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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 14, 2012	2012_208141_0008	H-002238-12	Follow up

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

SHARLEE MCNALLY (141)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 12, 13, 2012

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs) and residents

During the course of the inspection, the inspector(s) reviewed resident records, homes policies and procedures, resident incident reports, education and training records

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure where the Act or this Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with. The home's policy and procedure "Restraint Implementation Protocols" (VII-F-10.08) stated staff were to review and document all restraint orders, intervention, resident responses, outcomes and decisions to implement, continue or discontinue with the restraint interdisciplinary team, quarterly and with any changes in the resident. The DOC confirmed the assessment was to be completed quarterly using the Point Click Care (PCC) assessment tool "Restraint Alternative Checklist". Review of the documentation for two identified residents indicated the Restraint Alternative Checklist had not been completed quarterly. [s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

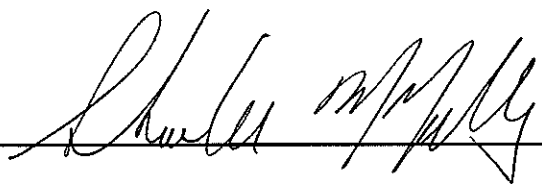
s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee did not ensure when a resident was restrained by a physical device as described in paragraph 3 of subsection 30(1) if the restraining of the resident was included in the resident's plan of care a physician, registered nurse in the extended class or other person provided for in the regulations had ordered or approved the restraining. An identified resident's plan of care included physical restraining of the resident by use of 2 full length bed rails when in bed. The DOC confirmed all full length bed rails were considered a physical restraint when both were up when the resident was in bed. Two full length bed rails were observed on the resident's bed and staff confirmed both rails were put up at all times when the resident was in bed for safety. The resident's records indicated a physician order was initially completed for 2 bed rails to be up when the resident was in bed but the order was not included in the current 3 month quarterly review signed by the physician and therefore was not current. The DOC confirmed there was not a current restraint order for the bed rails. [s. 31. (2) 4.]

Issued on this 20th day of December, 2012

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



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
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Date(s) of inspection/Date de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
December 12, 13, 2012	2012_208141_0008 / H-002238-12	Follow-up

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 L6T 3S1

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

Sharlee McNally #141

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

(*Please delete empty rows. Ensure the signature box is on the same page as the last row of corrected requirement.)*

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ORDER #/ GENRE DE MESURE/ORDRE NO	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007, S.O. 2007 c. 8, s.30(1)3	CO #001	2011-141-2928-07Feb161739	#141
O. Reg. 79/10, s.109(d)	CO#002	2011-141-2928-07Feb161739	#141

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ORDER #/ GENRE DE MESURE/ORDRE NO	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR

Issued on this 14 day of December, 2012

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