Ontario

Ministry of Health and Long-Term Care

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

Ministére 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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 5, 11, 12, 13, 17, 2012	2012_109153_0009	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

LYNN PARSONS (153)

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, Assistant Director of Care (ADOC), Registered Nurse(RN), Registered Practical Nurses(RPN), Restorative Care Aide, Personal Support Workers (PSW) and Residents

During the course of the inspection, the inspector(s) Reviewed clinical health records, staff in-service records and home policy titled Incident Reporting.
Observed staff/resident interactions and provision of care.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 care set out in the plan of care was not provided as specified in the plan.
Resident A with an identified risk for entanglement of the call bell received a physician order dated April 4, 2012 which indicated for the staff to ensure the call bell string from bed did not touch resident.
The resident is immobile with significant cognitive impairment rendering him unable to use the call bell.
The call bell cord was observed by the inspector on April 12, 2012 to be placed on top of the bed along Resident A's left side of body and touching resident's left arm while resting in bed.
The inspector informed nursing management of the observation and the call bell cord was relocated immediately. [s.6(7)]
2. The plan of care does not provide clear direction for the staff and others who provide direct care to the resident. The plan of care for Resident A provides conflicting information related to the use of side rails.
Under Bed Mobility staff are directed to have 1 rail down while in bed (closest to the window), used to assist with maintaining position of body pillows to prevent skin breakdown, while the section for Falls directs staff to put 2 side rails up at all times while resident is in bed to reduce the risk of resident accidentally rolling out of bed.
Observations completed on April 11 and 12, 2012 identified that 1 side rail was down (closest to the window) while the resident was in bed.
Interviews with staff confirmed 1 rail (closest to the window) is to be left down when the resident is in bed.[s.6(1)(c)]

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 for each resident includes:
- clear directions to staff and others who provide direct care to the resident
- 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 3rd day of May, 2012

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

Lynn Parsons