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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 30, 2015	2015_327570_0020	O-002057-15; O-002176-15; O-002177-15; O-002342-15	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 WYNFIELD
451 Woodmount Drive OSHAWA ON L1G 8E3

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

SAMI JAROUR (570)

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): June 29, 30 and July 3, 2015

**During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care(DOC), Personal Care Providers(PCP), Registered Practical Nurses (RPN),
Registered Nurses(RN) and Residents.**

The Inspector also toured the home, observed staff to resident interactions and reviewed clinical health records, the licensee's investigation documentation and the licensee's policies related to missing residents and abuse prevention.

**The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home**

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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	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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Related to log # O-002177-15 for Resident #01

The licensee has failed to comply with O. Reg. 79/10, s. 8 (1), by ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, is: (b) complied with:

Under O. Reg. 79/10, s. 230 (4)1. The licensee shall ensure that the emergency plans provide for the following:
vii. situations involving a missing resident

The licensee policy involving missing residents:
Emergency Response Plan / Code Yellow (Policy # ALL-CA-ALL-510-08, May 2015)
The policy directs staff to implement a Missing Resident Search Plan that consists of four stages upon the discovery of a resident missing from a designated event or occurrence for a routine check.
1. Stage one search plan: directs a general search within the building/property; if a resident is not located proceed to stage two search plan.
2. Stage two search plan: directs a code yellow announcement (3 times) and to implement the use of Code Yellow Checklist form.

Critical Incident Report (CIR)indicated on an identified date and time Resident #01 exited from a specified home area to the lobby and exited the home from the front door when RN #100 opened the door to let another resident in. The resident indicated going for a walk when questioned by RN #100.

The CIR report identified that RN #100 went after Resident #01 after confirming the resident should not be out walking alone but the resident was not found on the property at that time. The resident was missing for about 10 minutes when found walking down a main road by PCP #108. When the resident refused to go back, the home called the police who escorted the resident accompanied with PCP #108 back to the home.

Review of clinical records for Resident #01 indicated the resident was admitted to the home on an identified date with previous history of wandering and exit seeking and the resident relies on staff to assist with daily decisions due to poor decision making skills.

Interviews with several staff members indicated the resident was not exit seeking at the

time of incident and that all residents from a specified home area are always supervised when leaving home area.

Interview with the DOC and review of the home's investigation notes indicated the resident was seen unsupervised in the lobby by RN #100 who knew that Resident #01 is from a specified home area. When RN #100 opened the front door for another resident, Resident #01 exited through the front door. RN #100 did not attempt to stop the resident from leaving the home at a specified time. RN #100 notified RN #101 as the resident exited the building and both RN #100 and #101 proceeded to a specified home area to check if the resident can go for walks. By that time the resident was determined missing.

During the interview, the DOC indicated the home's Code Yellow policy was not followed as RN #100 and #101 did not initiate a code yellow when Resident #01 was determined missing. The DOC indicated that following the incident, code yellow (missing resident) drills were completed at the home for all staff. [s. 8. (1) (b)]

Issued on this 30th day of July, 2015

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

Original report signed by the inspector.