Ontario

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

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

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

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 11, 2014 | 2014_267528_0014 | H-000428-13 | Critical Incident System |

**Licensee/Titulaire de permis**

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

**Long-Term Care Home/Foyer de soins de longue durée**

THE WENLEIGH
2065 Leanne Boulevard, MISSISSAUGA, ON, L5K-2L6

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581)

**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 2 and 3, 2014

This inspection was done concurrently with complaint inspection #2014_267528_0013 / H-000858-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistance Director of Care (ADOC), Resident Assessment Instrument Coordinator (RAI Coordinator), Registered Practical Nurses (RPN), Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) observed the provision of care, reviewed relevant clinical health records, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

Findings of Non-Compliance were found during this inspection.

## NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.) | 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. |
| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed.

A. In July 2013, resident #100 was complaining of severe pain in their arm and was transferred to hospital for treatment. X-rays confirmed two fractures and the resident returned to the home with a cast. Review of the plan of care indicated that significant change assessments, related to skin and wound and safe transfer and lift, were not completed. During the interview with the Resident Assessment Instrument Coordinator (RAI Coordinator), she confirmed that a fracture was a significant change and the skin and wound and transfer and lift assessments were were not completed. The RAI Coordinator also confirmed that the care plan was not revised to reflect the significant change in resident #100. [s. 6. (10) (b)]

B. In April 2014, resident #100 was observed in bed with two side rails raised and both side rails were padded. The progress notes indicated that in June 2013, registered staff recommended padded side rails to protect the resident from injury. Interview with both direct care staff and registered staff confirmed that padded side rails were in place since July, 2013 but could not confirm the exact date. Although padded side rails have been in place since July 2013, as of April 2014 the plan of care was not updated to include padded side rails as a safety intervention. [s. 6. (10) (b)]

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**

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**Findings/Faits saillants :**

1. The licensee did not ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

A. In July 2014, resident #100 presented with severe pain in their arm. Review of the plan of care revealed that the resident was assessed by registered staff and an x-ray was taken in the home. The x-ray report suggested that there were two fractures and recommended follow-up. Resident #100 was sent to hospital in July 2014 for treatment, both fractures were confirmed and the resident returned back to the home on the same day. According to the Critical Incident Report this incident was not reported to the Director until four days later. In an interview, the Director of Care (DOC) confirmed that a fracture would be considered a significant change and that the incident was not reported to the Director within one business day . [s. 107. (3) 4.]

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**Issued on this 25th day of April, 2014**

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

M Messo #528