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

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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
Aug 14, 2014	2014_195166_0020	O-000324-14	Complaint

Licensee/Titulaire de permis

PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
1090 MORAND STREET, WINDSOR, ON, N9G-1J6

Long-Term Care Home/Foyer de soins de longue durée

REGENCY MANOR NURSING HOME, DIVISION OF PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
66 DORSET STREET EAST, PORT HOPE, ON, L1A-1E3

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

CAROLINE TOMPKINS (166)

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): July 28 , 29 2014

During the course of the inspection, the inspector(s) spoke with the resident, Administrator, Registered nursing staff, Personal Support Workers and the Activation Manager.

During the course of the inspection, the inspector(s) observed the resident and reviewed clinical documentation.

The following Inspection Protocols were used during this inspection: Responsive Behaviours

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 O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

Review of Resident #01's plan of care related to responsive behaviours directs:
-staff to observe and report any changes in mental status
-encourage verbalization
-offer activities of which the resident has shown interest
-resident is followed by the Behaviour Ontario Support Team (BSO)
-2 staff and sometimes 3 staff to provide care to resident due to possible aggression
-Registered staff to document each summary of aggression
-allow resident time to respond to direction or requests
-approach resident slowly and from the front
-be cognizant of invading resident's personal space.
-be sure you have the resident's attention before speaking or touching
if resident becomes aggressive, staff to leave resident and reapproach
-allow resident to wander on the unit
-provide supervision during recreation programs and ensure resident is escorted back by a staff member
-encourage family involvement/support
-staff to document resident's whereabouts every 2 hours
-resident is high risk for elopement.

Review of clinical documentation and interviews with Registered Nursing staff #101, #105, Personal Support staff #102,#103,#104 and Recreation Manager indicated Resident #01:
-indicated that specific responsive behaviours patterns and variations of mood and functioning during different times of the day for Resident #01 have not been included in the plan of care .

The licensee failed to ensure the resident's plan of care included behaviour patterns, any potential behaviour triggers and variations in the resident functioning at different times of the day. [s. 26. (3) 5.]

Issued on this 15th day of August, 2014

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