

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 prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance
Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la performance et de la
conformité

London Service Area Office 291 King Street, 4th Floor LONDON, ON, N6B-1R8 Telephone: (519) 675-7680 Facsimile: (519) 675-7685 Bureau régional de services de London 291, rue King, 4iém étage LONDON, ON, N6B-1R8 Téléphone: (519) 675-7680 Télécopieur: (519) 675-7685

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 29, Mar 1, 12, 14, 21, 2012	2012_069170_0004	Critical Incident
Licensee/Titulaire de permis		
REGENCY LTC OPERATING LP ON 100 Milverton Drive, Suite 700, MISSI Long-Term Care Home/Foyer de so	SSAUGA, ON, L5R-4H1	
THE WESTMOUNT 200 David Bergey Drive, KITCHENEF	R, ON, N2E-3Y4	
Name of Inspector(s)/Nom de l'insp	ecteur ou des inspecteurs	
DIANNE WILBEE (170)		
	nspection Summary/Résumé de l'inspe	ection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Director of Care, Director Clinical Services, Assistant Director of Care, Program Service Manager, and Personal Support Worker (2)

During the course of the inspection, the inspector(s) reviewed resident record, observed residents (2), reviewed policies and procedures specific to the inspection, observed a home area, reviewed information specific to a program and observed a program area related to Log# L-001787-11.

The following Inspection Protocols were used during this inspection:

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES		
	Legendé WN – Avis écrit	
VPC - Voluntary Plan of Correction	VPC – Plan de redressement volontaire	
DR - Director Referral	DR - Aiguillage au directeur	
CO – Compliance Order	CO – Ordre de conformité	
WAO – Work and Activity Order	WAO – Ordres : travaux et activités	



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 prévue le Loi de 2007 les foyers de soins de longue

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care Specifically failed to comply with the following subsections:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants:

- 1. The licensee did not ensure that the care set out in the plan of care was provided to a resident as specified in the plan. The resident's plan of care identified the resident as having an elopement risk, as requiring 15 minute checks by staff and requiring constant supervision when off the home area due to exit seeking behaviour. The plan of care was not provided as follows:
- a) Constant supervision was not provided when the resident was taken off the home area, to a program, resulting in the resident eloping from the building.
- b) Safety checks were not documented when the resident was off the home area. In addition, the resident's attendance at the program was not recorded resulting in the resident being at risk.

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 safety monitoring and supervision of residents who are identified as a safety risk are maintained on a ongoing basis, to be implemented voluntarily.

issued on this 21st day of March, 2012

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

Dianne Skilber # 170