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
Jun 11, 2021	2021_745690_0014	002153-21	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

TRACY MUCHMAKER (690)

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): May 25-28, 2021.

-One log, which was a critical incident that was submitted to the Director for a fall with a transfer to hospital and significant change in health status.

A Complaint Inspection #2021_745690_0015 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Associate Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), 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 interactions, reviewed relevant health care records, internal documents, 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.
- **2 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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies were implemented to reduce falls for a resident.

During a review of the resident's progress notes, the Inspector identified that the resident sustained a specified number of falls during a specified month. A review of the resident's plan of care on Point Click Care (PCC) identified that there had been no revisions to the care plan for falls prevention following the falls.

A review of post fall assessments for two of the falls, identified that no immediate actions were implemented in response to the falls. All three post fall assessments identified that there were no revisions to the care plan.

In interviews with staff, and the Associate Director of Care (ADOC), they identified that the resident continued to sustain falls and that there had been no new strategies implemented to prevent falls in response to the falls and that there should have been.

Sources: Review of a resident's progress notes and post fall assessments, interviews with PSW staff, Registered staff and ADOC. [s. 49. (1)]

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 strategies are implemented to reduce or mitigate falls, to be implemented voluntarily.

WN #2: 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 plan of care was revised at least every six months and at any other time when the care needs changed related to falls prevention interventions.

A Critical Incident (CI) report was submitted to the Director related to a resident's fall and subsequent identified injury. The CI report indicated that specified falls prevention interventions would be put in place to prevent a recurrence.

During observations of the resident, the inspector observed the specified interventions in place; however during a record review of the resident's plan of care, the inspector could not find any information related to the use of the aforementioned interventions. Interviews with staff, and the ADOC, verified that the interventions were not included in the plan of care and that they should have been.

Sources: Sources: Observations of a resident, review of the care plan, and interviews with staff, and ADOC. [s. 6. (10) (b)]

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Issued on this 23rd day of June, 2021

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

Original report signed by the inspector.