Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
Facsimile: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
February 8, 9, 10, 2011	2011_141_2928_07Feb161739	Critical Incidents H-00074, H-03065, H-00230

Licensee/Titulaire
Specialty Care/Woodhall Park Inc., 400 Applewood Crescent, Suite 110, Vaughan, ON L4K OC3

Long-Term Care Home/Foyer de soins de longue durée

Specialty Care Woodhall Park, 10260 Kennedy Road North, Brampton, ON L6T 3S1

Name of Inspector(s)/Nom de l'inspecteur(s)
Sharlee McNally, LTC Homes Inspector #141

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with: the Administrator, The Director of Care, Assistant Directors of Care, registered staff, Personal Support Workers and family.

During the course of the inspection, the inspector: reviewed residents records, home's policies and procedures, observed residents,

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Personal Support Services
Responsive Behaviours
Minimizing Restraining
Falls Prevention
Pain

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

7 WN
2 VPC
2 CO: CO # 001, #002

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le sulvant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.
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.)	Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with *LTC Homes Act, 2007,* S.O 2007, c. 8, s.30(1)3

Every licensee of a long-term care home shall ensure that no resident of the home is: 3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

Findings:

1. The use of bed rails as a restraint is not included in an identified resident's plan of care. The plan of care identifies the resident is at risk of falls, and interventions include the use of two full bed rails up at all times when in bed for safety. The staff confirmed that 2 full bed rails are used when the resident is in bed.
2. There is no physician order for an identified resident's use of two full bed rails as a restraint. The resident's records do not identify that alternative to restraining the resident have been considered. There is no documentation in the resident's records to indicate the Power of Attorney/ Substitute Decision Maker (POA/SDM) was involved in the decision to use two full bed rails.
3. An identified resident's records do not indicate that the resident is monitored minimally hourly when in bed with two full bed rails in the up position or that their condition is reassessed and the effectiveness of the restraining evaluated at least every eight hours. Staff confirmed that they do not monitor the resident hourly when in bed with bed rails up or that the effectiveness is reassessed every eight hours.

Inspector ID #:	141

Additional Required Actions:

CO # - #001 will be served on the licensee. Refer to the "Orders of the Inspector" form.

WN #2: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.6(1)(c)

Every licensee of a long-term care home shall ensure that there is a written plan of care for each

resident that sets out, clear directions to staff and others who provide direct care to the resident.

Findings:

1. An identified resident with alteration in the site of identified pain, for which they received regular pain medication, plan of care was not updated to give clear directions to staff providing care.

2. An identified resident, whose records identified the need to have padding on bedrails when up to prevent injury, plan of care did not identify the use of bed rails or padding of the rails to give clear directions to staff providing care.

Inspector ID #:	141

WN #3: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.6(5)

The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Findings:

1. An identified resident's substitute decision maker was not notified or provided an opportunity to participate in a revision in the resident's care needs related to safety. The home confirmed that the substitute decision-maker had not been informed.

Inspector ID #:	141

WN #4: The Licensee has failed to comply with *LTC Homes Act, 2007,* S.O 2007, c. 8, 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.

Findings:

1. An identified resident did not receive care by nursing staff as set out in the resident's plan of care. The resident did not have side rails in up position when in bed, as per plan of care, which resulted in a fall.

Inspector ID #:	141

WN #5: The Licensee has failed to comply with O. Reg. 79/10, s.36

Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Findings:

1. An identified resident was not transferred by staff using safe transferring techniques. During preparation for a transfer of the resident using a mechanical lift a staff left the resident in an unsafe position and unattended causing the resident to fall. The resident's written plan of care identifies the resident as non weight bearing with need for transferring by mechanical lift with two staff present.

Inspector ID #:	141

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 residents are transferred by staff using safe transferring and positioning devices and techniques, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O. Reg. 79/10, s.8(1)b

Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, and is complied with.

Findings:

1. The home staff did not follow the policy for Pain and Symptom Assessment and Management Protocol for an identified resident who had identified change in pain status. The resident was not assessed at the time of an identified change in pain care needs.
2. The home staff did not follow the policy for Transfers – Using a Sit/Stand Lift when transferring an identified resident. The policy states that a second staff person must be present during the entire procedure. The resident was prepared for a transfer by mechanical lift without the presence of a second staff person. The resident subsequently had a fall.

Inspector ID #:	141

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 in ensuring that homes policies and procedures are followed by the nursing staff providing care to ensure proper treatment and provision of care is given, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O. Reg. 79/10, s.109(d)

Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with, types of physical devices permitted to be used;

Findings:

1. The home's restraint policy does not address bed rails in the up position as a type of physical restraint when used to inhibit the movement of the resident when in bed.

Inspector ID #:	141

Additional Required Actions:

CO # - #002 will be served on the licensee. Refer to the "Orders of the Inspector" form.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: (if different from date(s) of inspection). August 16/11

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Sharlee McNally	**Inspector ID #**	141
Log #:	H-00074, H-03065, H-00230		
Inspection Report #:	2011_141_2928_07Feb161739		
Type of Inspection:	Critical Incident		
Date of Inspection:	February 8, 9, 10, 2011		
Licensee:	Specialty Care/Woodhall Park Inc., 400 Applewood Crescent, Suite 110, Vaughan, ON L4K OC3		
LTC Home:	Specialty Care/Woodhall Park		
Name of Administrator:	Shelley Fazackerley		

To Specialty Care/Woodhall Park Inc., you are hereby required to comply with the following orders by the dates set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: The Licensee has failed to comply with *LTC Homes Act, 2007,* S.O 2007, c. 8, s.30(1)3

Every licensee of a long-term care home shall ensure that no resident of the home is: 3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

Order: The licensee shall ensure that all residents who are restrained by the use of bed rails will have the physical restraint applied in accordance with section 31 of the LTC Homes Act, 2007.

Grounds:

1. The use of bed rails as a restraint is not included in an identified resident's plan of care. The plan of care identifies the resident is at risk of falls, and interventions include the use of two full bed rails up at all times when in bed for safety. The staff confirmed that 2 full bed rails are used when the

resident is in bed.

2. There is no physician order for an identified resident's use of two full bed rails as a restraint. The resident's records do not identify that alternative to restraining the resident have been considered. There is no documentation in the resident's records to indicate the Power of Attorney/ Substitute Decision Maker (POA/SDM) was involved in the decision to use two full bed rails.
3. An identified resident's records do not indicate that the resident is monitored minimally hourly when in bed with two full bed rails in the up position or that their condition is reassessed and the effectiveness of the restraining evaluated at least every eight hours. Staff confirmed that they do not monitor the resident hourly when in bed with bed rails up or that the effectiveness is reassessed every eight hours.

This order must be complied with by:	Immediate

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: The Licensee has failed to comply with O. Reg. 79/10, s.109(d)

Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with, types of physical devices permitted to be used;

Order: The Licensee shall prepare, submit and implement a plan to ensure the home's written policy includes all types of physical restraints to be used in the home including the utilization of bed rails as a restraint.
The plan is to be submitted by May 19, 2011 to Compliance Inspector Sharlee McNally, Ministry of Health and Long-Term Care, Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, Fax 905-546-8255

Grounds:

1. The home's restraint policy does not address bed rails in the up position as a type of physical restraint when used to inhibit the movement of the resident when in bed.

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This order must be complied with by:	July 12, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007.*

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 12th day of May, 2011.	
Signature of Inspector:	Thank you.
Name of Inspector:	Sharlee McNally
Service Area Office:	Hamilton Service Area Office