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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 27, 2015	2015_327570_0004	O-000807-14	Critical Incident System

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

THE WYNFIELD
451 Woodmount Drive OSHAWA ON L1G 8E3

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

SAMI JAROUR (570)

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): January 29, 2015

During the course of the inspection, the inspector(s) spoke with identified resident, Personal Support Workers (PSW), a Registered Nurse (RN), a Registered Practical Nurse (RPN), an Associate Director of Care, the Director of Care, Physiotherapist and Occupational Therapist.

Also, the inspector observed identified resident, reviewed clinical records and reviewed the Food and Nutrition Services Policy.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to Resident #01 as specified in the plan.

On an identified date in August 2014, a critical incident report was received identifying that Resident #01 tripped and fell while attempting to self transfer from a regular dining room chair. The resident was sent to hospital for assessment and diagnosed with a fracture.

Review of clinical records for Resident #01 indicated that the resident had 4 falls in one month period following admission. The clinical records indicate that Resident #01 is at high falls risk related to unsteady gait and confusion.

The current plan of care and plan of care in effect at time of incident direct staff to:
- provide extensive assistance of 2 staff for transfer.
- apply a lap belt at all times when up in wheelchair due to numerous falls and constant attempts to self transfer.
- use hip protectors and personal alarm when up in wheelchair.

The Home's policy Food and Nutrition Services Policy No: LTCE-FNS-C-02 under Dining Room Meal Service Protocol directs that Food Services Workers and Personal Support Workers must be present from beginning to end of the meal service and are responsible for the dining room service.

On January 29, 2015 at 15:15 hrs interview with PSW staff #103 indicated leaving the dining room for a couple of minutes to attend to another resident who was acting up and when returned to the dining room Resident #01 was on the floor. PSW staff #103 indicated that a dietary aid, a volunteer and other residents were present in the dining room.

Interviews with the ADOC and RN staff #101 indicated that Resident #01 was assisted by one staff to walk to dining room as part of the walk to dine program and sat in a regular chair in the dining room; no staff was available to supervise at time of fall; the staff should have not left the dining room until all residents leave the dining room.

The DOC indicated that the expectation of the home is that the dining room should have been supervised by PSW staff as they know the care needs of the residents and the PSW who last left the dining room was disciplined.

On January 29, 2015 Resident #01 was observed before and after the lunch meal sitting in a tilt wheelchair with no personal alarm and no hip protectors were in place.

On January 29, 2015 at 13:35 hrs the ADOC confirmed that the resident did not have an alarm in place and was not wearing hip protectors. The ADOC indicated that Resident #01 should have a personal alarm and hip protectors in place as per the plan of care.

On January 29, 2015 at 13:45 hrs interview with PSW staff #104 indicated that the resident's hip protectors are missing and the resident never refused to put them on.

On January 29, 2015 at 15:35 PSW staff #105 indicated that Resident #01 does not wear hip protectors all the time.

On January 29, 2015 at 16:00 the ADOC indicated that a personal alarm was just put in place while in wheelchair and new hip protectors were provided for resident's use to replace the missing ones.

The licensee did not provide care as specified, putting the resident at risk when the resident was not supervised while in the dining room sitting in a regular chair and when personal alarm and hip protectors were not in place when the resident was up in the wheelchair. [s. 6. (7)]

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 to ensure that the care set out in the plan of care for Resident #01 is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 27th day of February, 2015

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

Original report signed by the inspector.