



**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

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**Ministère de la Santé et des Soins de  
longue durée**

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<b>Date(s) of inspection/Date de l'inspection</b>	<b>Inspection No/ d'inspection</b>	<b>Type of Inspection/Genre d'inspection</b>
November 5, 2010	2010_167_2928_05Nov101846	H-01871 Other related to a CI Report
<b>Licensee/Titulaire</b>		
Specialty Care Woodhall Park Inc. 400 Applewood Crescent, Suite 110 Vaughan, Ontario L4K0C3		
<b>Long-Term Care Home/Foyer de soins de longue durée</b>		
Specialty Care Woodhall Park 10260 Kennedy Road North Brampton, Ontario L6T3S1		
<b>Name of Inspector(s)/Nom de l'inspecteur(s)</b>		
Marilyn Tone # 167		
<b>Inspection Summary/Sommaire d'inspection</b>		

The purpose of this inspection was to conduct an inspection related to a Critical Incident submitted by the home.

During the course of the inspection, the inspector spoke with: the Director of Care and the Administrator of the home.

During the course of the inspection, the inspector: Conducted a review of the health file for the resident involved in the incident, reviewed the investigation completed by the home related to the incident and reviewed the home's policy and procedure related to Abuse and Reporting.

The following Inspection Protocols were used during this inspection: Critical Incident Response Inspection Protocol and Personal Support Services Protocol.

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

[1] WN

### 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.

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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

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 O. Reg. 79/10, s.107(4)2ii

A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

2. A description of the individuals involved in the incident, including,
  - ii) names of any staff members or other persons who were present at or discovered the incident,

