



**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

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

Bureau régional de services de Hamilton
119, rue King Ouest, 11^{ème} étage
Hamilton ON L8P 4Y7

**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

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

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 October 19, 20 & 21, 2010	Inspection No/ d'inspection 2010_167_2928_19Oct165652	Type of Inspection/Genre d'inspection Complaint inspection H- 01415 & H-01348
Licensee/Titulaire Specialty Care Woodhall Park Inc. 400 Applewood Crescent, Suite 110 Vaughan, Ontario L4K0C3		
Long-Term Care Home/Foyer de soins de longue durée Specialty Care Woodhall Park 10260 Kennedy Road North Brampton, Ontario L6T3S1		
Name of Inspector(s)/Nom de l'inspecteur(s) Marilyn Tone # 167		
Inspection Summary/Sommaire d'inspection		

The purpose of this inspection was to conduct an inspection related to Complaint H-01415 & H-01348 involving care issues for an identified resident.

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

During the course of the inspection, the inspector: Conducted a review of the health records for the identified resident, including medication administration records, reviewed the home's policy and procedure related to reporting and complaints and observed care on the unit where the identified resident resides.

The following Inspection Protocols were used during this inspection: Continence Care and Bowel Management Inspection Protocol and Personal Support services Inspection Protocol.

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

[2] WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régleur 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 LTCHA, 2007, S.O.2007 c.8 s.6(10)(b)
The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary

Findings:

The most current plan of care for the identified resident was not updated to include changes in the resident's care needs or interventions that have been put in place to manage care for the resident.

- 1) The plan of care was not updated to reflect the incontinent product that the identified resident is currently using to manage continence.
- 2) Specific directions related to bathing for the identified resident were not identified on the resident's plan of care.
- 3) The most current plan of care for the identified resident has not been updated to include interventions to address the resident's high risk for skin breakdown.

Inspector ID #:	# 167
------------------------	-------

WN #2: The Licensee has failed to comply with O. Reg. 79/10, s.131(2)


The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Findings:

The identified resident did not have medications administered in accordance with the directions for use specified by the prescriber.

During the month of September 2010, on four occasions, the resident did not have medications administered as prescribed.

Inspector ID #:	# 167
------------------------	-------

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). November 22, 2010