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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 21, 2017	2017_543561_0010	014605-17	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

Woodhall Park Care Community
10260 KENNEDY ROAD NORTH BRAMPTON ON L6Z 4N7

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

DARIA TRZOS (561), HEATHER PRESTON (640), KATHLEEN MILLAR (527)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, 2017.

The following Critical Incident Inspections were completed during this RQI with the log numbers:

006652-16 related to a fall with injury,
012695-16 related to a fall with injury,
018118-16 related to a fall with injury,

019562-16 related to a fall with injury,
019693-16 related to a fall with injury,
002138-17 related to responsive behaviours,
003963-17 related to a fall with injury,
004159-17 related to alleged staff to resident abuse,
006318-17 related to alleged staff to resident neglect,
006565-17 related to alleged staff to resident abuse,
007934-17 related to a fall with injury,
014615-17 related to alleged abuse.

The following Complaint Inspections were completed with this RQI with the log numbers:

004405-17 related to allegation of neglect,
007689-17 related to an allegation of neglect of resident and failure to provide standard care,
016484-17 related to multiple care concerns.

The following inquiries were completed during this RQI with the log numbers:

026811-15 related to unknown cause of injury,
008862-16 related to falls,
009035-16 related to unknown cause of injury,
013041-17 related to insufficient staffing,
009722-17 related to resident common areas being used for staff.

Non compliances were identified in the Complaint Inspection, Inspection number 2017_543561_0011 / 004405-17, 016484-17 that was completed concurrently with this RQI.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Associate Director of Care (ADOC), Physiotherapist, Resident Relation Coordinator, Pharmacist, Restorative Care, RAI Coordinator, Behavioural Supports Ontario (BSO) Personal Support Worker, Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Council President, Family Council Representative, residents and families.

During the course of the inspection LTC Inspectors toured the home, observed provision of care, observed medication administration, reviewed clinical health records, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **6 VPC(s)**
- **2 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	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. (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. (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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident 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.

Resident #017 had an intervention identified as a Personal Assistive Services Device (PASD).
The clinical record was reviewed included a physician's order, consent for the PASD and there was an order for another intervention identified as a PASD; however it was discontinued on an identified date in 2017. In the written plan of care only one PASD was included. In the same written plan of care, under the focus for bed mobility it directed staff to use a different type of the PASD. The clinical record had a PASD assessment for only one of the PASDs.

The resident was observed on two different days during this inspection and had the PASD while in wheelchair in use.

Interview with registered staff #112 and PSW #100 revealed that the resident did not use a different type of the PASD while in bed. The PSW also indicated that the resident was also using a PASD while in wheelchair. Registered staff #112 indicated that the physician's order for the PASD in wheelchair was initiated on an identified date in 2017, but when they called the substitute decision maker (SDM), the SDM did not consent to its use. Interview with registered staff #105 identified that the resident used only one PASD for bed mobility. Interview with registered staff #106 was interviewed and they indicated that the resident had a PASD while in wheelchair.
When registered staff #112 was interviewed, they confirmed that the plan of care was not integrated and consistent.

The ADOC was interviewed and confirmed the resident had a PASD used while in bed for positioning, and they were not to have the PASD while in wheelchair. The ADOC confirmed that the written plan of care was inconsistent.

The home did not ensure that the staff involved in the different aspects of care for resident #017 collaborated with each other, and the plan of care was developed and implemented so that the different aspects of care were integrated and were consistent with and complemented each other. [s. 6. (4)]

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

A) A Critical Incident (CI) report was submitted to the Director on an identified date in 2017 with concerns related to neglect and care of resident #034.
The written plan of care at the time of the incident for resident #034, indicated that resident required assistance by two staff for different aspects of care.

PSW #145 was interviewed and indicated that on an identified date in 2017, they provided care to the resident and turned and repositioned resident without the assistance of another PSW. PSW #145 was aware that resident's plan of care stated that resident required two person assistance for repositioning.

The flow sheets were reviewed and during the month of the incident, staff had documented that turning and repositioning was done with one person assistance.

The investigation completed by the home and the interview with Executive Director (ED)

confirmed that the resident required two person assistance for turning and repositioning and confirmed that staff did not follow the plan of care.

B) Resident #032 had a plan of care indicating that they were at risk for falls and required to have devices in place while in the wheelchair. On an identified date in 2016, PSW #127 was providing care to the resident and did not provide care as per the plan of care and resident fell sustaining an injury.

The investigation notes indicated that PSW #127 failed to follow the care plan.

LTC Inspector interviewed the PSW involved.
The ADOC was interviewed and confirmed that the PSW #127 did not follow the plan of care.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan resulting in a fall and sustaining an injury.

C) Resident #025 had a care plan indicating they were at risk for falls according to the Fall Risk Assessment completed on an identified date in 2016. The Quarterly Interdisciplinary Care Conference on an identified date completed in 2016, indicated that resident remained on high risk for falls and had interventions in place to prevent falls. Resident required two person assistance for different aspects of care.

A Critical Incident report was submitted to the Director on an identified date in 2016 indicating that a PSW did not follow the care plan resulting in resident #025 falling. Resident sustained an injury and was sent to hospital for an assessment.

Investigation notes were reviewed and revealed that PSW #129 provided direct care to the resident and did not follow the plan of care during care. Resident fell and sustained an injury. The registered staff #112 on the unit was interviewed by the home and stated that when they went to respond to the fall, the falls interventions were not in place.

PSW #129 was interviewed by the LTC Inspector.
Maintenance records were reviewed for the month in question by LTC Inspector. The ADOC confirmed that no maintenance was required in this resident's room.

Registered staff #112 was interviewed by the LTC Inspector and confirmed that the PSW did not follow the plan of care. Resident sustained an injury and was sent out for an

assessment.

The interview with the ADOC confirmed that the staff did not follow the plan of care.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that if a resident was being reassessed and the plan of care was being revised because care set out in the plan was not effective, different approaches had been considered in the revision of the plan of care.

Resident #005 had a number of falls documented in the plan of care in 2016, prior to a fall that occurred on an identified date in 2016 which resulted in an injury.

The care plan was reviewed and after each fall and only two interventions were tried and implemented. There was no evidence that any other interventions were tried and no documentation was found to indicate that these interventions were effective.

In an interview, registered staff #137 stated that resident was cognitively impaired and intervention in place was not always effective.

After the fall in 2016, the post fall assessment indicated that new interventions were implemented. Progress note on an identified date following the fall assessment in 2016, another intervention was implemented. On another date in 2016, a progress note indicated that resident had additional intervention in place. Resident was also assessed by Physiotherapist and the level of transfer was changed and resident was in wheelchair.
On an identified date in 2016, it was documented that resident displayed an identified behaviour, and staff kept resident by the nursing station for close monitoring.
On an identified date in 2016, resident sustained another fall that resulted in an injury and resident was sent to the hospital for assessment. The post fall assessment indicated that a new intervention was initiated.
Resident sustained yet another fall after hospitalization in 2016 with no injury and the post fall assessment indicated that new intervention was initiated.
Resident sustained another fall on an identified date in 2017 that resulted in an injury.

The home submitted a CI and identified the falls interventions not being implemented was the contributing factor to the fall. The CI stated that the interventions in place to prevent falls were not implemented as per the plan of care.

Interviewed PSW #140 who stated that resident did not have some of the interventions in place and confirmed that they were not in the written plan of care.
In an interview, registered staff #139 stated that resident was at high risk for falls and had a number of interventions in place; however, not all were included in the written plan of care.
The review of health records revealed that some of the interventions mentioned by staff were added to the written plan of care on an identified dates in 2017 after the falls.

In 2016, resident #005 sustained a number of falls and after the fall which resulted in an injury, staff tried different interventions and documented them in the progress notes and post fall assessments; however, these interventions were not considered in the revision of the plan of care. Staff were not aware of these interventions, did not apply them and stated they were not in the care plan.

The ADOC was interviewed and stated that resident #005 was cognitively impaired and would not always be able to call for assistance. The home would evaluate interventions for falls at the quarterly MDS assessments; however, only at times that fall would trigger. This year the home had implemented a new post fall huddle that would ensure that interventions are being evaluated. This was not in place in 2016.

The Resident Assessment Protocol (RAP) on an identified date in 2016, was reviewed and falls did not trigger on this RAP. Falls was mentioned under the section called 'other clinical issues' and the home documented that resident was at risk for falls and was wondering on the unit. No interventions were mentioned on the RAP.
The RAP in a different quarter in 2016, indicated that under the 'other clinical issues' section the home identified that resident was at risk for falls and is ambulatory and wanders on the unit. No interventions were mentioned in the RAP.

The licensee failed to ensure that when resident was being assessed after each fall, interventions that were implemented in 2016 were not effective and different approaches were not considered and after the fall with injury in 2016, different interventions were tried; however, they were not considered in the revision of the plan of care. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 the staff and others involved in the different aspects of care of the resident collaborate with each other 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; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan; to 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 the resident's care needs change or care set out in the plan is no longer necessary and to ensure that if a resident is being reassessed and the plan of care is being revised because care set out in the plan is not effective, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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 put in place was complied with.

In accordance with Regulation, s.48, the licensee was required to ensure that the interdisciplinary programs including a skin and wound care program were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for assessment and reassessment instruments. O. Reg. 79/10, s.48

According to the home's policy titled "Resident Assessments", policy number VII-C-10.70 and revised January 2015, staff were directed to complete all required user defined assessments quarterly. The "Head-to-toe" assessment was to be completed and the specific information then captured in the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) quarterly assessment tool.

On MDS 2.0 Assessment Planner, for one of the quarters of 2016, registered staff #124 was assigned to complete a head-to-toe assessment for resident #027. The LTC Inspector reviewed the clinical record which revealed there was no head-to-toe quarterly assessment completed for resident #027 during the assessment period.

Interview with the RAI Coordinator by the LTC Inspector, the RAI Coordinator informed the LTC Inspector it was the expectation of the home that the head-to-toe assessment be completed prior to the completion of the RAI-MDS assessment tool.
During an interview with registered staff #124, they told the LTC Inspector they were scheduled to complete the assessment and did not recall why this had not been completed. The ADOC was interviewed and explained the home expected the head-to-toe assessment to be completed as assigned. The ADOC confirmed this had not been done for the assessment period.

The licensee failed to ensure that their "Resident Assessments" policy was complied with. [s. 8. (1) (a),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 put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

A) The CI report submitted to the Director on and identified date in 2017, indicated that there was a reported allegation of abuse by PSW #145 towards resident #034.
The CI report was reviewed by the LTC Inspector #561, and during the inspection the review of clinical records and investigative notes revealed that the home did not amend the critical incident report with the results of the investigation and did not submit this information to the Director.
The Executive Director (ED) was interviewed and confirmed that the results of the investigation were not reported to the Director after the investigation was completed.

B) The CI report submitted to the Director on an identified date in 2016, indicated that resident #025 may have received improper or incompetent treatment that resulted in harm.
The CI report was reviewed by the LTC Inspector #561, and during the inspection the review of clinical records and investigative notes revealed that the home did not amend the critical incident report with the results of the investigation and did not submit this information to the Director.

The ED was interviewed and confirmed that the results of the investigation were not reported to the Director after the investigation was completed. (561)

C) The CI report submitted to the Director on identified date in 2017, indicated that there was an allegation of abuse by PSW #116 towards resident #009. The CI report was reviewed by the LTC Inspector #527, and during the inspection the review of clinical records and investigative notes revealed that the home did not amend the critical incident report with the results of the investigation and did not submit this information to the Director.
The ADOC was interviewed and confirmed that the results of the investigation were not reported to the Director after the investigation was completed.

D) The CI report submitted to the Director on an identified date in 2016, indicated that resident #022 had an injury of unknown origin, which resulted in the resident being transferred to the hospital. The resident returned from the hospital and had a significant change in health status.
The CI report was reviewed by the LTC Inspector #527, and during the inspection the clinical records were reviewed and the investigative notes. The review revealed that the home did not amend the critical incident report with the results of the investigation and did not submit this information to the Director.
The ADOC was interviewed and confirmed that the results of the investigation were not reported to the Director after the investigation was completed.

E) The CI report submitted to the Director on an identified date in 2015, indicated that resident #021 may have received improper or incompetent treatment that resulted in injuries.
The CI report was reviewed by the LTC Inspector #527, and during the inspection the review of clinical records and investigative notes revealed that the home did not amend the critical incident report with the results of the investigation and did not submit this information to the Director.
The ADOC was interviewed and confirmed that the results of the investigation were not reported to the Director after the investigation was completed. [s. 23. (2)]

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 the results of the abuse or neglect investigation are reported to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #027 was admitted to the home on an identified date in 2012 and had several diagnoses.

A) On an identified date in 2017, staff identified that resident had an alteration in skin integrity.
Resident #027 was bathed twice a week and preferred a shower. During the bathing process, PSW staff were to review the resident's skin and note any concerns, redness, ulcers, bruising or any other changes. The information was to be documented on a "Skin and Wound – Weekly Skin Surveillance Worksheet and Tool' whether there were any abnormalities found or not. The PSW was to sign the document and leave for the nurse to review and sign. Once weekly, the nurse was to review the forms and note in the electronic documentation system, Point Click Care (PCC), under a progress note, the outcome of the weekly skin surveillance as documented by the PSWs.

During an interview with PSWs #131 and #132, the evening PSWs responsible to bathe resident #027, informed the LTC Inspector that they completed the surveillance tool after bathing the resident. The surveillance tool was always kept in the PSW documentation binders. Interview with PSWs #131, #132, #134 and #125 who told the LTC Inspector if they noticed any skin concerns, they reported this immediately to the nurse.

The LTC Inspector reviewed the clinical record of resident #027 with the ADOC. There were no Skin and Wound Weekly Surveillance Worksheets in the record nor were there any progress notes summarizing the findings of the weekly surveillance worksheets. The ADOC confirmed it was an expectation of the home that a summary note be done based on the documentation of the weekly skin and wound surveillance worksheet. The ADOC confirmed there were no such notes entered in the clinical record of resident #027.

B) On an identified date in 2017, PSW #101 reported to RPN #137 that resident #027 had an identified symptom. Review of the clinical record revealed there were no progress notes or assessments completed related to the assessment of the symptom.

During an interview, registered staff #137 informed the LTC Inspector they immediately went to the resident room to complete an assessment. The registered staff told the LTC Inspector they had not completed a head-to-toe assessment document for this assessment, but had done a progress note in the clinical record that day. The progress note was extensive and included the assessment. The registered staff believed the home had a new internet service provider that had caused some functionality issues with the electronic documentation tool, PCC.

The LTC Inspector interviewed the ADOC who told the LTC Inspector there was no change to the internet service provider and there were no documented issues or concerns related to the functioning of PCC. The ED confirmed there were no issues with PCC confirmed by a report from the home's Information Technology department. The ADOC told the LTC Inspector it was an expectation of the home that all assessments were to be documented. If there were any issues with the documentation system, staff were to notify the manager and complete a late entry note when the service had resumed. The ADOC confirmed that neither had occurred. [s. 30. (2)]

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 actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #017 had an intervention in place while in bed identified as a Personal Assistive Services Device (PASD); however the intervention used as a PASD while in wheelchair was not identified in the resident's plan of care.

The home's policy titled "Personal Assistance Service Devices (PASD's)", number VII-E-10.10, and revised November 2015, directed staff to obtain and document consent for the use of the PASD from the SDM on the Restraints/PASD electronic assessment form or a Restraints/PASD consent form.

The clinical record was reviewed and identified a physician's order and consent for the interventions while in bed as a PASD to assist the resident with positioning. There was also a physician's order for the intervention while in wheelchair as a PASD, however it was discontinued soon after. In the current written plan of care, there was no intervention for a wheelchair as a PASD. The clinical record had a PASD assessment for the PASD while in bed, but no assessment for the PASD while in wheelchair.

The resident was observed by the LTC Inspector #527, on two different days during this inspection, PASD was applied while in wheelchair.

PSW #100 was interviewed and indicated that the resident had two PASDs. Registered staff #106 was interviewed and indicated that the resident had a PASD while in wheelchair. Registered staff #112 was also interviewed and indicated that the physician's order for the PASD in wheelchair was initiated on an identified date in 2017, but when they called the SDM, the SDM did not consent to the PASD in wheelchair so the physician discontinued the order.
The ADOC was interviewed and confirmed that the staff were expected to obtain consent when implementing a PASD from resident #017's SDM, and because the SDM did not consent to it, it should not have been implemented.

The home did not ensure that the use of the PASD while in wheelchair had been

consented to by resident #017's SDM, who had the authority to give that consent for the resident. [s. 33. (4) 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 that use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies.

An inspection of a medication carts on the Country unit, third floor; the Lake House unit,

second floor and the Garden unit, first floor revealed the following items, which were not drugs or drug related:

(i) The Country unit registered staff #115, reviewed the medication cart with LTC Inspector #527, and along with drugs and drug related supplies there was a pair of resident eye glasses, health cards belonging to residents and locked in the narcotic and controlled substance bin was an envelope with twenty-five dollars and addressed to one of the physicians.
(ii) The Lake House unit registered staff #103, reviewed the medication cart with the LTC Inspector and identified that there were residents' health cards, residents' hospital cards, elastic bands and small packages of sweetener for tea or coffee.
(iii) The Garden unit registered staff #128, reviewed the medication cart with LTC Inspector and there were found residents' health cards, paper clips, scissors and a resident's nail clippers.

During an interview with registered staff #103, #115 and #128, they confirmed that the items were not expected to be stored in the medication cart because they were not drugs or drug related. They confirmed the items were either office supplies or belonged to residents. Registered staff #115 also indicated that they had no other place to store these items and this was convenient for the registered staff.

The home failed to ensure that drugs were stored in the medication cart on the Garden, Lake House and Country units and they were used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

2. The licensee has failed to ensure drugs were stored in an area or a medication cart that complied with the manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

The home's pharmacy policy titled "Expiry and Dating of Medications", policy number 5-1, and revised February 2017, directed staff to return all expired vaccines to Public Health. In addition, the home received a "Region of Peel - Health Professionals Update", dated May 18, 2017, Volume 10, Number 12, which directed the home to return all unused season influenza vaccine from the 2016/2017 season to Peel Public Health by June 30, 2017.

On July 19, 2017, the LTC Inspector #527, observed the vaccine fridge and identified eighteen 0.5 milliliter (ml) single dose prefilled syringes of Fluad vaccine and two vials of

Fluviral vaccine in a single box. All of the flu vaccines had expired in May 2017 and were not returned to Peel Public Health.
The manufacturer's instructions were reviewed and identified that the vaccine was not to be used when expired.

Registered staff #128 was interviewed and identified the vaccines were expired and should have been returned to Public Health as per their policy and direction from Public Health.

The ADOC was interviewed and confirmed the expired vaccines were expected to be removed and returned to Public Health as per the home's policy and as directed by Public Health. The ADOC further indicated that Public Health was in the home on July 13, 2017, however they were on vacation and the staff forgot to return the expired flu vaccine to the Public Health nurse.

The home did not comply with their policy for expiry of medication, the Public Health directive, or the manufacturer's instructions. [s. 129. (1) (a) (iv)]

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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies an to ensure that drugs are stored in an area or a medication cart that complied with the manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting), to be implemented voluntarily.

Issued on this 2nd day of October, 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) :	DARIA TRZOS (561), HEATHER PRESTON (640), KATHLEEN MILLAR (527)
Inspection No. / No de l'inspection :	2017_543561_0010
Log No. / No de registre :	014605-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 21, 2017
Licensee / Titulaire de permis :	SPECIALTY CARE / WOODHALL PARK INC 400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3
LTC Home / Foyer de SLD :	Woodhall Park Care Community 10260 KENNEDY ROAD NORTH, BRAMPTON, ON, L6Z-4N7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kerri Judge

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

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

Order # / Ordre no : 001

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. (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).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that the care set out in the plan of care is provided to residents as specified in the plan.

The plan shall include how the home will meet the following:

1) Ensuring the care set out in the plan of care is provided to residents as specified in the plan related to falls interventions, and all aspects of the provision of care of residents.
2) Ensuring that staff review all contents of the plan of care and are aware of the contents of the plan of care when providing care to residents.
3) Ensuring education is provided to all staff that are involved in the provision of care on the home's policies and procedures related to falls, and all aspects of the provision of care.
4) Ensuring that there are quality initiatives developed for auditing and improving the process to ensure resident safety and satisfaction.

The plan shall be submitted to Long-Term Care Homes Inspector Daria Trzos, via email at Daria.Trzos@ontario.ca or via mail to the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 119 King St. W, 11th floor, Hamilton, ON L8P 4Y7, by October 6, 2017.

Grounds / Motifs :

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

The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s. 6(7) of the Act.

There was actual harm to residents, the scope was isolated, and the Licensee's history of noncompliance (VPC) on the April 6, 2016 Critical Incident Inspection with the s. 6 (7), (VPC) on the April 5, 2016 Complaint Inspection, and (VPC) on the September 17, 2015 Resident Quality Inspection.

A) Resident #032 had a plan of care indicating that they were at risk for falls and required to have devices in place while in the wheelchair. On an identified date in 2016, PSW #127 was providing care to the resident and did not provide care as per the plan of care and resident fell sustaining an injury.

The investigation notes indicated that PSW #127 failed to follow the care plan.

LTC Inspector interviewed the PSW involved.
The ADOC was interviewed and confirmed that the PSW #127 did not follow the plan of care.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan resulting in a fall and sustaining an injury.

B) Resident #025 had a care plan indicating they were at risk for falls according to the Fall Risk Assessment completed on an identified date in 2016. The Quarterly Interdisciplinary Care Conference on an identified date completed in 2016, indicated that resident remained on high risk for falls and had interventions in place to prevent falls.
Resident required two person assistance for different aspects of care.

A Critical Incident report was submitted to the Director on an identified date in 2016 indicating that a PSW did not follow the care plan resulting in resident #025 falling. Resident sustained an injury and was sent to hospital for an assessment.

Investigation notes were reviewed and revealed that PSW #129 provided direct care to the resident and did not follow the plan of care during care. Resident fell and sustained an injury. The registered staff #112 on the unit was interviewed by the home and stated that when they went to respond to the fall, the falls interventions were not in place.

PSW #129 was interviewed by the LTC Inspector.
Maintenance records were reviewed for the month in question by LTC Inspector.
The ADOC confirmed that no maintenance was required in this resident's room.

Registered staff #112 was interviewed by the LTC Inspector and confirmed that the PSW did not follow the plan of care. Resident sustained an injury and was sent out for an assessment.

The interview with the ADOC confirmed that the staff did not follow the plan of care.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

C) A Critical Incident (CI) report was submitted to the Director on an identified date in 2017 with concerns related to neglect and care of resident #034.
The written plan of care at the time of the incident for resident #034, indicated that resident required assistance by two staff for different aspects of care.

PSW #145 was interviewed and indicated that on an identified date in 2017, they provided care to the resident and turned and repositioned resident without the assistance of another PSW. PSW #145 was aware that resident's plan of care stated that resident required two person assistance for repositioning.

The flow sheets were reviewed and during the month of the incident, staff had documented that turning and repositioning was done with one person assistance.

The investigation completed by the home and the interview with Executive Director (ED) confirmed that the resident required two person assistance for turning and repositioning and confirmed that staff did not follow the plan of care.

(561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 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. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that if a resident is being reassessed and the plan of care is being revised because care set out in the plan is not effective, different approaches are considered in the revision of the plan of care.

The plan shall include how the home will meet the following:

1) Ensuring that interventions related to falls for resident #005 and other residents at risk for falls are being reviewed after each fall.
2) Ensuring that interventions related to falls for resident #005 and other residents at risk for falls are being evaluated after each fall.
3) Ensuring that the plan of care is being revised based on the interventions considered and tried for resident #005 and other residents that are at risk for falls.
4) Ensuring that there are quality initiatives developed for auditing and improving the process to ensure resident safety.

The plan shall be submitted to Long-Term Care Homes Inspector Daria Trzos, via email at Daria.Trzos@ontario.ca or via mail to the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 119 King St. W, 11th floor, Hamilton, ON L8P 4Y7, by October 6, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that if a resident was being reassessed and the plan of care was being revised because care set out in the plan was not effective, different approaches had been considered in the revision of the plan of care.

The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (3), in keeping with s. 6 (11)(b) of the Act. There was actual harm to residents, the scope was isolated, and the Licensee's history of previous ongoing noncompliance with (VPC) in similar areas of section 6 of the Act on the December 29, 2016 Resident Quality Inspection, on the April 6, 2016 Critical Incident Inspection, on the April 5, 2016 Complaint Inspection, and on the September 17, 2015 Resident Quality Inspection.

Resident #005 had a number of falls documented in the plan of care in 2016, prior to a fall that occurred on an identified date in 2016 which resulted in an injury.

The care plan was reviewed and after each fall and only two interventions were tried and implemented. There was no evidence that any other interventions were tried and no documentation was found to indicate that these interventions were effective.

In an interview, registered staff #137 stated that resident was cognitively impaired and intervention in place was not always effective.

After the fall in 2016, the post fall assessment indicated that new interventions were implemented. Progress note on an identified date following the fall assessment in 2016, another intervention was implemented. On another date in 2016, a progress note indicated that resident had additional intervention in place. Resident was also assessed by Physiotherapist and the level of transfer was changed and resident was in wheelchair.
On an identified date in 2016, it was documented that resident displayed an identified behaviour, and staff kept resident by the nursing station for close monitoring.
On an identified date in 2016, resident sustained another fall that resulted in an injury and resident was sent to the hospital for assessment. The post fall

assessment indicated that a new intervention was initiated.
Resident sustained yet another fall after hospitalization in 2016 with no injury and the post fall assessment indicated that new intervention was initiated.
Resident sustained another fall on an identified date in 2017 that resulted in an injury.

The home submitted a CI and identified the falls interventions not being implemented was the contributing factor to the fall. The CI stated that the interventions in place to prevent falls were not implemented as per the plan of care.

Interviewed PSW #140 who stated that resident did not have some of the interventions in place and confirmed that they were not in the written plan of care.
In an interview, registered staff #139 stated that resident was at high risk for falls and had a number of interventions in place; however, not all were included in the written plan of care.
The review of health records revealed that some of the interventions mentioned by staff were added to the written plan of care on an identified dates in 2017 after the falls.

In 2016, resident #005 sustained a number of falls and after the fall which resulted in an injury, staff tried different interventions and documented them in the progress notes and post fall assessments; however, these interventions were not considered in the revision of the plan of care. Staff were not aware of these interventions, did not apply them and stated they were not in the care plan.

The ADOC was interviewed and stated that resident #005 was cognitively impaired and would not always be able to call for assistance. The home would evaluate interventions for falls at the quarterly MDS assessments; however, only at times that fall would trigger. This year the home had implemented a new post fall huddle that would ensure that interventions are being evaluated. This was not in place in 2016.

The Resident Assessment Protocol (RAP) on an identified date in 2016, was reviewed and falls did not trigger on this RAP. Falls was mentioned under the section called 'other clinical issues' and the home documented that resident was at risk for falls and was wondering on the unit. No interventions were mentioned

on the RAP.
The RAP in a different quarter in 2016, indicated that under the 'other clinical issues' section the home identified that resident was at risk for falls and is ambulatory and wanders on the unit. No interventions were mentioned in the RAP.

The licensee failed to ensure that when resident was being assessed after each fall, interventions that were implemented in 2016 were not effective and different approaches were not considered and after the fall with injury in 2016, different interventions were tried; however, they were not considered in the revision of the plan of care.
(561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 21st day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

Service Area Office /
Bureau régional de services : Hamilton Service Area Office