



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

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

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

**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**

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de
Hamilton
119, rue King Ouest, 11^{ième} étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

Public Copy/Copie du public

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_0013	H-000858- 13	Complaint

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)

Inspection Summary/Résumé de l'inspection



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

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

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

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

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 2 and 3, 2014

**This inspection was done concurrently with Critical Incident Inspection
#2014_267528_0014**

**During the course of the inspection, the inspector(s) spoke with Administrator,
Director of Care (DOC), Assistant Director of Care (ADOC), Registered Practical
Nurse (RPN), Personal Support Workers (PSW).**

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

**The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation**

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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 :



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

1. The licensee did not ensure that any policy instituted or otherwise put in place was complied with.

A. Resident #003 sustained two falls in March 2014, no injuries noted. Review of the plan of care for the resident revealed that the post falls initial assessment and documentation of the incident were not completed. The homes "Policy #LTCE-CNS-G-10:Falls-Resident, last updated January 2013" outlined that in the event of a fall registered staff were to document the occurrence in Point Click Care (PCC) and include a narrative about what happened, the initial assessment, nursing actions, significant pre-falls factors, and family/substitute decision maker (SDM) notification. The Assistant Director of Care (ADOC) confirmed that the occurrence note was not completed for both falls in March 2014. [s. 8. (1) (a),s. 8. (1) (b)]

2. B. Resident #001, high risk for falls, sustained a fall in July 2013 and December 2013. Review of the plan of care for the resident revealed that post falls analysis were not completed in Point Click Care (PCC) . The homes "Policy #LTCE-CNS-G-10:Falls-Resident, last updated January 2013" outlined that in the event of a fall of a high risk resident, post falls analysis is to be completed by the interdisciplinary team after the first fall in the quarter. The Director of Care (DOC) confirmed that the post falls analysis was not completed in PCC following two falls in July 2013 and December 2013. [s. 8. (1) (a),s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement



Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:

- 1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
- 2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
- 3. The use of the PASD has been approved by,**
 - i. a physician,**
 - ii. a registered nurse,**
 - iii. a registered practical nurse,**
 - iv. a member of the College of Occupational Therapists of Ontario,**
 - v. a member of the College of Physiotherapists of Ontario, or**
 - vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).**
- 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).**
- 5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).**

Findings/Faits saillants :

1. The licensee did not ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

In April 2014, observed resident #001 in bed with right and left half rails rails up. The plan of care identified that staff place both bed rails up while resident in bed to assist with bed mobility and safety. A consent for the use of both bed rails as a Personal Assistance Services Device (PASD) was not completed. [s. 33. (4) 4.]



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

Issued on this 25th day of April, 2014

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

W. Tomasso #528