



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

**Rapport d'inspection  
prévues le *Loi de 2007  
les foyers de soins de  
longue durée***

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

Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch

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

Division de la responsabilisation et de la performance du  
système de santé  
Direction de l'amélioration de la performance et de la  
conformité

Ottawa Service Area Office  
347 Preston St., 4<sup>th</sup> Floor  
Ottawa ON K1S 3J4

Telephone: 613-569-5602  
Facsimile: 613-569-9670

Bureau régional de services d'Ottawa  
347, rue Preston, 4<sup>ième</sup> étage  
Ottawa ON K1S 3J4

Téléphone: 613-569-5602  
Télécopieur: 613-569-9670

Licensee Copy/Copie du Titulaire  Public Copy/Copie Public

<b>Date(s) of inspection/Date de l'inspection</b> January 12, January 13 2011	<b>Inspection No/ d'inspection</b> 2011_166_2511_12Jan130035	<b>Type of Inspection/Genre d'inspection</b> O-003035 Critical Incident
<b>Licensee/Titulaire</b> Provincial Nursing Homes Limited Partnership Fax 519-966-3002 1090 Morand Street, Windsor, ON N9G 1J6		
<b>Long-Term Care Home/Foyer de soins de longue durée</b> Regency Manor Nursing Home, Division of Provincial Nursing Homes Limited Partnership 66 Dorset Street, Port Hope, ON L1A 1E3 Fax 905-885-7386		
<b>Name of Inspector(s)/Nom de l'inspecteur(s)</b> Caroline Tompkins #166 Chantal Lafreniere #194		
<b>Inspection Summary/Sommaire d'inspection</b>		
<p>The purpose of this inspection was to conduct a critical incident inspection related to resident care.</p> <p>During the course of the inspection, the inspectors spoke with: The Acting Administrator, the Director of Care, a Registered Practical Nurse, 3 Personal Support Workers (PSW) and the Resident Service Manager. During the course of the inspection, the inspectors: Reviewed the resident's clinical records, including the staff communication binder.</p> <p>Findings of Non-Compliance were found during this inspection. The following action was taken:</p> <p>3 WN 2 CO: CO #001,#002</p>		

**NON- COMPLIANCE / (Non-respectés)**
**Definitions/Définitions**

**WN** – Written Notifications/Avis écrit  
**VPC** – Voluntary Plan of Correction/Plan de redressement volontaire  
**DR** – Director Referral/Régisseur envoyé  
**CO** – Compliance Order/Ordres de conformité  
**WAO** – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

**WN #1:** The Licensee has failed to comply with O.Reg.79/10,s.17(1) Every Licensee of a long term care home shall ensure that the home is equipped with a resident –staff communication and response system that,  
(a) can be seen, accessed and used by residents, staff and visitors at all times;

**Findings.** The Director of Care, the Registered Practical Nurse and the Resident Service Manager all identified that at the time of the resident's fall the nurse call bell was not within the resident's reach .

**Inspector ID #:** 166 and 194

**Additional Required Actions:**

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

**WN #2:** The Licensee has failed to comply with LTCHA , 2007, S.O.2007 c.8,s.6(10)The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every 6 months and at any other time when,  
(b) the resident care needs change or care set out in the plan of care is no longer necessary;

**Findings:** There was no plan of care addressing the changes of the resident, in relation to:

1. Potential for falls
2. Change in mobility status.
- 3.The home's compliance history prior to the LTCHA,2007 coming into force identified that resident assessments had previously been issued:
  - March 25 2010 and May 27,28 2010, under criteria B4.3
  - February 25 2010 under criteria B1.2

**Inspector ID #:** 166 and 194

**Additonal Required Actions:**

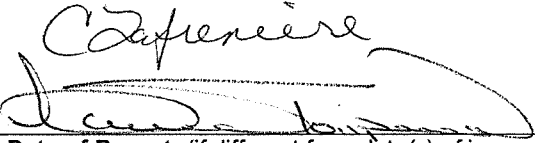

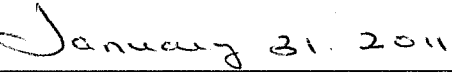
CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

**WN #3:** The Licensee has failed to comply with O.Reg.79/10,s.212 (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,  
(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long –term care home administration or management that is a minimum of 100 hours in duration of instruction time.



**Findings:** During an interview with Acting Administrator it was identified that there has been no permanent administrator of the home since January 6 2011. The acting Administrator role is a temporary arrangement . There was no indication when a permanent replacement would take place. The Acting Administrator, advised that she did not have the qualifications required under O.Reg.79/10,s.212 (4).

<b>Inspector ID #:</b>	166
------------------------	-----

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné		Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.	
Title: _____ Date: _____		  Date of Report: (if different from date(s) of inspection). 	



## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the  
*Long-Term Care Homes Act, 2007, S.O. 2007, c.8*

	<input type="checkbox"/> Licensee Copy/Copie du Titulaire	<input checked="" type="checkbox"/> Public Copy/Copie Public
<b>Name of Inspector:</b>	Caroline Tompkins	<b>Inspector ID #</b> 166
<b>Log #:</b>	O-003035	
<b>Inspection Report #:</b>	2011_166_2511_12Jan130035	
<b>Type of Inspection:</b>	Critical Incident	
<b>Date of Inspection:</b>	January 12,13 2011	
<b>Licensee:</b>	Provincial Nursing Homes Limited Partnership Fax 519-966-3002 1090 Morand Street, Windsor, ON N9G 1J6	
<b>LTC Home:</b>	Regency Manor Nursing Home, Division of Provincial Nursing Homes Limited Partnership 66 Dorset Street, Port Hope, ON Fax 905-885-7386 L1A 1E3	
<b>Name of Administrator:</b>	Patty Aitken Acting Administrator	

To Provincial Nursing Homes Limited Partnership , you are hereby required to comply with the following orders by the dates set out below:

<b>Order #:</b>	001	<b>Order Type:</b>	Compliance Order, Section 153 (1)(a)
<b>Pursuant to:</b> O.Reg.79/10,s.17(1) Every Licensee of a long term care home shall ensure that the home is equipped with a resident –staff communication and response system that, (a) can be seen, accessed and used by residents, staff and visitors at all times;			
<b>Order:</b> The licensee shall ensure that every resident in the home has access to a resident- staff communication system at all times.			



Table with 2 columns: Grounds (The Director of Care, the Registered Practical Nurse and the Resident Service Manager all identified that at the time of the resident's fall the nurse call bell was not within the resident's reach .) and This order must be complied with by: (Immediately)

Table with 2 columns: Order #: (002) and Order Type: (Compliance Order, Section 153 (1)(b)). Pursuant to: : The Licensee has failed to comply with LTCHA, S.O. 2007, c.8, s.6(10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every 6 months and at any other time when, (b) the resident care needs change or care set out in the plan of care is no longer necessary; Order: The licensee shall prepare, submit and implement a plan to ensure that all residents in the home are reassessed and the plan of care reviewed and revised at least every 6 months and at any other time when the resident care needs change.

Table with 2 columns: Grounds : (There was no plan of care addressing the changes of the resident, in relation to: 1. Potential for falls 2. Change in mobility status. 3. The home's compliance history prior to the LTCHA, 2007 coming into force identified that resident assessments had previously been issued: March 25 2010 and May 27, 28 2010, under criteria B4.3 February 25 2010 under criteria B1.2) and This order must be complied with by: (February 14 2011)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.



**Ministry of Health and Long-Term Care**  
 Health System Accountability and Performance Division  
 Performance Improvement and Compliance Branch

**Ministère de la Santé et des Soins de longue durée**  
 Division de la responsabilisation et de la performance du système de santé  
 Direction de l'amélioration de la performance et de la conformité

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

**Director**  
 c/o Appeals Clerk  
 Performance Improvement and Compliance Branch  
 Ministry of Health and Long-Term Care  
 55 St. Clair Ave. West  
 Suite 800, 8<sup>th</sup> floor  
 Toronto, ON M4V 2Y2  
 Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

**Health Services Appeal and Review Board and the**  
 Attention Registrar  
 151 Bloor Street West  
 9th Floor  
 Toronto, ON  
 M5S 2T5

**Director**  
 c/o Appeals Clerk  
 Performance Improvement and Compliance Branch  
 55 St. Claire Avenue, West  
 Suite 800, 8<sup>th</sup> Floor  
 Toronto, ON M4V 2Y2  
 Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).

Issued on this 31 day of January , 2011.	
Signature of Inspector:	
Name of Inspector:	Caroline Tompkins
Service Area Office:	Ottawa