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
Aug 22, 2013	2013_210169_0020	H-00171-13 AND H-00127-13	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

YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 26, 29, 30 2013

This report refers to the following complaints. Logs # H-00171-13 and H-00127-13,

During the course of the inspection, the inspector(s) spoke with the Acting Administrator/Director of Care, Clinical Educator, Registered Nurses, Registered Practical Nurses and Nurse Practitioner.

During the course of the inspection, the inspector(s) conducted a retrospective clinical review, reviewed policies and procedures, reviewed wound care education manual and attendance documentation and the licensee's internal investigative documentation.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Medication

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	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

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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has not ensured that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. Resident #3 developed a change in health status and was subsequently transferred to the hospital after an assessment by the Nurse Practitioner.

The first documented assessment in the clinical record was completed by the day shift. The second documented assessment occurred by the evening shift. There is no documentation of a reassessment by the night nurse. Interview with the night nurse revealed there was a reassessment of resident #3, but the nurse did not document the assessment. The day nurse on the following day completed an assessment, documented it and then contacted the nurse practitioner to assess and determine the appropriate treatment. The clinical documentation confirmed the night nurse did not document the reassessment. The registered nurse and Director of Care/Administrator confirmed the reassessment by the night nurse was not documented. [s. 30. (2)]

Issued on this 22nd day of August, 2013

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

Yvonne Walton