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

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☐ 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_07Feb161806	Complaint H-00017, H-03108

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 complaint inspection received at the Hamilton Service Area office on December 29, 2010 and January 4, 2011.

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

During the course of the inspection, the inspector: reviewed residents records, homes policies and procedures, observed residents and their personal environment.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Falls Prevention

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

2 WN
1 VPC

2WN – *LTC Homes Act, 2007,* S.O 2007, c. 8, s.6(1)(c) and s.6(5) were issued under inspection report 2011_141_2928_07Feb161739, Log # H-00074 completed on February 8, 9, 10, 2011. The following actions were taken 2WN.

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 the *LTC Homes Act, 2007,* S.O 2007, c. 8, s.19(1)

Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Findings:

1. The home did not protect identified residents from abuse on multiple occasions.

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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 protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with the *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's did not have care provided related to safety needs, as set out in the plan of care identified within the resident's progress notes.

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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). May 30, 2011