Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 4, 2019	2019_826606_0023	015209-19, 016883-19	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 9, 10, 11, and 15, 2019.

The following Critical Incident System (CIS) inspection was completed: Log #015209-19 regarding to a resident who sustained an injury related to bed entrapment; and Log #016883-19 regarding a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), Physiotherapist (PT), Restorative Care Aide, Maintenance Personnel, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Substitute Decision Makers (SDM), and residents.

During the course of the inspection, the inspector(s) conducted observations of resident care, residents and staff interactions, completed interviews and reviewed residents' clinical records such as progress notes, assessments, physician orders, written care plans, reviewed relevant home's investigation records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **1 VPC(s)**
- **1 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. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the admission care plan included the resident's risk of falling, and interventions to mitigate those risks.

A) A critical Incident reported resident #001 was found on the floor and sustained a serious injury.

An identified document for resident #001 stated that the resident was found on the floor in a specified position and location in their room. The report indicated that the circumstances surrounding the fall were unknown and suggestion of how the resident may have fallen was provided. Resident #001 was assessed and due to the injuries was transferred to the hospital.

Resident #001 was admitted a short time before they fell and their admission records stated that the resident had no history of falling. As part of the home's admission practice, resident #001 was assessed and was at an identified risk level for falling.

Resident #001's 24 hour admission plan of care was incomplete and did not specify the resident's identified risk level for falling and did not include any interventions to manage the resident's fall risk until after the resident fell on an identified date. This was acknowledged by Registered Nurse (RN) #107 and Staff #104.

B) Resident #003 was admitted on an identified date and was assessed as being at risk for falling. Resident #003's 24 hour admission plan of care was incomplete and did not include the resident's identified risk level for falling and any interventions to manage the resident's fall risks.

Registered Practical Nurse (RPN) #111 said that it was the home's practice that when a resident was a new admission, they were considered to be at high risk for falling regardless of what the admission fall risk assessment indicated. The RPN revealed that a plan of care would be initiated on admission to include various interventions to manage the resident's risk and that the resident sleep pattern would be observed for a number of days to further assess the resident's fall risk.

The licensee failed to ensure that resident #001 and #003's admission care plans included the resident's risk of falling, and interventions to mitigate those risks. [s. 24. (2) 1.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) A CI reported resident #004 was found caught between the bed's mattress and the bed rail.

Resident #004's progress notes stated that on an identified date, Personal Support Worker (PSW) #110 discovered resident #004 caught between the mattress and the bed rail. RN #105 was alerted by PSW #110 and the two staff repositioned resident #004. RN #105 assessed resident #004 and found they had sustained an injury.

Resident #004's plan of care stated the resident required bed rails to be used when in bed for an activity of daily living (ADL) and that the rails were identified as a Personal Assistance Services Device (PASDs).

RN #107 stated that resident #004's bed mattress was switched to a different mattress as an intervention to meet their care needs. The DOC stated resident #004 received the new mattress on an identified date and continued to have the bed rails.

Personal Support Worker (PSW) #110 stated that there had been another incident where resident #004 was caught between the bed rail and mattress but they could not remember the date this happened and the issue was reported to Registered Nurse (RN) #105. RN #105 confirmed this and said they documented the incident but did not report this to the Director of Care (DOC). The DOC confirmed that they were not informed of this incident.

There was no evidence in resident #004's clinical records or home records that a bed entrapment assessment was completed when the resident's bed mattress was switched to a different type of mattress or when it was reported resident #004 had been caught between the bed rail and mattress as reported by PSW #110 and RN #105.

Maintenance Personnel #102 said that when a resident received an identified type of mattress and had bed rails, the maintenance department would complete a bed entrapment assessment to assess the bed and bed rails for entrapment zones. They acknowledged that a bed entrapment assessment was not completed when resident #004's mattress was changed to this type of mattress.

The licensee has failed to ensure that when bed rails were used for resident #004, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (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 when bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

Issued on this 15th day of November, 2019

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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) : JANET GROUX (606)

Inspection No. / No de l'inspection : 2019_826606_0023

Log No. / No de registre : 015209-19, 016883-19

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Nov 4, 2019

Licensee / Titulaire de permis : The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8

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 The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.
3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
5. Drugs and treatments required.
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.
7. Skin condition, including interventions.
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Order / Ordre :

The licensee must comply with s. 24 (2) of O.Reg.79/10.

Specifically, the licensee shall ensure:

1) That when a resident is admitted to the home, their admission care plan includes the resident's risk of falling, and interventions to mitigate those risks.

Grounds / Motifs :

1. 1. The licensee failed to ensure that the admission care plan included the resident's risk of falling, and interventions to mitigate those risks.

A) A critical Incident reported resident #001 was found on the floor and sustained a serious injury.

An identified document for resident #001 stated that the resident was found on the floor in a specified position and location in their room. The report indicated

that the circumstances surrounding the fall were unknown and suggestion of how the resident may have fallen was provided. Resident #001 was assessed and due to the injuries was transferred to the hospital.

Resident #001 was admitted a short time before they fell and their admission records stated that the resident had no history of falling. As part of the home's admission practice, resident #001 was assessed and was at an identified risk level for falling.

Resident #001's 24 hour admission plan of care was incomplete and did not specify the resident's identified risk level for falling and did not include any interventions to manage the resident's fall risk until after the resident fell on an identified date. This was acknowledged by Registered Nurse (RN) #107 and Staff #104.

B) Resident #003 was admitted on an identified date and was assessed as being at risk for falling. Resident #003's 24 hour admission plan of care was incomplete and did not include the resident's identified risk level for falling and any interventions to manage the resident's fall risks.

Registered Practical Nurse (RPN) #111 said that it was the home's practice that when a resident was a new admission, they were considered to be at high risk for falling regardless of what the admission fall risk assessment indicated. The RPN revealed that a plan of care would be initiated on admission to include various interventions to manage the resident's risk and that the resident sleep pattern would be observed for a number of days to further assess the resident's fall risk.

The licensee failed to ensure that resident #001 and #003's admission care plans included the resident's risk of falling, and interventions to mitigate those risks.

The severity of this issue was determined to be a level 3 as there was actual harm/risk to the resident. The scope of the incident was a level 2 pattern as it related to 2 out of 3 residents (67%) inspected. The home had a level 2 compliance history with a previous non compliance (NC) to different subsection. (606)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 04, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 4th day of November, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Janet Groux

Service Area Office / Bureau régional de services : Central West Service Area Office