



**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
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Hamilton ON L8P 4Y7

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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
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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 0C3		
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		
<p>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.</p> <p>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.</p> <p>During the course of the inspection, the inspector: reviewed residents records, homes policies and procedures, observed residents and their personal environment.</p> <p>The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation Responsive Behaviours Falls Prevention</p> <p><input checked="" type="checkbox"/> Findings of Non-Compliance were found during this inspection. The following action was taken:</p> <p>2 WN 1 VPC</p> <p>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.</p>		

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.

Inspector ID #: 141

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.

Inspector ID #: 141

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.

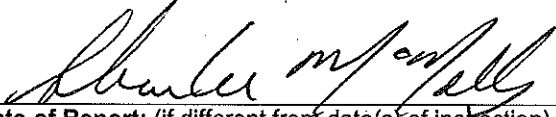


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le Loi de 2007 les
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Title:	Date:	Date of Report: (if different from date(s) of inspection). <i>May 30, 2011</i>