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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 30, 2013	2013_207147_0023	H-001454-12	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

SPECIALTY CARE WOODHALL PARK
10260 KENNEDY ROAD NORTH, BRAMPTON, ON, L6Z-4N7

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

LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): Ocotber 8, 9, 10 and 11, 2013

H-001609-12
H-002094-12
H-000047-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care. Personal Support Worker Manager and registered staff.

During the course of the inspection, the inspector(s) reviewed resident clinical charts, home's internal investigation notes, home's policy and procedure related to Responsive Behaviours, Resident Assessments and Falls Prevention and Management.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 failed to 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.

Review of the resident #104 Resident Assessment Protocol (RAP) summary and Fall Risk Assessment completed indicated the resident was assessed at high risk for falls and falls interventions were put in place to minimize further falls. However, this information was not included in the resident's Kardex or included in the resident's plan of care, to provide clear direction to staff and others who provide direct care to the resident related to falls prevention and safety.
Review of the home's internal investigation notes and interview with the DOC confirmed that in January 2013, the resident was transferred from bed to wheelchair by a staff who did not follow the falls prevention strategies in place. Resident subsequently fall and was assessed at the time of the fall and transferred to hospital where the resident was diagnosed with an injury. [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 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care plan must include, at a minimum, the following with respect to the resident, any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

Review of the resident #102 clinical records and interview the DOC confirmed that the resident was admitted to the home in July 2012 from another facility. The resident's admission package included strategies and interventions related to potential behavioural triggers and safety measures to be implemented by the staff in the home. Interview with the DOC and review of the progress notes indicated that the resident had several episodes of responsive behavious towards staff and residents. Resident's admission plan of care indicated that the recommendation and intervention related to possible triggers to the resident's responsive behaviours were not included in the resident's plan of care or communicated to staff on the unit until a few days later. [s. 24. (2) 2.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age.

The home made an offer of employment to a personal support worker in November 2012. Review of the employees personnel file, home's internal investigation notes and interview with the DOC confirmed the employee did not have a criminal reference check completed and submitted to the home until a few months after the employment date. [s. 75. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 145. When licensee may discharge

Specifically failed to comply with the following:

s. 145. (2) For the purposes of subsection (1), the licensee shall be informed by, (a) in the case of a resident who is at the home, the Director of Nursing and Personal Care, the resident's physician or a registered nurse in the extended class attending the resident, after consultation with the interdisciplinary team providing the resident's care; or O. Reg. 79/10, s. 145 (2).
(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident. O. Reg. 79/10, s. 145 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that for the purposes of subsection (1), the licensee shall be informed by, in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident.

Resident #102 was admitted to the home in July 2012 from another facility and was subsequently sent to hospital for further psychiatric evaluation a few weeks later due to aggressive behavious towards staff and resident.
Review of the resident's clinical chart and interview with the DOC confirmed the resident was discharged while absent from the home without the permission of a physician or a registered nurse in the extended class attending the resident. [s. 145. (2) (b)]

Issued on this 30th day of October, 2013

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

Laleh Nevell