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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Jan 14, 2020	2020_746692_0001	022897-19	Critical Incident System

Licensee/Titulaire de permis

Woods Park Care Centre Inc.
110 Lillian Crescent BARRIE ON L4N 5H7

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

Woods Park Care Centre
110 Lillian Crescent BARRIE ON L4N 5H7

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

SHANNON RUSSELL (692)

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 9-10, 2020.

The Following intake(s) was inspected upon during this Critical Incident System Inspection:
-One log, which was related to a critical incident that the home submitted to the Director regarding an incident that caused an injury for which the resident was taken to the hospital resulting in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members, and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, as well as licensee policies, procedures and programs.

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

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, for an incident that caused an injury to a resident, which resulted in a significant change in the resident's health status. A review of the CIS report indicated that resident #001 had sustained a fall the previous day, was transferred to the hospital for assessment, and was diagnosed with an identified injury. The CIS report further indicated that resident #001 had returned to the home with specified interventions put in place.

Inspector #692 observed resident #001 on multiple occasions with the specified interventions implemented.

In an interview with resident #001's Substitute Decision Maker (SDM), they identified that since resident #001 had sustained the identified injury the home had put specified interventions in place in order to treat the injury and for fall prevention measures.

The Inspector reviewed resident #001's health care records, identifying a specified document, dated the day the resident returned to the home from the hospital that had been signed by the physician, indicating that they were to have a specified intervention in place. A further review identified a progress note, which indicated that specified interventions were to be implemented for fall prevention. Inspector #692 reviewed a specific document that indicated that resident #001's fall risk had changed.

The Inspector reviewed resident #001's care plan, that was in effect at the time of the inspection, and was unable to locate a focus indicating that the specified interventions were to be implemented.

A review of the home's policy, titled "Documentation – Plan of Care", #VII-G-30.10, last revised April, 2019, identified "the care plan [was] a documentation tool that communicates and directs the plan to team members for specific care approaches not established in standard operating procedures". The policy further indicates that they were to reassess and update the care set out in the plan of care as required if the care was no longer necessary or a change had occurred.

In separate interviews with Personal Support Workers (PSWs) #105 and #108, they identified that they were to review the residents care plan in order to know what care needs the residents required. Both PSWs indicated that they recalled when resident #001 had sustained an identified injury and that their care needs had changed.

During separate interviews with Registered Practical Nurse (RPN) #109 and Registered Nurse (RN) #107, they identified to Inspector #692 that staff were to review the residents care plan in order to know what care was to be provided, and it was to be updated with the current needs of the resident. Together, the Inspector with RPN #109 and RN #107, reviewed the residents care plan, that was in effect at the time of the inspection, and they both identified that resident #001's care plan had not been updated with the current interventions after the resident sustained an identified injury, and it should have been.

During an interview with the Director of Care (DOC), they identified that direct care staff were to refer to the care plan to know what specific care needs the resident required and that it was to be updated when there were changes, in order for it to reflect the current needs. The DOC identified that resident #001's care plan had not been revised to identify that staff were to complete specific interventions to ensure their safety for fall prevention, and it should have been. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is reviewed and revised when the resident's care needs changed or the care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 14th day of January, 2020

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

Original report signed by the inspector.