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

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
SudburySAO.moh@ontario.ca

Amended Public Report (A1)

Report Issue Date June 6, 2022
Inspection Number 2022_1307_0001
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
L4N 5H7

Lead Inspector
Shelley Murphy #684

Inspector Digital Signature
Shelley Murphy
2022.06.17 10:14:01 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 9-13, 2022

The following intake(s) were inspected:

- One intake related to nutrition; and,
- One intake related to resident abuse.

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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Responsive Behaviours

INSPECTION RESULTS

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During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

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

Non-compliance with: O. Reg. 246/22 102 (9)(a)

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with any standard or protocol issued by the Director under subsection (2).

Rationale and Summary: During the completion of the IPAC check list, the Daily Active Screening was reviewed for a resident. It was noted that on several days the COVID-19 screening was not completed.

The licensee's policy titled Novel Coronavirus- COVID-19 Prevention and Management, indicated: The Nurse or designate would document once daily, unless twice daily enhanced screening was required for 10 days after an absence or after admission from another healthcare facility the findings of active screening on electronic Active Illness Screening Assessment in the resident health record.

The IPAC Lead reviewed the Daily Active screening and confirmed that the screening was not completed.

The home's failure to ensure that the registered staff complied with the Novel Coronavirus- COVID-19 Prevention and Management policy put a resident at actual risk and harm as registered staff were not completing required assessments at scheduled times to identify changes to the resident's health status.

Sources: Daily Active Screening Assessment for a resident, Licensee policy Novel Coronavirus- COVID-19 Prevention and Management; and, interview with the IPAC Lead and other staff members.

[Inspector # 684]

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO DIRECTOR

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

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Non-compliance with: LTCHA, 2007 s. 24 (1) 2

The licensee has failed to ensure that a person who has reasonable grounds to suspect that Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary: In accordance with LTCHA, 2007, s. 24 (1) 2., the licensee must ensure that when a person has reasonable grounds or suspects that Abuse has occurred, they must immediately report to the Director.

An incident of abuse occurred, involving a couple of residents. The Critical Incident Summary (CIS) Report was submitted to the Ministry of Long-Term Care (MLTC) Director the day following the incident.

The licensee's policy indicated the following: All team members and families with reasonable grounds to suspect abuse of a resident were required to immediately report to the provincial health authorities and the Executive Director or designate in charge of the care community.

The Director of Care (DOC) reviewed the CIS report that was submitted to the MLTC Director, which indicated that staff noted the resident-to-resident abuse occurred the day before the CIS was submitted to the Director. They stated the reason for the CIS being reported late was that the staff likely did not contact the manager on call, or the manager on call would have at least advised the staff to start the process.

The home's failure to ensure that the registered staff complied with the Prevention of Abuse and Neglect policy did not put the residents in harm.

Sources: CIS report; the licensee's Prevention of Abuse and Neglect policy; resident progress notes and interview with the DOC.

[Inspector #684]