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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 14, 2015	2015_271532_0019	014110-15	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF WINSTON PARK
695 BLOCK LINE ROAD KITCHENER ON N2E 3K1

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

NUZHAT UDDIN (532)

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): August 05, 2015

During the course of the inspection, the inspector(s) spoke with the General Manager, Director of Nursing Care, Resident Assessment Instrument (RAI) Coordinator, Neighbourhood Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Resident and Family Member.
Inspector also toured the resident home areas, observed resident care provision; resident/staff interaction, reviewed relevant resident's clinical records, relevant policies and procedures, as well as notes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other. 2007, c. 8, s. 6 (4).

An identified resident was admitted to the home with multiple diagnosis.

In an interview the Neighbourhood Coordinator shared that the identified resident was having difficulty adjusting to the home’s routine. The Neighbourhood Coordinator reported that she sat down with the resident to come up with specific routines to assist with personal care.

The Neighbourhood Coordinator shared that she developed a memo which included specific routines, preferences and needs for each individual shift and posted it in the communication binder, however, the specific routines and preferences for the identified resident was not incorporated in the initial plan of care.

The Neighbourhood Coordinator explained that as a Personal Support Worker, she was not able to document in the care plan and confirmed that she did not collaborate with the Registered Nurse (RN) or the Resident Assessment Instrument (RAI) Coordinator to ensure the information gathered during an assessment with the resident was included in the development and implementation of the plan of care.

The Director of Resident Care (DRC) confirmed that the expectation was that all staff collaborated in the development and implementation of the plan of care so that the different aspects of care would be integrated and were consistent with and complemented each other. [s. 6. (4) (b)]

Issued on this 14th day of August, 2015

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

Original report signed by the inspector.