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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
December 14, 21, 2010 and January 10, 2011	2011-173-2921-10Jan114254 2010-127-2921-14Dec083713	Complaint Log # H02917/H03026 CIS Review Log #H02877

Licensee/Titulaire
Regency LTC Operating Limited Partnership on
100 Milverton Dr, Suite 700, Mississauga, Ontario L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée
The Willowgrove
1217 Old Mohawk Rd, Ancaster Ontario L9K 1P6

Name of Inspector(s)/Nom de l'inspecteur(s)
Lesa Wulff – LTC Inspector – Nursing, #173
Richard Hayden – LTC Inspector – Environmental Health, #127

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to falls management and critical incident review related to allegation of abuse.

During the course of the inspection, the inspector spoke with: Administrator, Director of Care, Registered Staff, Personal Support Workers, residents

During the course of the inspection, the inspector: Reviewed policy and procedure, reviewed clinical health records, observed resident care, viewed areas of home.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse and Neglect Inspection Protocol
Falls Prevention Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
3 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007, S.O., 2007 c8, 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,
(1) clear directions to staff and others who provide direct care to the resident.

Findings:

1. During inspection of fall with injury involving resident an identified resident, it was noted that this resident had exhibited previous behaviours of wandering and exit seeking. This was confirmed by staff during interview on January 10, 2011. There is currently no written plan of care in place that addresses the behaviour of exit seeking with interventions that set out clear directions to staff and others who provide direct care to the resident.
2. During inspection related to an identified resident, it was noted that this resident had been treated for a Urinary Tract infection in the last quarter. There is currently no written plan of care in place that addresses this concern with interventions that set out clear direction to staff and others who provide direct care to the resident.

Inspector ID #:	173

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 developing a process to ensure that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA 2007, S.O., 2007 c8, s. 6(7)
The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Findings:

1. An identified resident has a history of wandering and exit seeking. Staff confirmed during interview that the resident has been seen trying to exit through stairwell doors as well as the main front door.
2. This resident's plan of care states that staff are to monitor the whereabouts of the resident every 15-30 minutes and report if resident is not found.
3. Staff did not provide care as set out in the plan of care as follows;
   - Staff report that resident was last seen at approximately 10:00am on the day of the incident in the hallway of the resident home area. Staff did not look for resident again until approximately 11:40am. During this time the staff became aware that the magnetic locks to the stairwell doors were not functioning. The resident was able to exit through an open door and sustained a fall with injury

Inspector ID #:	173

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 developing a process to ensure that care is provided to the resident as set out in the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c8, s.19(1)
Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that the residents are not neglected by the licensee or staff.

Findings:

1. The management of the home became aware of several residents on one resident home area that had bruising of unknown origin. The management team initiated an investigation into the matter. During interview with residents, it was suspected that a staff member was rough with care.
2. An identified resident was confronted and made to repeat information related to the allegations of abuse in front of the accused and another staff member.

Inspector ID #:	173

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 developing a process to ensure that the home shall protect all residents from abuse and neglect, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Lisa Wulff
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Aug 3/11