



Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division Performance Improvement and Compliance Branch Division de la responsabilisation et de la performance du système de santé Direction de l'amélioration de la performance et de la conformité

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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Oct 4, 9, 10, 11, 12, 15, 16, 2012; 2012_168202_0008; Complaint

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

VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (Acting), Assistant Director of Care (Acting), Dietitian, Housekeeping Supervisor, Care Coordinator, Registered Nursing Staff, Personal Support Workers, Residents

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, observed meal services, reviewed educational records, reviewed home's policies titled, Palliative Care Protocols, Pain and Symptom, Oral and Dental Care and Referral, Skin and Wound Care Management Protocol, Weights-Monitoring of Resident Weights

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Nutrition and Hydration

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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	Legendé 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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 subsections:

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 failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s.6.(7)]

Resident #001's plan of care identifies this resident as requiring oxygen to be administered at 4 L/Min using a concentrator while in room and portable oxygen tank while in the dining room. Staff interviews revealed that resident #001 was often found in bed after the lunch meal with the portable oxygen tank in use and empty of oxygen. [s.6.(7)]

Resident #004's plan of care directs staff to administer oxygen at 2 L/Min via nasal prongs continuously.

An interview with resident #004 revealed that the portable oxygen tank used to provide oxygen at 2 L/Min will often run out after lunch and will have to request staff assistance to replace the oxygen tank. Resident #004 indicated during an interview that running out of oxygen in the afternoon occurs far too often and is uncomfortable. [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 to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 16th day of October, 2012



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prévus le Loi de 2007 les
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Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

A handwritten signature in black ink, appearing to be "C. H.", written in a cursive style.