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 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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 7, 2018	2018_745690_0013	022829-18	Complaint

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

TRACY MUCHMAKER (690)

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): November 19-23, 2018

A complaint submitted to the Director related to resident care concerns was completed during this inspection

Critical Incident inspection #2018_745690_0014 and Other inspection #2018_745690_0015 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Maintenance Manager (MM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Residents, Family Members and Substitute Decision Makers.

During the course of the inspection, the inspector(s) conducted observations in resident home areas, observation of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Food Quality
Hospitalization and Change in Condition
Medication
Personal Support Services
Reporting and Complaints

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

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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home had been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint, and that a documented record was kept in the home that included: the nature of each verbal complaint, the date the complaint was received, actions taken to resolve the complaint, final resolution, dates communicating with the complainant, any response made by the complainant.

A complaint was submitted to the Director related to resident #001's care and the home's management of complaints.

In an interview with Inspector #690, resident #001 indicated that they had written the Director of Care (DOC) a letter outlining an identified complaint. Resident #001 had indicated that they had previously requested a meeting with the DOC on an identified date. Resident #001 recalled having a meeting with the DOC and discussing the concern, but that there had been no resolution provided by the home and that the issue had worsened. Resident #001 indicated that they had written a letter to the DOC six days following the meeting with the DOC, and that the home had not replied to them or addressed the concern.

Inspector #690 reviewed the home's complaint concern logs for 2018 and could not locate a record of the written complaint from resident #001. Inspector #690 requested a copy of the written complaint from the Administrator. The Administrator did not have knowledge of the written complaint from resident #001 and indicated that the DOC may have knowledge of the complaint. The DOC provided Inspector #690 with a hand written

complaint letter from resident #001. The complaint letter described resident #001's complaint and further detailed that they had been requesting relief from the issue and that there was no follow up or resolution to the complaint.

A review of progress notes revealed that two days after resident #001 requested a meeting with the DOC, the DOC met with resident #001 to discuss the concerns and offered resident #001 a possible resolution. Progress notes during a specific time period following the meeting with the DOC, indicated that resident #001 continued to complain about the identified concern.

A review of a policy titled "Complaints Management Program", policy #XXIII-A-10.40, last revised October 2017, indicated under the heading "Written Complaints": The Executive Director or designate will: Immediately forward all written complaints to the MOHLTC Critical Incident and Triage Team (CIATT) as per Ministry Regulations, contact or arrange to meet with the complainant to obtain information about the area(s) of concern, and conduct and document an internal investigation using the complaint record form.

In an interview with Inspector #690, the DOC indicated that they had received the complaint letter from resident #001 on an identified date, six days after the meeting with resident #001 and that they had not acknowledged or replied to the complaint letter. The DOC further indicated that it was the expectation that all written complaints were to be followed up on and that a written response be provided to the complainant within 10 days. [s. 101. (1) 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 any written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee immediately forwarded any written complaints that had been received concerning the care of a resident or the operation of the home to the Director.

A complaint was submitted to the Director related to resident #001's care and the home's management of complaints.

Please see WN #1 for details.

A review of a policy titled "Complaints Management Program", policy #XXIII-A-10.40, last revised October 2017 indicated that in the event of a written complaint, the Executive Director will immediately forward a copy of the complaint to the MOHLTC Critical Incident and Triage Team (CIATT) as per the Ministry regulations, and follow the procedure in the written complaint section.

In an interview with Inspector #690, the DOC indicated that the home did not forward the written complaint received by resident #001 to CIATT and that they should have. [s. 22. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was submitted to the Director related to resident #001's care. The complainant indicated that resident #001 was prescribed a 1/2 dose of an identified medication and that resident #001 had received a full dose of the medication.

A review of resident #001's electronic medication administration record (emar) at the time of the medication incident indicated that resident #001 was prescribed a 1/2 dose of an identified medication.

A review of a medication incident report indicated that on an identified date, it was discovered that resident #001 was administered a whole dose of an identified medication instead of the 1/2 dose that was prescribed.

A review of the home's policy titled "The Medication Pass", policy #3-6 indicated that all medications were to be listed on the resident's emar and that each resident was to receive the correct medication in the correct prescribed dose. The policy further indicated that staff were to locate the medications for the resident and check each medication label against the emar to ensure accuracy.

In an interview Inspector #690, RPN #115 indicated that they had administered medications to resident #001 on the identified date, and that they had misread the emar and administered an incorrect dose of the identified medication. RPN #115 indicated that it is the expectation that all medications were to be administered in accordance with the directions for use specified by the prescriber, including the correct mediation and the correct dosage.

In an interview with Inspector #690, the DOC indicated that resident #001's identified medication was not administered in accordance with the directions for use specified by the prescriber and that it should have been. [s. 131. (2)]

Issued on this 19th day of December, 2018

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

Original report signed by the inspector.