Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
May 24, 2018	2018_538144_0011	018991-16, 026555-16, 015903-17, 017351-17	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

CAROLEE MILLINER (144)

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): April 19 and 20, 2018

The following intakes were completed with this inspection:
018991-16, CI 2760-000001-16 related to falls prevention and management
026555-16, CI 2760-000010-16 related to continence and bowel management and falls prevention and management
015903-17, CI 2760-000003-17 related to reporting matters to the Director and the plan of care
017351-17, CI 2760-000005-17 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with one resident, the Director of Resident Care, one Registered Nurse, one Registered Practical Nurse and one Personal Service Worker.

During the course of the inspection, the inspector reviewed four resident clinical records.

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

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for one resident set out clear directions to staff and others who provided direct care to the resident.

Review of the clinical record for one resident stated that the resident had sustained a fracture of unknown origin.

The written plan of care for the resident was not revised to include interventions related to the fracture.

One Registered Nurse and one Registered Practical Nurse shared that the resident's care plan had not provided clear directions to staff and should have included the fracture.

The Director of Resident Care agreed that the care plan for the resident should have been reviewed and revised to include the fractured and that the care plan had not provided clear direction to staff.

The licensee failed to ensure that the plan of care set out clear directions for one resident related to their fracture. [s. 6. (1) (c)]

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 plan of care for one resident set out clear directions to staff and others who provided direct care to the resident., to be implemented voluntarily.

Issued on this 24th day of May, 2018

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

Original report signed by the inspector.