Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 21, 2017	2017_543561_0011	004405-17, 016484-17	Complaint

Licensee/Titulaire de permis

SPECIALTY CARE / WOODHALL PARK INC
400 Applewood Crescent Suite 110 VAUGHAN ON L4K 0C3

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

Woodhall Park Care Community
10260 KENNEDY ROAD NORTH BRAMPTON ON L6Z 4N7

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

DARIA TRZOS (561)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, 2017.

This Inspection was conducted along with the Resident Quality Inspection (RQI) inspection number 2017_543561_0010 / 014605-17.
Inspector #640 was also inspecting on several items of this complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Assistant Director of Care (ADOC), Restorative Care, Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family and residents.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed clinical records and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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). 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:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A concern was reported to the Director related to the use of bed rails by resident #028. It was reported that there was a requested to apply the second bed rail for the resident while they were in bed.

When clinical records were reviewed, LTC Inspector found that the use of the bed rail was not included in the written plan of care.

Interviews were conducted with several PSWs and registered staff during this inspection.

PSW #142 stated that resident had one rail applied in bed. PSW #118 stated that there were two rails on the bed; however, none were being applied. PSW #144 stated that resident required one bed rail to be applied.
Registered staff #143 was interviewed and confirmed that resident required to have one rail applied on one side of the bed; however, the rail identified was a different length than the rails previously identified.

The home's policy titled "Bed Rails", policy number VII-E-10.20, revised June 2016, indicated that the registered staff were expected to document on resident's care plan the resident's need for bed rails, including the number of rails raised and the decision to use, remove, or change bed rails.

The ADOC was interviewed and confirmed that the resident used one bed rail while in bed and that the use was not included in resident's written plan of care.

The licensee failed to ensure that the written plan of care set out the planned care for the resident in relation to the use of bed rails. [s. 6. (1) (a)]

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 there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A concern was reported to the Director related to the use of bed rails by resident #028. It was reported that there was a request to apply the second bed rail for the resident while they were in bed.

Interviews were conducted with several PSWs and registered staff during this inspection. PSW #142 stated that resident had one rail applied in bed. PSW #118 stated that there were two rails on the bed; however, none were being applied. PSW #144 stated that resident required one bed rail to be applied.
Registered staff #143 was interviewed and confirmed that resident required to have one rail applied on one side of the bed; however, the rail identified was a different length than indicated by PSW #142 and #118.
Clinical records were reviewed and indicated that there was no assessment completed for the use of the bed rail that was applied.

The home's policy titled "Bed Rails", policy number VII-E-10.20, revised June 2016, indicated that if a bed rail of any size was used, the Restraint/PASD assessment was required to be completed.

The ADOC confirmed that resident required to have one bed rail applied while in bed and there was no assessment completed for the use of the bed rail.

The licensee failed to ensure that the resident was assessed for the use of bed rails to minimize risk to the resident. [s. 15. (1) (a)]

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 where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

Issued on this 2nd day of October, 2017

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

Original report signed by the inspector.