Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 28, 29, 30, Dec 12, 2012	2012_094144_0046	Other

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 an Other inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of care and Food Service Supervisor

During the course of the inspection, the inspector(s) completed a tour of the home, observed dietary and nursing services during the lunch meal and reviewed the maintenance log binder.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Admission Process

Dining Observation

Hospitalization and Death

Infection Prevention and Control

Residents' Council

Findings of Non-Compliance were found during this inspection.

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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. 15. Accommodation services

Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. During a walk through of the home, the following observations were noted:
A) dining room door panel is lifting and door has jagged edges, nicks and scrapes
B) base boards in front of the elevator have nicks and scrapes
C) one ceiling tile missing in dining room
D) paint and encasement around ceiling beam in dining room coming away from the beam
E) missing cover plates on 4 electric outlets
F) multiple resident rooms and corridors with unfinished wall repairs
G) multiple water stained ceiling tiles
H) duck tape holding the edging of one washroom counter top to the counter
I) one washroom ceiling fan not working
J) one resident room with yellow tape stretched across the floor of washroom entrance
K) caulking around the base of multiple toilets is split in several areas
L) multiple chipped and scraped door frames leading into resident rooms
M) review of the maintenance binder revealed a recent entry identifying there is still no seat belt for the whirlpool chair and that the belt was ordered; item not signed off as completed
N) review of the maintenance binder identified a recent entry that one resident needed a high low bed & bed alarm as the resident was high risk for falls; item has not been signed off as completed.
O) review of the maintenance binder identified a recent entry about mould in the shower stall; the item is not signed off as completed
P) a heavy duty, long extension cord was noted stretched across the floor of one resident room and plugged in to the television with the excess cord rolled up under the head of residents bed. [LTCHA,2007,S.O.c.8,s.15(2)(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 related to ensuring the home, furnishings and equipment are maintained in a safe condition and in a good state of repair,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following subsections:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The Administrator and Director of care confirmed a resident was transferred to hospital and

A) discharged from the home without notification to the POA; a voice mail message was left for the POA

B) discharged from the home without collaboration with the placement coordinator and other health service organizations.[O.Reg.79/10,s.142(b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. During a walk through of the home, the following observations were noted:
A) multiple unlabeled wash basins in resident washrooms; two unlabeled basins stored on the washroom floor
B) multiple unlabeled toothbrushes, hair combs and brushes, toothpaste, razors and, shampoos stored together in one container in resident semi private and basic rooms
C) absence of toilet paper on the toilet paper roll in common male and female washrooms on the basement level of the home
D) unlabeled nail clippers in spa room on first floor. [O.Reg.79/10,s.229(4)]

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Issued on this 12th day of December, 2012

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

Carolee Millen