Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2020	2020_747725_0019	017017-20, 017316-20	Critical Incident System

Licensee/Titulaire de permis

DTOC Long Term Care LP, by its general partner, DTOC Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.
161 Bay Street, Suite 2100 TD Canada Trust Tower TORONTO ON M5J 2S1

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

CASSANDRA TAYLOR (725)

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): November 18-20, 2020.

The following Critical Incident intakes were completed within this inspection:

Related to falls prevention:
Critical Incident Log #017017-20 / CIS #2760-000009-20;
Critical Incident Log #017316-20 / CIS #2760-000010-20.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, a Registered Nurse, three Practical Nurses, and a Personal Support Worker.

The inspector also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents.

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	Légende 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 O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 and #003’s written records were kept up to date at all times.

During a chart review for resident #001 documentation indicated that the resident had been hospitalized. During resident #001's hospitalization documentation was added to their chart indicating the resident’s body temperature as part of the on-going infection monitoring, however the resident was not in the home during those dates. Resident #001 later died and there was documentation on the resident’s body temperature again in their chart after their date of death. During a chart review for resident #003 documentation from Physiotherapist Assistant (PTA) #107 indicated that the resident was approached and had refused physiotherapy treatment, however the resident was hospitalized on that day.

It was indicated by the Director of Resident Care (DRC) that when entering the resident’s temperatures, it was done as a batch entry and that the PTA should have documented the resident was unavailable, the expectation would be for staff to chart accurately.

Not keeping resident records up to date presented a potential risk for treatments or assessments to be missed.

Sources: Resident #001 and #003's records and interview with DRC. [s. 231.]

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 resident #001 and #003’s written records are kept up to date, to be implemented voluntarily.

Issued on this 23rd day of November, 2020

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

Original report signed by the inspector.