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
Jun 2, 2014	2014_205129_0009	H-000699-13	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

PHYLLIS HILTZ-BONTJE (129)

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): May 7, 8, 9 and 12, 2014

During the course of the inspection, the inspector(s) spoke with residents, regulated and unregulated nursing staff, the Director of Care and the Administrator in relation to Log # H-000699-13.

During the course of the inspection, the inspector(s) observed residents, reviewed clinical documents and reviewed the home's Foot Care and Referrals policy.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Findings of Non-Compliance were found during this inspection.

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

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee did not ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other in relation to the following: [6(4)(a)]
1. Staff providing care to resident #002 did not collaborate in the assessment of the resident's foot care needs. On an identified date in May 2014 family reported to nursing staff that they noticed the unusual appearance of the resident's feet. It was noted at the time of this inspection that the resident's toe nails were deformed and the skin around all the nails on the resident's feet appeared discoloured. A Nurse Practitioner assessed the resident on an identified date in May 2014 and indicated that the resident had a condition of the feet and toenails that required treatment. Personal Support Workers (PSWs) documented on the care flow sheets that the resident was provided with hygiene and nail care during baths on April 2, 5, 9, 12, 16, 19, 23 and 30, 2014. Registered staff did not collaborate with PSW staff providing foot and nail care and were unaware of the condition of the resident's feet and toenails. The lack of collaboration between direct care staff and registered staff in the observation of the resident's feet and in the assessment of the condition of the resident's feet and nails contributed to a deteriorating condition of the resident's feet.
2. Resident #003 was noted to have long toenails, both nails on the resident's great toes were thickened and cut at an angle leaving the toe nails sharply pointed. Clinical records indicated that the resident was receiving food care from a contracted service provider who was providing the services in the home. PSW staff documented on care flow sheets that the resident was provided with hygiene and nail care during baths on April 11, 18 and 28, 2014. At the time of this inspection a PSW who regularly provided care to the resident indicated that it was difficult to provide care because of the condition of the resident's toenails. Registered staff did not collaborate with the contracted foot care provider or the direct care staff in the assessment of the resident's foot care needs and were unaware of the condition of the resident's toenails. The Administrator confirmed that there is not a method established for staff to collaborate with contracted services providers in the home. [s. 6. (4) (a)]

2. The licensee did not ensure that staff and others involved in different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of the care are integrated and are consistent with and complement each other, in relation to the following: [6(4)b)]
1. Registered staff and a Nurse Practitioner did not collaborate with each other in the

development of a plan of care when it was identified that the condition of Resident #002's feet and nails had deteriorated. Registered staff assessed the resident on an identified date in May 2014 and identified a number of abnormalities with the resident's feet and toenails. The Nurse Practitioner assessed the resident and contacted the family following their assessment of the resident's feet. Registered staff in the home and the Nurse Practitioner did not collaborate in the development of the plan of care for resident #002 related to foot care. The Administrator and clinical documentation confirmed that at the time of this inspection the document used by the home to provide care directions for staff did not contain directions for foot care or the management of the condition identified by the Nurse Practitioner.
2. Registered staff and a contracted service provider, providing foot care to Resident #003 did not collaborate in the development of a plan of care when it was identified that the resident demonstrated a condition affected the resident's toe nails. Resident #003 was noted to have thickened toenails that were cut on an angle leaving the resident's great toenails sharply pointed. The Administrator and clinical documentation confirmed that at the time of this inspection the document used by the home to provide care directions for staff did not contain information that the resident was receiving foot care from a contracted service provider, that the resident had a condition causing thickening of the toenails and the documents did not provide care directions to PSW who were providing hygiene and foot care during scheduled baths for this resident. [s. 6. (4) (b)]

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 and ensuring that staff involved in different aspects of care of the resident collaborate with each other in the assessment as well as the development and implementation of the plan of care so that different aspects of care are integrated and consistent with and complement each other, to be implemented voluntarily.

WN #2: 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 that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure that staff comply with the policy, protocol or procedure, in relation to the following: [8(1)(b)]

Staff did not comply with the home's [Foot Care Protocols and Referrals] policy, identified as VI-G-10.34 and dated as current on September 2013, when they did not evaluate the resident's foot care needs and documents on the Head to Toe Assessment form quarterly, as directed in the policy.
- A quarterly Head to Toe Assessment completed for Resident #002 on February 25, 2014 had been checked that a foot care assessment was completed; however, there was no indication in the clinical record of the assessment or the outcome of the assessment of the resident's feet.
- A quarterly Head to Toe Assessment completed for Resident #003 on January 5, 2014 and March 14, 2014 had been checked to indicate that a foot care assessment had been completed; however, there is no indication in the clinical record of the assessment or the outcome of an assessment of the resident's feet. [s. 8. (1) (b)]

Issued on this 3rd day of July, 2014

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