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
Mar 28, 2014	2014_195166_0009	O-000207-14	Resident Quality Inspection

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

CAROLINE TOMPKINS (166), AMBER MOASE (541), MATTHEW STICCA (553)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 24-March 28, 2014

Critical incidents log O-000851-13, O-000164-13 and complaint log O-000849-13 were inspected concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, the Resident Council President, the Administrator, the Director of Care, the Associate Directors of Care, the Environmental Service Manager, the Director of Program Support Services, the Food Service Manager, a member of the Maintenance staff, Dietary Aides, Recreation Aide, Registered Nurses, Registered Practical Nurses and Personal Care Providers.

During the course of the inspection, the inspector(s) observed staff to resident interactions, resident meal service, resident social and recreational activities, observed the licensee's infection prevention and control practices, reviewed residents' clinical records, licensee's policies related to prevention of abuse and neglect, medication administration, skin and wound, resident and staff immunization, falls management and pets. Reviewed Resident Council and Family Forum minutes.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Related to Log O-000851-13
The licensee failed to notify the Director within one business day under section 107(3) (3) when a missing or unaccounted for controlled substance occurred.

On September 3, 2013, critical incident (#2885-000019-13)
was received indicating that on August 29, 2013: One tab Dilaudid 1mg was missing. There were no adverse effects on Resident #11. The medication was a PRN and no doses were missed.
Review of documentation and interview with the Director of Care confirm that the Director was not notified within one business day when a missing or unaccounted for controlled substance occurred. [s. 107. (3)]

Issued on this 31st day of March, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Caroline Tompkins, #166 Amber Moase, #541 Matthew Sticca #553.