessed to require a specified level of assistance with the ADL.

A review of resident #001's current electronic care plan in Point Click Care (PCC), indicated that the resident required a different level of assistance with the ADL, than had been identified in the above RAP.

During an interview with registered staff #106 on an identified date, they indicated that staff set the resident up to complete this ADL and remained with the resident for the entire process. Registered staff #106 indicated that staff assisted the resident with this ADL at specified times, on a daily basis.

During an interview with PSW staff #108 on an identified date, they indicated that staff set the resident up to complete this ADL at specified times, on a daily basis. The staff indicated that they remain with the resident through the entire process and will provide any assistance if needed.

During an interview with the DRC, they confirmed that the residents plan of care in relation to this ADL, had not been based on the corresponding RAP. [s. 6. (2)]

**Issued on this 29th day of October, 2019**

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

**Original report signed by the inspector.**