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
May 28, 2021	2021_791739_0023	003823-21, 004747-21, 005004-21	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

JULIE DALESSANDRO (739)

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): May 25,26, and 27, 2021

During the course of this inspection the following intakes were completed:
Log #003823-21/AH: IL-88214-AH/CI #2760-000003-21 related to falls
Log #005004-21/CI #2760-000005-21 related to falls
Log #004747-21/AH: IL-88701-AH/CI #2760-000004-21 related to resident care

During the course of this inspection an infection control inspection was also completed.

During the course of the inspection, the inspector(s) spoke with Resident(s), Housekeeper(s), Personal Support Worker(s), a Physiotherapy Assistant, Registered Practical Nurse(s), the Administrative Director of Care and Director of Care.

During the course of this inspection the inspector(s) also conducted record review and observation relevant to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
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	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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee had failed to ensure that Personal Support Worker (PSW) #110 used safe techniques when assisting a resident.

During an interview with the Registered Practical Nurse (RPN) they stated that they heard a resident moaning in their room. The RPN went to see the resident and noticed visible injury to the resident. The RPN then called PSW #102 and #110 into the room and inquired about resident care. PSW #102 stated that PSW #110 had provided care to the resident using unsafe techniques.

A review of progress notes in Point Click Care (PCC) related to the incident indicated that the resident was found with injuries and later that day was further assessed for a change in condition.

During an interview with the Director of Nursing they acknowledged that PSW #110 did not use safe techniques when providing care to a resident.

Not using safe techniques when providing care to a resident in harm to the resident.

Sources: The home’s policies, the resident’s progress notes and plan of care in PCC as well as interviews with PSW #102, RPN #111, and the home’s DOC.

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 staff use safe techniques when assisting residents, to be implemented voluntarily.

Issued on this 28th day of May, 2021

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

Original report signed by the inspector.