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
Jul 26, 2013	2013_190159_0018	H-000433-13	Critical Incident System

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

ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 15, 16, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, the Director of Care(DOC), registered staff, Personal Support Workers (PSWs), the Registered Dietitian, Food Service Manager, and residents.

During the course of the inspection, the inspector(s) Observed meal service in one home area, reviewed health records and policies and procedures specific to nutrition and hydration, and staff orientation/training.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. Resident #0001 had a Full Minimum Data Set (MDS) Annual Review Assessment conducted on May 2013. This assessment identified that the resident had changes in weight. The progress notes and the Interdisciplinary Care Conference notes dated May 2013 documented by the registered dietitian identified that the resident had an unplanned weight change of 2 kg in one month and the Basal Metabolic Index (BMI) was 31.8. The Active plan of care for the resident indicated the goal was to prevent weight change from 100kg. The weights recorded in Point Click Care were reviewed and identified the resident had a significant weight change since the admission. Interview with the registered dietitian confirmed that the resident has had a significant undesirable weight change. The intervention to prevent weight change was not effective and alternative approaches/strategies were not considered. [s. 6. (11) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not inform the Director within one business day after the occurrence of an incident. Interview with the Director of Care confirmed that an incident did occur. The Emergency service was called and the resident was transferred to the hospital. The report was sent to the Director, however, the home did not inform the Director within one business day after the occurrence of the incident. [s. 107. (3) 4.]

Issued on this 19th day of August, 2013

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

Hélène Schmidt