Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 21, 2020	2020_821640_0006	021917-19, 000814-20	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

HEATHER PRESTON (640)

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): January 28, 29, 30 and 31, 2020.

During the course of the inspection, the LTCH Inspector toured the home, observed the provision of care, conducted interviews and reviewed clinical records, policy and procedure.

The following Critical Incident (CI) Report was reviewed:

Log #000814-20 related to fall with injury and transfer to hospital

The following Follow-Up Inspection report was reviewed:

Log #021917-19 related to Compliance Order #001 issued under inspection #2019_826606_0023.

During the course of the inspection, the inspector(s) spoke with residents, families, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Continence Care and Bowel Management Lead, Falls Prevention Program Lead, Associate Director of Care (ADOC), Director of Care (DOC), the Acting Executive Director and the Executive Director.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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
O.Reg 79/10 s. 24. (2)	CO #001	2019_826606_0023	640

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. 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with.

In accordance with O. Reg. 79/10, s. 48(1) and in reference to s.49(1), the license was required to have a falls prevention and management program that provided strategies to monitor residents.

Specifically, staff did not comply with the licensee's policy:

"Falls Prevention & Management", policy #VII-G-30.10 with a revision date of April 2019, directed staff to complete an initial post fall assessment to include vital signs of temperature, pulse, respiration and blood pressure. The policy directed staff to initiate head injury routine (HIR) for all un-witnessed falls. HIR was to be completed every 30 minutes for one hour, then every hour for four hours followed by every 8 hours for 56 hours.

The home submitted a Critical Incident (CI) report to the Ministry of Long-Term Care (MLTC) related to resident #004 who fell on an identified date in January 2020. The fall was not witnessed. They had a previous unwitnessed fall the previous month in the same location. The initial post fall assessments were initiated for both falls. The first fall, the resident’s initial vital signs documented on the initial post fall assessment form were those from the previous day as an auto-default.

On the day of the fall in December 2019, the HIR was initiated 30 minutes following the fall. The HIR document was not completed on two occasions with a note that stated "sleeping" with no signature of the nurse.

The Associate Director of Care (ADOC) said that all assessment times were required to be done regardless of whether the resident was asleep.

The ADOC acknowledged that initial vital signs were not obtained and the HIR was not completed as per the licensee’s policy.

The licensee failed to ensure that staff complied with their “Falls Prevention and Management” policy. [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 the licensee must ensure that their policy "Falls Prevention & Management", policy #VII-G-30.10, specifically Head Injury Routine (HIR) is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #004, #009 and #010 had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on an assessment and the plan was implemented.

i) Resident # 004 had two un-witnessed falls six months after admission during the night. The second fall resulted in transfer to the hospital with an injury.

They required an identified level of assistance to transfer to the toilet. The last time the

resident was toileted on the identified date in January 2020 was earlier in the evening.

The resident was assessed on their Minimum Data Set (MDS) assessment to be frequently incontinent of bowel and bladder day, evening and night.

The licensee's policy "Continence Program – Guidelines for Care", policy # VII-D-10.00 with a revised date of April 2019, directed staff to obtain information about the resident's bowel and bladder routine and to record voiding and incontinence patterns using a three-day bladder diary for residents with urinary incontinence. The policy directed staff to develop toileting schedules. The policy directed, under the clinical chart audit – move in section, that the audit was to review whether the voiding diary had been completed. A completed clinical chart audit form for resident #004 was not located.

The LTCH Inspector reviewed the clinical record, specifically the assessments, the plan of care and the Kardex. The Kardex directed staff to toilet resident #004 at specific times of the day and mid-evening. There was no direction for the night shift. There was no assessment of resident #004 that determined this schedule.

PSWs #101 and #102 said there may be specific times to toilet the resident, but they could not recall what they were or if they had completed a three-day bladder diary for resident #004.

RPN #103 said there was no assessment completed for resident #004 to determine the toileting schedule.

ii) Resident #009's MDS assessment, assessed the resident to be frequently incontinent of bowel and bladder and they used continence care products. They required extensive assistance of two or more persons for toileting and transfer.

The LTCH Inspector reviewed the clinical record, specifically the assessments, the plan of care and the Kardex. The plan of care and Kardex directed that resident #009 required total assistance of two staff to assist with toileting. They used continence care products as per the distribution list. The resident's level of continence was frequently incontinent.

The plan of care and Kardex did not include an individualized plan to manage continence.

PSW #112 said that staff changed resident #009's continence care products in the

morning, then took them to the toilet about two hours after breakfast. After that they would ask if they needed to void.

The Director of Care said the resident was not on an individualized plan to promote and manage continence. They typically toilet residents before breakfast and after meals to see if they were clean. They said this routine was not included in the plan of care as it was a standard and staff knew what the standard expectation was.

The DOC said they did implement specific toileting plans for residents who were frequently incontinent with identified issues such as having large volumes of urine and the bed would become wet or other issues as identified by staff. At that time, the specific plan would be included in the plan of care, but not necessarily based on an assessment. The plan would be implemented based on the identified issue.

iii) Resident #010's MDS assessment assessed the resident to be frequently incontinent of bowel and bladder and they used continence care products. They required total dependence of two persons for toileting and extensive assistance of two persons for transfer.

The LTCH Inspector reviewed the clinical record, specifically the assessments, the plan of care and the Kardex. The plan of care and Kardex directed that resident #010 required extensive assistance of staff for toileting and product management. The resident's continence management system was a specific continence care product during the day and another product at night. It directed staff to see the distribution list for product selection.

The plan of care directed staff to change the resident at two specific times during the night.

The clinical record did not include an assessment to determine the two times provided and there was no further directions for the remainder of the day to manage resident #010’s continence.

The DOC said that resident #010 did not have an individualized toileting plan. They said this plan was not based on an assessment. It was based on the observation that the resident’s bed would become wet during the night. As a result, the two specific brief change times were implemented.

The licensee failed to ensure that resident #004, #009 and #010 had an individualized plan to promote continence that was based on an assessment. [s. 51. (2) (b)]

2. The licensee failed to ensure that residents #006, #007 and #010 were provided a range of continence care products that promoted their comfort, dignity and ease of use.

i)Resident #006's MDS assessment assessed the resident to be occasionally incontinent of urine and they used continence care products.

The residents plan of care directed that the resident needed some assistance with toileting and used a specific continence care product as per the distribution list. The distribution list, as confirmed by the Continence Care Lead (ADOC) directed that the resident used a specific continence care product and they purchased their own.

Resident #006 told the LTCH Inspector that they used a specific continence care product that they purchased on their own. They said they had not been informed upon admission or at any other time, that the home provided this product. The resident wished to use the product as provided by the home and no longer purchase their own. They liked the use of the specific continence care product to enable them to maintain their independence and comfort.

ii)Resident #007's MDS assessment assessed the resident to be occasionally incontinent of bowel and bladder and they used a continence care product.

The plan of care directed they required one-person assistance. They used a continence care product as per the distribution list.

The distribution list, as confirmed by the Continence Care Lead (ADOC) directed that the resident used a specific continence care product and they purchased their own.

Resident #007 told the LTCH Inspector that they used a specific continence care product that they purchased on their own. They said they had not been informed at any time, that the home provided this product. The resident wished to use the product if provided by the home and no longer purchase their own. They liked the use of the specific continence care product to enable them to maintain their independence and comfort.

iii) Resident #010's MDS assessment assessed the resident to be frequently incontinent of bowel and bladder and they used a continence care product. They required total

dependence of two persons for toileting and extensive assistance of two persons for transfer.

The plan of care directed that the resident was incontinent of bladder and bowels and used a continence care product. See distribution list for product selection.

The distribution list directed the resident used a specific continence care product, was incontinent and purchased their own continent care products.

PSWs #105, #110 and #111 said the resident had provided their own specific continence care product. They said that the specific continence care product was a continent care product available for residents.

Resident #010's SDM said they had provided the resident's specific continence care product since their admission. The home told them they had adult diapers and if they wanted something else, they would have to purchase them.

The licensee failed to ensure that a range of continence care products were provided to resident #006, #007 and #010. [s. 51. (2) (h) (iii)]

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 the licensee must ensure that:
a) residents who are incontinent, have an individualized plan, as part of their care, to promote and manage bowel and bladder continence that is based on an assessment, and that plan is implemented and,
b) residents are are provided with a range of continence care products that promote resident comfort, ease of use and dignity, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure the provision of care provided to resident #010 was documented.

Resident #010's MDS assessment, assessed the resident to be frequently incontinent of bowel and bladder and they used continence care products. They required total dependence of two persons for toileting and extensive assistance of two persons for transfer.

The plan of care and Kardex directed that resident #010 required extensive assistance of staff for toileting and continence care product management. The plan of care directed staff to change the resident at two specific times during the night.

PSW #105 said that the plan of care did not direct them when to toilet or change the resident but they did provide the care twice per shift.

The LTCH Inspector reviewed the PSWs documentation record. It did not include the documentation of the continence care product changes as per the plan of care.

The DOC said that staff were not expected to document the intervention of the specific brief changes.

The licensee failed to ensure that the care provided, as set out in the plan of care, was documented for resident #010. [s. 6. (9) 1.]

Issued on this 26th day of February, 2020

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

Original report signed by the inspector.