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

Sudbury Service Area Office
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Original Public Report

Report Issue Date August 29, 2022
Inspection Number 2022_1307_0002
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Woods Park Care Centre Inc.

Long-Term Care Home and City
Woods Park Care Centre, Barrie, ON

Lead Inspector
Tracy Muchmaker #690

Inspector Digital Signature
Tracy L Muchmaker
Digitally signed by Tracy L Muchmaker
Date: 2022.08.30 11:13:21 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 18-22, 2022.

The following intake(s) were inspected:

- One intake, which was a complaint related to the care of a resident.

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Medication Management
- Palliative Care
- Safe and Secure Home

WRITTEN NOTIFICATION PLAN OF CARE

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (5).

The licensee has failed to ensure that a resident's substitute decision-maker, was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A resident's Physician wrote a progress note indicating that the resident had a change in heath condition, and prescribed medications and a diagnostic test. There was no progress notes to indicate that the resident's Substitute Decision Maker (SDM) was made aware of the changes. The resident's SDM was not updated on the status of the resident until four days later.

Registered staff indicated that the resident's health condition had changed and that the Physician had ordered the diagnostic test and medications. Registered staff and the Interim Director of Care (IDOC) verified that there was no documentation to support that the SDM had been notified of the resident's health status or medication orders at the time of the changes.

Sources: A resident's progress notes, and Physician's orders; interviews with the complainant, Registered staff, and the IDOC.

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WRITTEN NOTIFICATION PLAN OF CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (7).

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident, as specified in the plan related to falls prevention.

A resident's care plan indicated that the resident required an intervention as a fall prevention intervention.

Personal Support Worker (PSW) staff indicated that the resident was found on the floor, that the intervention was not in use at the time of the incident, and they did not know why. The IDOC verified that according to the resident's care plan, the intervention was to be in use at the time of the incident.

Sources: A resident's care plan; interviews with PSW, and Registered staff, and the IDOC.

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WRITTEN NOTIFICATION PLAN OF CARE

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *s.* 6 (9).

The licensee has failed to ensure that the provision, and the outcomes of the care set out in the plan of care, were documented for a resident.

Progress notes for the resident, identified that an incident had occurred, however there was no documentation in any of the resident's health records that included information related to specified details of the incident.

RPN staff verified that there was no documentation related to specified details of the incident, and could not state why. An RN stated that they should have documented on the incident, and that they likely didn't as it was shift change and they were busy. The Administrator stated that the details should have been documented.

Sources: A resident's progress notes, health records; interviews with PSW, and Registered staff, the Physician, ADOC, DOC, and the Administrator.

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WRITTEN NOTIFICATION ADMINISTRATION OF DRUGS

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 131 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A resident's Physician had ordered specified medications for specified symptoms to be administered as needed. A progress note documented on a specified date described that the resident had worsening symptoms and the medications were administered on two identified dates. There were no progress notes or entries on the electronic medication record (eMar) that indicated that staff had administered the specified medications on any other dates, despite the resident continuing to demonstrate symptoms.

PSW, and RPN staff that worked after the two dates that the specified medication was administered, indicated that the resident continued to have the worsening symptoms. An RPN stated that stated they could not recall if they had administered any of the specified medications on identified dates, and that if they had known that the medications were ordered, they would have administered them.

Sources: A resident's progress notes, and eMar records; Interviews with PSW, and Registered Staff, and the DOC.

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WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 229 (5).

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and the symptoms were recorded, and that immediate action was taken as required for a resident.

A resident's progress note, indicated that the resident had specified symptoms that started on an identified date. A review of the resident's progress notes during a specified time period that the resident continued to have symptoms, identified that there were 27 out of 42 shifts, where there was no symptom monitoring or documentation of the resident's status.

Registered staff, the IPAC Lead, IDOC, and Administrator verified that residents were to have symptom monitoring on every shift, and it was to be documented in a progress note. An RPN, the IDOC and the Administrator verified that there were shifts during the specified time period in which there was no symptom monitoring documented for the resident.

Sources: A resident's progress notes; interviews with PSW and Registered staff, the IPAC Lead, IDOC, and Administrator.

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