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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 23, 2013	2013_208141_0003	H-000990-12, H-001309-12	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

SHARLEE MCNALLY (141)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 15, 16, 2012

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), laundry aide, and residents

During the course of the inspection, the inspector(s) reviewed residents records, home's investigation summary notes, home's policies and procedures, agency staffing usage, physician levels and physician on-call records, and process for lost and found laundry.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Responsive Behaviours

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.) 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 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 did not ensure that staff used safe transferring and positioning devices or techniques when assisting a resident. In June, 2012 an identified resident had a sling for a mechanical lift put in place while in a chair by one staff person, without the assistance of a second staff person. The resident's plan of care stated two staff were to transfer with mechanical lift for all transfers and the resident was totally dependent for the entire process. The DOC confirmed a second staff person should of been present when the PSW was putting the lift sling in place. [s. 36.]

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 that staff use safe transferring and positioning devices or techniques when assisting a resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the written plan of care for each resident set out clear directions to staff and others who provide care to the resident. An identified resident was observed during the inspection period to have their lunch tray in the bedroom. The resident's quarterly assessment of November, 2012 stated the resident did not go to the dining room for any meals, tray service was provided to them and staff confirmed the resident received meals in the bedroom. The resident's written plan of care did not identify resident's location for eating meals, diet requirements and texture, specifics of set up or supervision required to direct staff in providing care. [s. 6. (1) (c)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee did not ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. An identified resident sustained an injury in June, 2012. The resident received pain medication for expressed pain and a new physician order for pain medication. A pain assessment was not completed until 7 days after receiving pain medication. The home's policy "Pain and Symptom – Assessment and Management Protocol" (VII-G-70.00) stated a pain assessment should be conducted with significant change of status, on initiation of a pain medication or when there is significant change in condition with pain onset. The DOC confirmed the pain assessments are completed in Point Click Care electronic program. [s. 52. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home had a dining and snack service that included appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. An identified resident was observed by the compliance inspector to have a meal tray placed on a seat of a chair in their room. Documentation identified the resident took all meals in their room. There was not an appropriate table observed in the bedroom for a meal tray to be placed. Staff confirmed the resident did not have a proper table by which to eat their meal in the bedroom. [s. 73. (1) 11.]

Issued on this 23rd day of January, 2013

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