



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**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  
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## **Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Jun 24, 2014	2014_256517_0029	L-000521-14	Critical Incident System

### **Licensee/Titulaire de permis**

MERITAS CARE CORPORATION  
567 VICTORIA AVENUE, WINDSOR, ON, N9A-4N1

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

REGENCY PARK LONG TERM CARE HOME  
567 VICTORIA AVENUE, WINDSOR, ON, N9A-4N1

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

PATRICIA VENTURA (517)

## **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): June 3, 2014**

**During the course of the inspection, the inspector(s) spoke with the Director of Care, one Registered Practical Nurse and two Health Care Aids.**

**During the course of the inspection, the inspector(s) Reviewed one resident's health record, reviewed the home's policies and procedures for falls, observed the resident and resident-staff interaction.**

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



**Findings of Non-Compliance were found during this inspection.**

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.



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**WN #1: 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).**

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**Findings/Faits saillants :**

1. The licensee did not ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident:

An incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to hospital.

- The Director of Care submitted a Critical Incident Report for this incident seven days following the resident's return from hospital.

- The Director of Care verified the staff were aware there was a significant change in the resident's health condition upon the resident's return from hospital.

- The Director of Care further verified the expectation that the Director should have been informed within one business day of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to hospital. [s. 107. (3) 4.]

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**Issued on this 24th day of June, 2014**

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