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 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 apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 12, 2017 | 2017_491647_0003 | 004122-17 | Resident Quality Inspection |

### Licensee/Titulaire de permis

WOODS PARK CARE CENTRE INC.
110 LILLIAN CRESCENT BARRIE ON L4N 5H7

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

WOODS PARK CARE CENTRE
110 LILLIAN CRESCENT BARRIE ON L4N 5H7

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

JENNIFER BROWN (647), JANET GROUX (606), MATTHEW CHIU (565), NITAL SHETH (500)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): February 27, 28, March 1, 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 2017**

**The following critical incidents were inspected concurrently with this inspection:**
**004981-16**
**003403-17**
**000416-17**
**004384-17**

**Two follow-up to previously served compliance orders were inspected concurrently with this inspection, log #004122-17**

**Three complaints was inspected concurrently with this inspection, Log #004122-17**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager (ESM), Care Coordinator, Director of Resident and Family Services (DRFS), Dietary Manager, Volunteer Coordinator, Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nursing Students, Residents, Family Members, and Substitute Decision Makers.**

**During the course of the inspection, the inspectors conducted observations in the home and resident home areas, observations of care delivery processes including medication passes and meal delivery services, review of the home's policies and procedures, and residents' health records.**

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

**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **7 WN(s)**
- **1 VPC(s)**
- **3 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 | 2015_414110_0004 | 647 |
| LTCHA, 2007 S.O. 2007, c.8 s. 19. (1) | CO #001 | 2016_268604_0007 | 647 |
| LTCHA, 2007 S.O. 2007, c.8 s. 24. (1) | CO #002 | 2016_268604_0007 | 647 |

| 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 | Legendé<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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.

The home submitted a Critical Incident Report (CIS) on an identified date, indicating that there had been an incident which had caused injury to a resident which had resulted in

the resident being transferred to the hospital. A review of the above CIS indicated that during transfer of a resident using a mechanical lift, resident's lower extremity slipped off of the mechanical lift. The resident was transferred to hospital resulting in an identified injury.

A review of the resident's plan of care identified the resident as dependent and required the use of a mechanical lift with two staff for all transfers.

An interview with direct care staff indicated that on the above mentioned identified date, they had transferred resident using a mechanical lift.

Interviews with direct care staff members and registered staff indicated the mechanical lift is equipped with a leg strap that is used to secure the residents feet and lower legs to the mechanical lift during transfer. The direct care staff mentioned above further indicated that the use of the safety strap is mandatory to ensure the residents' feet and lower legs remain secure to the lift during transfer and to avoid the risk of the foot or leg slipping off of the lift resulting in injury to a resident.

Interviews with the Physiotherapist and train the trainer lift champion both indicated that lift and transfer training for all staff occurs annually and upon hire with the direction to use the leg and foot safety buckle on the mechanical lift when transferring residents at all times. The above mentioned staff further indicated that the safety strap is used to ensure resident safety during transfer and confirmed that if the above mentioned resident had the leg safety strap fastened at the time of the incident then the lower extremity would have not been able to slip off of the platform which had led to the injury.

The Director of Care confirmed during an interview that the expectation is for all staff to use the leg and foot safety strap on the mechanical lift for all transfers and further confirmed that staff performed an unsafe transfer by not using the leg safety strap during transfer which had allowed the resident's lower extremity to slip off the platform resulting in the resident's identified injury.

The severity of the non-compliance and the severity of harm and risk was actual harm or risk.

The scope of the non-compliance is isolated.

A review of the compliance history revealed the home had no previous compliance

history related to staff use of safe transferring and positioning devices or techniques when assisting residents. [s. 36.]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

The licensee of has failed to ensure that residents are not neglected by the licensee or staff.

For the purposes of the definition of "neglect" in subsection 2 (1) of the O. Reg. 79/10, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one of more residents.

A review of the CIS on an identified date, revealed that a resident had been neglected by staff for not providing care after being incontinent. As per the CIS, the resident had been identified as being incontinent on an identified date and time. A direct care staff member reported that the resident refused evening care prior to bed. Staff did not re-approach the resident to provide evening care prior to bed. The registered staff was notified by a direct care staff member about the incontinent episode at change of shift. The registered staff member neglected to attend and assess the resident until a later identified date and time, being aware that the resident had been incontinent. The registered staff member communicated to the following shift that the identified resident's clothes had been adhered to the resident's skin which had caused the resident pain while being washed.

A review of the resident's written plan of care revealed the resident required assistance

for using the washroom.

Interview with a direct care staff member revealed that he/she had been aware of the resident's incontinence however indicated that the resident had not been his/her primary assignment and therefore not his/her responsibility. The direct care staff member confirmed that the resident had definitely been neglected because he/she did not receive a care from the primary care provider.

The inspector had been unable to interview the primary care giver for the identified resident, as he/she is no longer working in the home.

Interview with a registered staff member revealed that he/she did not assess the identified resident after the incontinence episode prior to bed and further confirmed that if the resident was left without receiving care until the following morning it is considered neglect.

Interview with a direct care staff member revealed that they had reported the incontinence to the registered staff. The direct care staff member confirmed that resident had been neglected as he/she did not receive continence care for the entire identified shift and had been left in that condition.

Interview with a registered staff member revealed that the direct care staff member did not assess the resident as the resident had been able to verbalize his/her needs and therefore the direct care staff did not feel it was necessary. The registered staff member further confirmed that because the resident stayed in a situation of incontinence for an entire shift that it met the definition of neglect.

Interview with a direct care staff member revealed that on an identified date and time it had been discussed during shift change that the identified resident had been incontinent. The direct care staff member tended to resident and took resident to the shower room. The direct care staff member indicated that resident's clothing had been adhered to resident's skin and during removal of the clothing resident had expressed it had been painful. The direct care staff stopped the procedure and reported the incident to the on duty manager. The direct care staff member reported that it was neglect and felt very upset that the resident had not been assisted during the previous shift.

The inspector was unable to interview with registered staff member who had worked on the identified date, after leaving several voice mails on his/her phone.

A review of the home's policy #VII-G-10.00-WP, entitled "Prevention of Abuse & Neglect of a Resident", revised July 2016, indicated the organization has a zero tolerance policy for resident abuse and neglect. Neglect is defined as the failure to provide the care and assistance required for the health, safety, and/or wellbeing of resident, withholding food services, includes inaction and/or a pattern of inaction that jeopardizes the health, safety, or wellbeing of a resident.

A review of the home's investigation record and an interview with the Administrator revealed that upon investigation the home found resident #043 was neglected by staff from various shifts and appropriate actions were commenced by the home.

The severity of the non-compliance and the severity of harm and risk was actual harm or risk.

The scope of the non-compliance is isolated.

A review of the compliance history revealed the home was served with a compliance order related to the Long Term Care Homes Act, O. Reg. c*8*, s.19 (1):
-Resident Quality Inspection 2015_414110_0004 carried out March 12, 2015, home was served a compliance order
-Resident Quality Inspection 2016_268604_0007 carried out February 24, 2016, home was served a compliance order

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #3: 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. (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 the care set out in the plan of care provided to the resident as specified in the plan.

During stage one of the Resident Quality Inspection (RQI), Resident Assessment Instrument Minimum Data Set (RAI-MDS), revealed that a resident had a fall.

A review of the resident's clinical records indicated that the resident had been identified as a high risk for falls. The clinical records further indicated that the resident experienced a fall.

A review of the resident's plan of care indicated that resident requires two staff members to assist the resident to get out of bed and had interventions in place to minimize the risk of falls.

During observations on an identified date, it had been observed by inspector that the interventions in the plan of care had not be in place.

An interview with direct care staff indicated that he/she had been responsible for the care of the identified resident and had forgotten to use the above mentioned interventions. The direct care staff further indicated that the interventions are required to be in place at all times as the resident does not have the cognitive insight to know the risks of falling.

An interview with a registered staff member indicated that the resident requires the above mentioned interventions at all times as resident is at risk of falling. The registered staff

member further indicated that the interventions in the residents' plan of care are expected to be followed.

An interview with the DOC confirmed that all interventions in the plan of care for the above mentioned resident are expected to be followed. The DOC further confirmed that when the resident had been observed by the inspector without the interventions that staff did not provide the care as specified in the plan of care. [s. 6. (7)]

2. During stage one of the RQI, RAI-MDS assessment on an identified date, revealed a resident had a fall.

Review of the resident's progress notes and plan of care indicated the resident was at risk for falls due to physical impairments and fell on an identified date. Further review of the plan of care indicated that the resident had interventions to follow.

On an identified day the inspector observed the resident without the above mentioned interventions in place.

Interview with a registered staff member indicated that the resident has a risk for falls and the interventions for resident should be used for the resident at all times.

Interview with the DOC confirmed that the use of the above mentioned interventions that are set out in the plan of care had not been provided to the resident as required. [s. 6. (7)]

3. During stage one of the RQI, RAI-MDS assessment on an identified date, revealed that a resident was incontinent.

Review of the resident's plan of care revealed that the identified resident required two staff members to assist resident at identified times throughout the day to use the washroom.

On an identified date during two observations between the above mentioned specific times, the inspector observed the resident not being assisted.

Interview with direct care staff indicated the resident required assistance and further confirmed that resident did not receive assistance.

Interview with a registered staff member and the DOC indicated that the resident should receive assistance at specified times and further confirmed that since the resident had not received assistance, the care set out in the plan of care was not provided to the resident as required. [s. 6. (7)]

4. The home submitted a Critical Incident Report (CIS) on an identified date, indicating that there had been an incident which had caused injury to a resident which had resulted in the resident being transferred to the hospital. A review of the above CIS indicated that during transfer of a resident using a mechanical lift, resident's lower extremity slipped off of the mechanical lift. The resident was transferred to hospital resulting in an identified injury.

A review of the resident's plan of care identified the resident as dependent and required the use of a mechanical lift with two staff for all transfers.

An interview with direct care staff indicated that on the above mentioned identified date, they had transferred resident using a mechanical lift.

Interviews with direct care staff members and registered staff indicated the mechanical lift is equipped with a leg strap that is used to secure the residents feet and lower legs to the mechanical lift during transfer. The direct care staff mentioned above further indicated that the use of the safety strap is mandatory to ensure the residents' feet and lower legs remain secure to the lift during transfer and to avoid the risk of the foot or leg slipping off of the lift resulting in injury to a resident.

Interviews with the Physiotherapist and train the trainer lift champion both indicated that lift and transfer training for all staff occurs annually and upon hire with the direction to use the leg and foot safety buckle on the mechanical lift when transferring residents at all times. The above mentioned staff further indicated that the safety strap is used to ensure resident safety during transfer and confirmed that if the above mentioned resident had the leg safety strap fastened at the time of the incident then the lower extremity would have not been able to slip off of the platform which had led to the injury.

The DOC confirmed during an interview that the expectation is for all staff to follow the plan of care and use the leg and foot safety strap on the mechanical lift for all transfers and further confirmed that staff had not followed the plan of care by not using the leg safety strap during transfer which had allowed the resident's lower extremity to slip off the platform resulting in the resident's identified injury.

5. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs change.

Record review of a CIS on an identified date, reported an incident had been caused by a resident on an identified date. The home reported that other residents had to be relocated to another area of the home and had been later returned to the home area at a later date and time. The resident had been transferred to the hospital after the incident and treated for minor injuries.

Record review indicated that an identified resident was admitted on an identified date. The records indicated that during the resident's stay he/she had verbalized to several staff in the home that he/she wanted to leave.

Interviews with direct care staff revealed the home had begun observing behavioural changes in the resident the day after being admitted into the home.

Review of resident's progress notes from an identified date, indicated resident had been expressing to staff that he/she wanted to leave. The progress notes further indicated that the family had informed the home that the resident's behavioural changes had been ongoing and had previously been treated by a physician.

-On an identified date it had been documented that the resident indicated he/she told a staff member that he/she had wanted to leave. The progress notes indicated that the resident was observed to express identified responsive behaviours.

-On another identified date the staff expressed ongoing concerns with the resident that he/she remained unsettled, still thinking of leaving the home and had been packing his/her belongings. It had been reported by family that resident had a history of this behavior and indicated that medical treatment had been successful in the past.

-On another identified date the resident had informed staff that he/she was leaving the home. The progress notes indicated that the home had been in contact with family to inform then that the above mentioned resident was making more serious statements and ongoing responsive behaviours.

-On another identified date that resident had stated to staff that the reason of the above

mentioned incident was to leave the home.

Review of the resident’s assessments showed no evidence that he/she was reassessed regarding his/her change in behavior.

Interview with the family of the above mentioned resident indicated that they had informed the home on previous occasions of the resident's behaviours and the previous medical treatment.

Interview with Life Skills Coordinator and the Administrator revealed that the resident stated that he/she had caused the incident because he/she wanted to leave the home.

Interview with a registered staff member stated that when a resident is observed to have a change in their condition such as a change in their behaviour, staff are required to assess the resident to find out the cause.

Interviews with a registered staff member and the DOC stated the resident was not assessed for his/her change in condition.

An order has been issued based on the severity of harm actual harm/risk  and the scope was isolated. [s. 6. (10) (b)]

6. During stage one of the RQI, RAI-MDS assessment on an identified date revealed an identified resident had a fall.

Review of the resident’s progress notes and plan of care indicated the resident was at risk for falls. The resident fell on an identified day when he/she attempted to self-transfer. The fall was unwitnessed and the resident sustained some minor injuries. Further review of the plan of care indicated that resident had interventions to be put into place to prevent injury from falls.

On an identified day the inspector observed the resident and there had been no intervention in place.

Interview with direct care staff revealed the above interventions had been discontinued for the resident for a long period of time. Interviews with registered staff indicated the interventions had been discontinued since other interventions had been implemented.

The staff members confirmed that the use of the intervention in the plan of care was not revised at the time when the resident's care needs changed. [s. 6. (10) (b)]

***Additional Required Actions:***

***CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Record review of the home's policy entitled, "Responsive Behaviors – Management", POLICY #: VII-F-10.20, the Registered Staff will:

2) Complete an electronic Responsive Behavior Referral to the internal Behavior Support Outreach (BSO) Lead / Designate when:
-there is a new, worsening, or change in responsive behaviors
-upon move in of a resident with identified responsive behavior that poses a risk to themselves or others

3) Refer to available resources in the care community or healthcare community resource such as Behavioral Support Team (BSO) or Behavioral Intervention Response Team (BIRT) if available, or other similar type community team e.g. Psychogeriatric Resource Team and/or Psychogeriatric Resource Consultant (PRC) and RN(EC).

Record review of a CIS on an identified date indicated an incident in an identified area by an identified resident.

Record review of the resident's progress notes and interviews with staff indicated the resident was observed to display a change in his/her behavior. It further indicated both the staff and family had concerns with resident's change in behavior.

Interview with the BSO, stated he/she did not receive any referral for the identified resident's change in behavior and was not involved in his/her care.

Interview with the DOC stated that the resident was not referred to the BSO program because they did not see any indication as to the resident's behaviors. [s. 8. (1) (b)]

2. Review of the home's Pharmacy Policy entitled, "Disposal for Monitored Medication", Policy 6-8, July 2016, directs registered staff to:

-remove any used identified medications from the resident and place on "Disposal Record Sheet".
-the nurse will sign on the 'nurse signature one" line of the "Disposal Record Sheet."
-at the end of the shift, once all identified medications have been removed and documented, there will be a reconciliation of the number of identified medications by the second nurse. The second nurse will verify that the number of identified medications placed on the "Disposal Record Sheet" equals the number of identified medications wasted on the count sheet. Once this reconciliation has taken place, the second nurse will cosign the "Disposal Record Sheet" on the "nurse signature two" line and will cosign the count sheet in the quantity/remaining in the card column.

Record review of CIS on an identified date reported a medication error involving an identified resident.

Review of resident's electronic medication administration records (e-MARs) indicated to administer a medication on an identified schedule.

Interview with a registered staff member revealed he/she was the registered staff who administered the medication on the designated day and was distracted during the medication pass and had forgotten to remove the previously applied medication.

Interview with a registered staff member stated that prior to applying a new medication, the old medication must be removed.

Interview with the DOC stated that the staff did not follow the home's Patch Disposal Monitored Medication policy. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place in complied with.

A review of the homes' Fall Prevention policy, #VII-G-30.00, dated January 2015, indicated that the Falls Prevention program is to be reviewed annually.

An interview with the DOC indicated that the Fall Prevention and management program is in place to reduce the incidence of falls and the risk of injury to the residents. The DOC confirmed that the Fall Prevention program had not been reviewed in 2016 as indicated in the above mentioned policy and further confirmed that the above mentioned policy had not been complied with. [s. 30. (1) 3.]

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:**

**1. A change of 5 per cent of body weight, or more, over one month.**
**2. A change of 7.5 per cent of body weight, or more, over three months.**
**3. A change of 10 per cent of body weight, or more, over 6 months.**
**4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach:

-a change of 5 per cent of body weight, or more, over one month.

During stage one of the RQI, record review revealed an identified resident had significant weight loss.

Review of the resident's plan of care revealed the resident had both physical and cognitive impairments, and had a moderate nutritional risk related weight loss. The resident required staff assistance for eating.

Record review of resident's weight records revealed the resident represented a weight loss of greater than 5 per cent over one month.

Review of assessment records revealed no assessment was completed for the resident's weight loss.

Interview with a registered staff and Dietary Manager (DM) indicated that a significant weight change would be assessed by the Registered Dietitian (RD), and a referral should be sent to the RD for the assessment. The staff members indicated no referral was sent to the RD related to the above mentioned weight loss. The DM further indicated the last quarterly nutritional assessment was done on an identified day based on the resident's previously recorded weights. The DM confirmed the resident's significant weight loss was not assessed as required. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (2) The licensee shall ensure,**
**(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the infection prevention and control interdisciplinary team meet as least quarterly.

A review of the homes' Infection Prevention and Control team minutes indicated the home had one meeting in 2016 dated February 8, 2016.

An interview with the DOC indicated that the Infection Prevention and Control team had only met once in 2016 due to lack of staff and not at least quarterly as the legislation requires. [s. 229. (2) (b)]

2. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A complaint had been reported to Ministry of Health and Long-Term Care (MOHLTC) on an identified date related to infection prevention and control.

Observations conducted on several days for an identified time frame, of a shared resident space revealed two unlabelled containers placed on each side of the counter top. The area observed had been shared by two residents.

Interviews with direct care staff revealed that when these containers are empty, staff will take the bottles to the refill station. Each bottle belongs to each resident sharing the room and bathroom, and they should not be mixed. The staff member indicated the bottles were not labelled.

Interview with registered staff indicated that staff labelled residents' personal care item using a permanent marker, but the shampoo and body wash bottles were not labelled for residents. The staff member indicated there is a risk for cross contamination if they were shared by other residents accidentally.

Interview with the DOC indicated that the home's infection prevention and control program directs staff members to label residents' personal care items. These items should be labelled and not to be shared with other residents. The DOC confirmed that staff did not participated in the implementation of the infection prevention and control program. [s. 229. (4)]

**Issued on this 19th day of April, 2017**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

**Ministére de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | JENNIFER BROWN (647), JANET GROUX (606), MATTHEW CHIU (565), NITAL SHETH (500) |
| **Inspection No. / No de l'inspection :** | 2017_491647_0003 |
| **Log No. / Registre no:** | 004122-17 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Apr 12, 2017 |
| **Licensee / Titulaire de permis :** | WOODS PARK CARE CENTRE INC.<br>110 LILLIAN CRESCENT, BARRIE, ON, L4N-5H7 |
| **LTC Home / Foyer de SLD :** | WOODS PARK CARE CENTRE<br>110 LILLIAN CRESCENT, BARRIE, ON, L4N-5H7 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | CATHY COTTON |

To WOODS PARK CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

**Order / Ordre :**

Upon a receipt of this order the licensee shall,

1. Provide hands on training to all direct care staff in the home related to safe transferring and positioning techniques when assisting residents ,including but no limited to all mechanical lifts used in the home and in accordance to manufacturer directions.

2. Maintain record of the content of the training in-service and all staff in attendance.

3. A record of staff signatures acknowledging when education has been received and understood.

**Grounds / Motifs :**

1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.

The home submitted a Critical Incident Report (CIS) on an identified date, indicating that there had been an incident which had caused injury to a resident which had resulted in the resident being transferred to the hospital. A review of the above CIS indicated that during transfer of a resident using a mechanical lift, resident's lower extremity slipped off of the mechanical lift. The resident was transferred to hospital resulting in an identified injury.

A review of the resident's plan of care identified the resident as dependent and required the use of a mechanical lift with two staff for all transfers.

An interview with direct care staff indicated that on the above mentioned identified date, they had transferred resident using a mechanical lift.

Interviews with direct care staff members and registered staff indicated the mechanical lift is equipped with a leg strap that is used to secure the residents feet and lower legs to the mechanical lift during transfer. The direct care staff mentioned above further indicated that the use of the safety strap is mandatory to ensure the residents' feet and lower legs remain secure to the lift during transfer and to avoid the risk of the foot or leg slipping off of the lift resulting in injury to a resident.

Interviews with the Physiotherapist and train the trainer lift champion both indicated that lift and transfer training for all staff occurs annually and upon hire with the direction to use the leg and foot safety buckle on the mechanical lift when transferring residents at all times. The above mentioned staff further indicated that the safety strap is used to ensure resident safety during transfer and confirmed that if the above mentioned resident had the leg safety strap fastened at the time of the incident then the lower extremity would have not been able to slip off of the platform which had led to the injury.

The Director of Care confirmed during an interview that the expectation is for all staff to use the leg and foot safety strap on the mechanical lift for all transfers and further confirmed that staff performed an unsafe transfer by not using the leg safety strap during transfer which had allowed the resident's lower extremity to slip off the platform resulting in the resident's identified injury.

The severity of the non-compliance and the severity of harm and risk was actual harm or risk.

The scope of the non-compliance is isolated.

A review of the compliance history revealed the home had no previous compliance history related to staff use of safe transferring and positioning devices or techniques when assisting residents. [s. 36.] (647)

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

**Ministére de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** May 31, 2017

**Order # / Ordre no :** 002

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

Upon a receipt of this order the licensee shall,

1. The licensee shall develop and submit a plan that includes the following requirements and the person responsible for completing the tasks. The plan is to be submitted to jennifer.brown6@ontario.ca by April 30, 2017 and implemented by June 30, 2017.

2. Provide re-education and training to all staff in the home on the home's policy to promote zero tolerance of abuse and neglect of residents.

3. The policy review and training shall include all definitions of abuse, and not be limited to neglect, as identified within the home's abuse policy and within the Long-Term Care Homes Act, 2007, Ontario Regulations 79/10.

4. At the end of the review, staff shall be able to recognize and define all forms of abuse under the legislation.

**Grounds / Motifs :**

1. The licensee of has failed to ensure that residents are not neglected by the licensee or staff.

For the purposes of the definition of "neglect" in subsection 2 (1) of the O. Reg. 79/10, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one of more residents.

A review of the CIS on an identified date, revealed that a resident had been neglected by staff for not providing care after being incontinent. As per the CIS, the resident had been identified as being incontinent on an identified date and time. A direct care staff member reported that the resident refused evening care prior to bed. Staff did not re-approach the resident to provide evening care prior to bed. The registered staff was notified by a direct care staff member about the incontinent episode at change of shift. The registered staff member neglected to attend and assess the resident until a later identified date and time, being aware that the resident had been incontinent. The registered staff member communicated to the following shift that the identified resident's clothes had been adhered to the resident's skin which had caused the resident pain while being washed.

A review of the resident's written plan of care revealed the resident required assistance for using the washroom.

Interview with a direct care staff member revealed that he/she had been aware of the resident's incontinence however indicated that the resident had not been his/her primary assignment and therefore not his/her responsibility. The direct care staff member confirmed that the resident had definitely been neglected because he/she did not receive a care from the primary care provider.

The inspector had been unable to interview the primary care giver for the identified resident, as he/she is no longer working in the home.

Interview with a registered staff member revealed that he/she did not assess the identified resident after the incontinence episode prior to bed and further confirmed that if the resident was left without receiving care until the following morning it is considered neglect.

Interview with a direct care staff member revealed that they had reported the incontinence to the registered staff. The direct care staff member confirmed that resident had been neglected as he/she did not receive continence care for the entire identified shift and had been left in that condition.

Interview with a registered staff member revealed that the direct care staff member did not assess the resident as the resident had been able to verbalize his/her needs and therefore the direct care staff did not feel it was necessary. The registered staff member further confirmed that because the resident stayed

in a situation of incontinence for an entire shift that it met the definition of neglect.

Interview with a direct care staff member revealed that on an identified date and time it had been discussed during shift change that the identified resident had been incontinent. The direct care staff member tended to resident and took resident to the shower room. The direct care staff member indicated that resident's clothing had been adhered to resident's skin and during removal of the clothing resident had expressed it had been painful. The direct care staff stopped the procedure and reported the incident to the on duty manager. The direct care staff member reported that it was neglect and felt very upset that the resident had not been assisted during the previous shift.

The inspector was unable to interview with registered staff member who had worked on the identified date, after leaving several voice mails on his/her phone.

A review of the home's policy #VII-G-10.00-WP, entitled "Prevention of Abuse & Neglect of a Resident", revised July 2016, indicated the organization has a zero tolerance policy for resident abuse and neglect. Neglect is defined as the failure to provide the care and assistance required for the health, safety, and/or wellbeing of resident, withholding food services, includes inaction and/or a pattern of inaction that jeopardizes the health, safety, or wellbeing of a resident.

A review of the home's investigation record and an interview with the Administrator revealed that upon investigation the home found resident #043 was neglected by staff from various shifts and appropriate actions were commenced by the home.

The severity of the non-compliance and the severity of harm and risk was actual harm or risk.

The scope of the non-compliance is isolated.

A review of the compliance history revealed the home was served with a compliance order related to the Long Term Care Homes Act, O. Reg. c.8, s.19 (1):
-Resident Quality Inspection 2015_414110_0004 carried out March 12, 2015, home was served a compliance order

-Resident Quality Inspection 2016_268604_0007 carried out February 24, 2016, home was served a compliance order (500)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 30, 2017

**Order # / Ordre no :** 003

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that residents are reassessed and the plan of care reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary.

The plan must include training of all staff on the recognition and identification of changes in a resident's condition which prompt reassessment and review of a resident's plan of care. The training of all staff shall include but not be limited to responsive behaviours that may result in harm or risk of harm.

The plan is to be submitted to jgroux@ontario.ca by April 30, 2017.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

Record review of a CIS on an identified date, reported an incident had been caused by a resident on an identified date. The home reported that other residents had to be relocated to another area of the home and had been later returned to the home area at a later date and time. The resident had been transferred to the hospital after the incident and treated for minor injuries.

Record review indicated that an identified resident was admitted on an identified date. The records indicated that during the resident's stay he/she had verbalized to several staff in the home that he/she wanted to leave.

Interviews with direct care staff revealed the home had begun observing behavioural changes in the resident the day after being admitted into the home.

Review of resident's progress notes from an identified date, indicated resident had been expressing to staff that he/she wanted to leave. The progress notes further indicated that the family had informed the home that the resident's behavioural changes had been ongoing and had previously been treated by a physician.

-On an identified date it had been documented that the resident indicated he/she told a staff member that he/she had wanted to leave. The progress notes indicated that the resident was observed to express identified responsive behaviours.

-On another identified date the staff expressed ongoing concerns with the resident that he/she remained unsettled, still thinking of leaving the home and had been packing his/her belongings. It had been reported by family that resident had a history of this behavior and indicated that medical treatment had been successful in the past.

-On another identified date the resident had informed staff that he/she was leaving the home. The progress notes indicated that the home had been in contact with family to inform then that the above mentioned resident was making more serious statements and ongoing responsive behaviours.

-On another identified date that resident had stated to staff that the reason of the above mentioned incident was to leave the home.

Review of the resident's assessments showed no evidence that he/she was reassessed regarding his/her change in behavior.

Interview with the family of the above mentioned resident indicated that they had informed the home on previous occasions of the resident's behaviours and the previous medical treatment.

Interview with Life Skills Coordinator and the Administrator revealed that the resident stated that he/she had caused the incident because he/she wanted to leave the home.

Interview with a registered staff member stated that when a resident is observed to have a change in their condition such as a change in their behaviour, staff are required to assess the resident to find out the cause.

Interviews with a registered staff member and the DOC stated the resident was not assessed for his/her change in condition.

An order has been issued based on the severity of harm actual harm/risk and the scope was isolated. [s. 6. (10) (b)] (606)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 30, 2017

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 12th day of April, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Jennifer Brown

**Service Area Office /**
**Bureau régional de services :** Toronto Service Area Office