Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prevue 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

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 Quest, 11iém étage
Hamilton ON L8P 4Y7

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	Inspection No/ d'inspection	Type of Inspection/Genre d'insptection
November 5 and 8, 2010	2010_192_2928_05Nov141947 2010_192_2928_05Nov101641	Critical Incident H-01363 H-01610

Licensee/Titulaire
Specialty Care/Woodhall Park Inc., 400 Applewood Crescent, Suite 110, Vaughan, Ontario, L4K 0C3

Long-Term Care Home/Foyer de soins de longue durée
Specialty Care Woodhall Park, 10260 Kennedy Road North, Brampton, Ontario, L6T 3S1

Name of Inspector(s)/Nom de l'inspecteur(s)
Debora Saville LTC Homes Inspector #192, Marilyn Tone LTC Homes Inspector #167.

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct critical incident inspections.

During the course of the inspection, the inspectors spoke with: The Administrator, Director of Care (DOC), and Associate Director of Care (ADOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspectors: Reviewed resident records, home investigation documentation, training records and the Abuse Policy.

The following Inspection Protocols were used during this inspection: Prevention of Abuse and Neglect

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

3 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activitiés

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'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue 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. 20(2) (d)

At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(d) shall contain an explanation of the duty under section 24 to make mandatory reports

Findings:

The homes abuse policy; dated September 2007 directs the home to "send a MOH Unusual Occurrence Record within 10 working days of the incident." There is no explanation of the duty to make mandatory or immediate reports.

Inspector ID #:	Debora Saville LTC Homes Inspector # 192

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 24(1) and (2)

A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Findings:

1. An incident of abuse was reported, to the home. An investigation was completed. The Critical Incident report was not completed and submitted to the Director for 48 hours. Immediate reporting is required.

2. A critical incident related to abuse/neglect occurred and was not reported to the Director by phone or critical incident report for 5 days following the incident. Immediate reporting is required.

Inspector ID #:	Debora Saville LTC Homes Inspector # 192

WN #3: The Licensee has failed to comply with O. Reg. 79/10 s.104(1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
Findings: The date and time of a critical incident is recorded on the Critical Incident report incorrectly. The Director was not notified of the actual date and time of the incident.

Inspector ID #:	Debora Saville LTC Homes Inspector # 192

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.** Debora Saville
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). January 14, 2011