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
Oct 27, 2021	2021_954618_0002	008381-21, 009098-21, 009192-21, 011080-21, 013175-21, 013614-21	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

CECILIA FULTON (618)

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 20, 21, 22, 25, 2021.

The following intakes were included in this inspection:
Logs #009192-21, 009098-21 and 008381-21 related to change in condition and hospitalization.
Logs #011080-21, 013175-21 and 013614-21 related to resident falls.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Associate Director of Care (ADOC), Registered Nurses (RN/RPN)s, Personal Support Workers (PSW)s, and a Housekeeper.

Observations were completed of resident meal and snack service, Infection Prevention and Control (IPAC) procedures, staff to resident interactions and general care and cleanliness of the home.

The following records were reviewed including but not limited to: resident progress notes, care plans, electronic medication administration records (eMAR), resident assessments, and relevant policies and procedures

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

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

On an identified date in 2021, resident #001 was assessed to have injuries.

The home conducted an investigation and determined that the injuries were caused when staff #101 transferred resident #001 in a manner inconsistent with the resident's plan of care.

Interview with staff #101, identified that they had access to the resident's plans of care and that the plan of care provided clear direction. Staff #101 confirmed that on this occasion they had not followed the resident's plan of care regarding transfers. [s. 6. (7)]

2. On an identified date in 2021, resident #002 fell and incurred an injury. The plan of care for resident #002's identified the fall prevention/safety interventions.

Interview with PSW #104 identified that they had convenient access to the resident's plan of care and that the plan of care provided clear direction. Staff #104 confirmed that at the time of this fall they had not followed the plan of care for resident #002.

Sources:Critical incident reports, resident #001’s and #002's care plan, home's investigation of incident involving resident #001and interviews with PSW #101 and 104, and ADOC #102. [s. 6. (7)]

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 care set out in the plan of care is provided residents as specified in the plan,, to be implemented voluntarily.

Issued on this 28th day of October, 2021

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

Original report signed by the inspector.