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
Dec 19, 2019	2019_792659_0026	015347-19	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Winston Park
695 Block Line Road KITCHENER ON N2E 3K1

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

JANETM EVANS (659)

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): December 9, 11 and 13, 2019.

The following intake was included as part of the inspection:
Log #015347-19\AH IL-69069-AH, Critical Incident (CI) #2783-000006-19 related to a resident fall.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Neighbourhood Coordinator (NC), Registered Nurses (RN), Registered Practical Nurse (RPN), Kinesiologist, Personal Support Workers (PSW) and residents.

Observations were completed related to the provision of care, cleanliness of residents, and staff to resident interactions.

A review of relevant clinical records, complaint records, policies and procedures and training records was completed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Reporting and Complaints

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. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the verbal and written complaint made to a staff member related to the care of an identified resident was immediately investigated.

On a specified date, a verbal report was made to the DOC which alleged an identified resident had not been assessed by the registered staff following a fall. The DOC said they asked the staff member to put the concern in writing. The DOC said that they received a written statement from the staff member the following day.

The DOC stated they had given the complaint to the NC.

The NC said they had a conversation with the staff member about the identified resident's falls. The NC said they had no prior knowledge of a written complaint related to the resident's falls. They submitted a Critical Incident (CI) for the identified resident’s fall with transfer to hospital.

The DOC and NC acknowledged an investigation into the complaint had not been completed.

The licensee failed to ensure that the verbal and written complaint concerning the care of identified resident was immediately investigated. [s. 101. (1) 1.]

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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident is investigated and where the complaint alleges harm or risk of harm the investigation will be commenced immediately, to be implemented voluntarily.

Issued on this 19th day of December, 2019

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

Original report signed by the inspector.