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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 2, 2015	2015_344586_0019	H-003259-15	Resident Quality Inspection

Licensee/Titulaire de permis

SPECIALTY CARE / WOODHALL PARK INC
400 Applewood Crescent Suite 110 VAUGHAN ON L4K 0C3

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

SPECIALTY CARE WOODHALL PARK
10260 KENNEDY ROAD NORTH BRAMPTON ON L6Z 4N7

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

JESSICA PALADINO (586), CATHIE ROBITAILLE (536), MELODY GRAY (123), THERESA MCMILLAN (526)

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): September 17, 18, 21, 22, 23, 24, 25, 28, 29, 30 and October 1, 29, 2015.

The following inspections were completed during simultaneously with this Resident Quality Inspection;
Follow-up Inspections: H-001222-14 and H-001223-14.
Critical Incident Inspections: H-001048-14, H-001323-14, H-001234-14, H-001363-14, H-002557-15, H-002864-15, H-003015-15, H-003060-15, H-003167-15, and H-003193-15.
Complaint Inspections: H-000847-14, H-001310-14, H-002411-15, H-003257-15, and H-002316-15.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Scheduling Coordinator, Resident Assessment Instrument (RAI) Coordinator, Director of Resident Programs and Admissions (DRPA), Director of Dietary and Support Services (DDSS), Director of Environmental Services (DES), Registered Dietitian (RD), Recreation Therapist (RT), Recreation Therapy Assistant (RTA), dietary aides, housekeeping and maintenance staff, personal support workers (PSWs), Registered nurses (RNs), Registered practical nurses (RPNs), residents and family members.

During the course of the inspection, the inspector(s) toured the home; observed residents and the provision of care; and reviewed relevant policies and procedures, resident health records, the home's internal investigation notes and staff schedules.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **3 VPC(s)**
- **0 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. 6. (1)	CO #003	2014_266527_0014	586
O.Reg 79/10 s. 8. (1)	CO #002	2014_266527_0014	526

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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 written plan of care for resident #021 set out clear directions to staff and others who provide direct care to the resident.

Resident #021's documented plan of care directed staff to ensure that the resident's dietary intervention was to be refrigerated and kept cold when administering to the resident.
Observation of afternoon medication pass on September 27, 2015, confirmed the resident was given the dietary intervention at room temperature. The electronic medication administration record (eMAR) on the medication cart did not identify the need for the intervention to be kept refrigerated until dispensing, therefore there was no direction provided to the RPN distributing the intervention. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care for resident #021 was based on an assessment of the resident and the needs and preferences of that resident.

Resident #021's substitute-decision maker (SDM) voiced concern that the resident was not involved in the pet therapy program in the home even though the resident loved animals.
i. Review of the resident's Participation Report from October 2014 – September 2015 revealed that the resident only participated in the Pet Therapy Program once in 2014, and not again until the end of August 2015, when the resident's SDM brought forward their concern.
ii. The RTA could not confirm why the resident was not invited to participate in the Pet Therapy program for eight months. The RTA also confirmed the resident's preference for pet therapy was not included in their documented plan of care.
The resident's plan of care was not based on the needs and preferences of the resident. [s. 6. (2)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident #021 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A summary of resident #021's most recent care conference was documented on an identified date in July 2015, which was attended by the DOC, ADOC, physician, an RPN, and the resident's SDM, among others. The summary identified that the resident had been hoarding pills, therefore a particular intervention was documented to be put in place

to mitigate this.
i. Review of the resident's documented care plan, which the front line staff use to direct care, did not use the specific strategy for medication administration.
ii. Observation of lunch medication pass on an identified date in September 2015, confirmed that the specific strategy was not in place.
iii. Interview with the RPN confirmed they were not aware of the need for the specific strategy for medication administration; this was not identified on the eMAR.
The staff did not collaborate in the development and implementation of the resident's plan of care. [s. 6. (4) (b)]

4. The licensee has failed to ensure that resident #050's SDM was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Review of resident #050's documented care plan and interview with front line, registered, and management staff at the home on October 29, 2015, confirmed that one of the resident's family members had to be present for all transfers, but that if they were unavailable, a manager could be present for the transfer. In an interview with the resident's SDM, they denied providing consent to having a manager present for transfers rather than a family member. Review of the resident's health file confirmed there was no documented evidence to support that the SDM consented to the change in the resident's plan of care. [s. 6. (5)]

5. The licensee has failed to ensure that the care set out in each resident's plan of care was provided to the resident as specified in the plan.

A) Resident #021's documented plan of care directed staff to ensure that the resident's dietary intervention was to be refrigerated and kept cold when administering to the resident.
i. As per progress notes, the resident's SDM indicated the resident's preference was to have the dietary intervention cold, rather than room temperature, otherwise they would dislike it and thus not consume it.
ii. Observation of the afternoon medication pass on September 29, 2015, confirmed the resident was given the dietary intervention at room temperature. The RPN confirmed the dietary intervention was refrigerated after opening; however, unopened items were kept at room temperature.
iii. In an interview with the DDSS, they indicated that the dietary intervention was to be kept in a cam chiller on the medication cart and thus always cold; however, observation and interview with the RPN confirmed there were no cam chillers on the med cart.

The resident was provided the care as specified in their plan of care.

B) A progress note from an identified date in September 2014, documented that resident #050 was transferred by two PSW's in the presence of the PSW Manager from the wheelchair to the bed using a mechanical lift, and that no family members were present. Interview with the front line, registered, and management staff of the home, and review of the home's internal investigation notes, confirmed the resident was transferred without one of the family members present. Care was not provided to the resident as per the resident's plan of care. [s. 6. (7)]

6. The licensee has failed to ensure that resident #036 reassessed and the plan of care reviewed and revised when their plan was no longer necessary in relation to minimizing of restraints.

On September 17, 2015, resident #036 was observed to have an identified restraint device while they were sitting in a wheelchair. On September 22 and 23, 2015, the restraint was not in place. Review of resident #036's health record indicated that the restraint had been discontinued on an identified date in August 2015. During interview, the RPN stated that the restraint had been discontinued, that staff may not have known about the discontinuation, and that the resident's family member would apply the restraint. The RPN confirmed that the plan of care should have been updated to reflect that the resident no longer required the application of the restraint when the order for its discontinuation was made on an identified date in August 2015. [s. 6. (10) (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 every resident's written plan of care sets out clear directions to staff and others who provide direct care to the resident; to ensure the care set out in each resident's plan of care is based on assessment of the resident and the needs and preferences of the residents; to ensure staff and others involved in different aspects of care of each resident collaborate with each other in the development and implementation of the plans of care so that the different aspects of care are integrated and are consistent with and complement each other; to ensure each resident's substitute decision-maker is given the opportunity to participate fully in the development and implementation of the resident's plan of care; to ensure the care set out in each resident's plan of care is provided to the residents as specified in the plan; and to ensure each resident's plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's "Prevention of Abuse and Neglect of a Resident" (policy number VII-G-10.00, last revised January 2015) stated "If any employee or volunteer witnesses and incident, or has any knowledge of an incident, that constitutes resident abuse or neglect; all Staff are responsible to immediately take these steps:

1) Stop the abusive situation and intervene immediately if safe for them to do so while ensuring the safety of the resident.
2) Remove resident from the abuser, or if that is not possible, remove the abuser from the resident if safe for them to do so while ensuring the safety of the resident.
3) Immediately inform the Executive Director (ED)/Administrator and/or Charge Nurse in the home."

Review of the home's investigative notes revealed that on an identified date in May 2015, resident #043 was allegedly abused by a visitor as witnessed by a PSW. According to notes and interview with the PSW, the visitor was trying to assist the resident into their room and the resident was yelling that they did not want to go. The incident resulted in the resident falling onto the floor. During interview with the Long Term Care Homes (LTCH) Inspector, the PSW stated that, at the time of the incident, the visitor's actions seemed abusive toward the resident and they did not intervene. The PSW confirmed that they did not stay with the resident while calling for help; that they did not remove the resident or the alleged abuser, prior to leaving to get help. The DOC confirmed the home's expectation that the PSW should have stayed with the resident and their family member while calling for help from other staff. [s. 20. (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 the home's written policy that promoted zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff had received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

Review of the home's training records for 2014 indicated that 140 of 179 (78.21 per cent) staff in the home had completed the home's "Abuse and Neglect for Canada" training. This was confirmed by the ADOC. [s. 76. (4)]

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 all staff receive retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, was available in every area accessible by residents as evidenced by;
The secure outdoor space accessible and used by residents which was located to the right of the front entrance was inspected during the initial tour of the home and a communication response system was not located in that area. The inspector toured the area with the home's DES and they confirmed that area is accessible and used by residents and that the area was not equipped with a communication and response system. [s. 17. (1) (e)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who was a member of the staff of the home.

Review of resident #051's health record indicated that they were a high risk for falls, and had several fall interventions in place; progress notes indicated that the resident frequently attempted to get up from their wheelchair.
i. Progress notes indicated that on an identified date in June 2015, the resident attempted to stand while seated in their wheelchair. In the process, the resident injured their foot and was sent to hospital for further assessment.
ii. Health records indicated that the resident received treatment for the altered skin integrity between identified dates in June and July 2015. During review of health records, a referral to dietitian could not be found. During interview with the LTCH Inspector, a full-time RPN stated that they did not normally make a dietary referral unless the resident had a large wound or pressure ulcer. During interview, the RD confirmed that they had not received a referral for resident #051 following the incident in June 2015, that led to altered skin integrity. The RD confirmed that they would have initiated dietary interventions to promote wound healing had they received the referral.
iii. On interview, the DOC confirmed that residents who had a laceration should be assessed by the home's RD. [s. 50. (2) (b) (iii)]

WN #6: 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:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made had a response within 10 business days of the receipt of the complaint.

On an identified date in April 2015, a verbal complaint was left by a family member for the DOC. Thirteen days later, an email was sent to the DOC by the family member; stating a message had been left to address these concerns at least three weeks earlier.
i. The LTCH Inspector completed a review of the homes complaint log for 2015. The complaint log identified that originally a verbal complaint had been received on the identified date in April 2015. It also noted that a phone call was made to acknowledge the letter and to arrange a meeting. There was no mention of any call to the complainant, in regards to their original verbal complaint. The DOC was unable to confirm that the home responded to the original verbal complaint. [s. 101. (1) 3.]

2. The licensee has failed to ensure that the documented record (of complaints received) was reviewed and analyzed for trends, at least quarterly.

On October 1, 2015, the LTCH Inspector met with the ED to review any quarterly evaluations completed. The ED confirmed that a quarterly evaluation had not been completed of the complaints received. [s. 101. (3)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital and that results in a significant change in the resident's health condition as evidenced by:

Record review confirmed resident #048 was found on the floor in July 2014. They were transferred to the hospital and returned to the home the following day with an injury.
i. The home's records, including the Critical Incident Report, were reviewed and it was noted that the resident returned to the home the following day with a significant change in status, and that the incident was reported to the Director nine days later. [s. 107. (3) 4.]

Issued on this 18th day of November, 2015

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

Original report signed by the inspector.