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 prévue le Loi de 2007 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
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Téléphone: (905) 546-8294
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Nov 27, 2015;	2015_265526_0020 (A1)	H-000847-14	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

THERESA MCMILLAN (526) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date change from November 30, 2015 to January 31, 2016 as requested and granted to the home.

Issued on this 27 day of November 2015 (A1)

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

Original report signed by the inspector.

Ontario

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10260 KENNEDY ROAD NORTH BRAMPTON ON L6Z 4N7

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

THERESA MCMILLAN (526) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): September 22, 23, 24, 25, 28, 29, and 30, 2015 simultaneously during the home's Resident Quality Inspection H-003259-15

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), the Assistant Director of Care (ADOC), the Scheduling Coordinator, Registered Nurses (RN's), Registered Practical Nurses (RPN's), Personal Support Workers (PSW's), and family members.

During the course of this inspection, the inspector reviewed investigative notes, resident health records, policies and procedures, staffing schedules; and observed residents and staff.

The following Inspection Protocols were used during this inspection:

Pain

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (10) 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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Resident #042's health record from 2014, indicated that the resident had cognitive impairment, required total assistance from two staff members for transferring using a non weight bearing lift and used briefs only for toileting.

Review of investigative and progress notes revealed that on a specified day in 2014, personal support workers (PSW's) transferred resident #042 using a weight bearing lift resulting in an improper transfer and subsequent deterioration in the resident's health condition. This was confirmed during interview with the Long Term Care Homes (LTC) Inspector, by a PSW and Registered Nurse (RN) who were present during the incident. During interview, the full time Registered Practical Nurse (RPN) confirmed that they monitored the resident until the end of their shift.

During interview with the LTC Inspector, a PSW who cared for resident #042 on the day of the incident and three days after, stated that they reported to the RPN on two separate days during that time that the resident had an alteration to their skin integrity and seemed to be experiencing pain.

However, review of health records between the day of the incident and three days later did not include that the resident had an area of altered skin integrity or pain. No assessments or updates to the plan of care were found for resident #042 for three days after the incident involving the improper transfer and deterioration in their health.

During interview, the DOC stated that the resident's care needs had changed as the result of the improper transfer. Resident #042 should have been reassessed and their plan of care updated accordingly between the day of the incident and three days later. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Resident #042's health record from 2014, indicated that the resident had cognitive impairment, required total assistance from two staff members for transferring using a non weight bearing lift and used briefs only for toileting.

Review of health records and the home's investigative notes revealed that on a specified day in 2014, personal support workers (PSW's) began transferring resident #042 to the toilet using a weight bearing lift. While transferring, staff recognized that the resident was not able to participate or bear weight. This was confirmed during interview with the Long Term Care Homes (LTC) Inspector, by a PSW and Registered Nurse (RN) who were present during the incident.

The PSW staff also stated that they were unfamiliar with the resident #042's transfer needs and did not consult the plan of care. During interview with the LTC Inspector, the RN who attended to resident #042 on the day of the incident, confirmed that the wrong type of transfer was used and that the resident's toileting plan of care had not been followed.

According to progress notes and assessments three days later, the resident was noted to have pain and an area of altered skin integrity, the plan of care was updated and treatments initiated.

The home's "Zero Lifts and Transfers Assessment" (number XII-G-40.41 last reviewed May 2014) directed PSW staff to use a higher level of assistance (lift/transfer) if unsure about the resident's capabilities. During interview, the DOC stated that the home's expectation is that PSW staff should refer to the resident's plan of care to inform them about their usual method of transferring and toileting. Staff were also expected to assess the resident's ability prior to transferring to ensure the care was provided safely and the most appropriate transferring technique was used. [s. 36.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #042's health record from 2014, indicated that the resident had cognitive impairment, required total assistance from two staff members for transferring using a non weight bearing lift and used briefs only for toileting.

Review of investigative and progress notes revealed that on a specified day in 2014, personal support workers (PSW's) transferred resident #042 using a weight bearing lift resulting in an improper transfer and subsequent deterioration in the resident's health condition. This was confirmed during interview with the Long Term Care Homes (LTC) Inspector, by a PSW and Registered Nurse (RN) who were present during the incident. During interview, the full time Registered Practical Nurse (RPN) confirmed that they monitored the resident and conducted assessments until the end of their shift.

Review of resident #042's health records did not include documentation of ongoing monitoring or assessments completed on the day of the incident. The RPN confirmed that there was a gap in the documentation of these assessments. The DOC confirmed the home's expectation that assessments be documented and included in residents' health records. [s. 30. (2)]

Issued on this 27 day of November 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : THERESA MCMILLAN (526) - (A1)

Inspection No. / No de l'inspection : 2015_265526_0020 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-000847-14 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Nov 27, 2015;(A1)

Licensee / Titulaire de permis : SPECIALTY CARE / WOODHALL PARK INC
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

LTC Home / Foyer de SLD : SPECIALTY CARE WOODHALL PARK
10260 KENNEDY ROAD NORTH, BRAMPTON, ON, L6Z-4N7

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Debbie McIntosh

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To SPECIALTY CARE / WOODHALL PARK INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (10) 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,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

(A1)
The licensee shall do the following:

A) Reassess while clinically indicated, residents who have had an incident or unusual occurrence involving transfers and or loss of consciousness to determine if care needs have changed;

B) Update plans of care according to the changing needs of residents;

C) Develop and implement policies that include PSW accountability and documentation of resident pain, and skin and wound observations.

D) Initiate skin and wound and pain assessments when PSW staff inform registered staff of their concern or observation.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Grounds / Motifs :

1. This area of non compliance was previously issued as a VPC on April 3, 2013, and June 6, 2013.

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Resident #042's health record from 2014, indicated that the resident had cognitive impairment, required total assistance from two staff members for transferring using a non weight bearing lift and used briefs only for toileting.

Review of investigative and progress notes revealed that on a specified day in 2014, personal support workers (PSW's) transferred resident #042 using a weight bearing lift resulting in an improper transfer and subsequent deterioration in the resident's health condition. This was confirmed during interview with the Long Term Care Homes (LTC) Inspector, by a PSW and Registered Nurse (RN) who were present during the incident. During interview, the full time Registered Practical Nurse (RPN) confirmed that they monitored the resident until the end of their shift.

During interview with the LTC Inspector, a PSW who cared for resident #042 on the day of the incident and three days after, stated that they reported to the RPN on two separate days during that time that the resident had an alteration to their skin integrity and seemed to be experiencing pain.

However, review of health records between the day of the incident and three days later did not include that the resident had an area of altered skin integrity or pain. No assessments or updates to the plan of care were found for resident #042 for three days after the incident involving the improper transfer and deterioration in their health.

During interview, the DOC stated that the resident's care needs had changed as the result of the improper transfer. Resident #042 should have been reassessed and their plan of care updated accordingly between the day of the incident and three days later. [s. 6. (10) (b)] (526)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jan 31, 2016(A1)

Order # /
Ordre no : 002

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

(A1)
The licensee shall do the following:

A) Review safe lifts and transfers policy with all relevant staff members;

B) Provide easy access of residents plans of care to direct care staff;

C) Transfer and assist residents with toileting according to their assessed needs or plan of care.

D) Implement the home s incident reporting process and reassess the resident for pain and skin and wound issues in the event of an unusual occurrence during transferring and or toileting.

Grounds / Motifs :

1. This area of non compliance was previously issued as a VPC on April 3, 2013 and June 6, 2013.

2. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Resident #042's health record from 2014, indicated that the resident had cognitive impairment, required total assistance from two staff members for transferring using a non weight bearing lift and used briefs only for toileting.

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Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Jan 31, 2016(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27 day of November 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : THERESA MCMILLAN

Service Area Office /
Bureau régional de services : Hamilton