



Ministry of Health and Long-Term Care
 Health System Accountability and Performance Division
 Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
 Division de la responsabilisation et de la performance du système de santé
 Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
 119 King Street West, 11th Floor
 Hamilton, ON L8P 4Y7

Bureau régional de services de Hamilton
 119, rue King Ouest, 11^{ème} étage
 Hamilton, ON L8P 4Y7

Telephone: 905-546-8294
 Facsimilie: 905-546-8255

Téléphone: 905-546-8294
 Télécopieur: 905-546-8255

Inspection Report under the LTC Homes Act, 2007/ Rapport d'inspection prévue de la Loi de 2007 les foyers de soins de longue durée

Public Copy/Copie Publique Licensee Copy/Copie du Titulaire

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
August 23 and 24, 2010	2010_170_2880_23Aug1157 12	Critical Incident (L-00512)

Licensee/Titulaire
 Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner,
 100 Milverton Drive, Suite 700, Mississauga, Ontario L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée
 The Westmount, 200 David Bergey Drive, Kitchener Ontario N2E 3Y4

Name of Inspector(s)/Nom de l'inspecteur(s)
 Dianne Wilbee, LTC Homes Inspector, ID#170

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

The inspection occurred on August 23 and August 24, 2010.

During the course of the inspection, the inspector spoke with:
 Director of Care, Registered Nurse, Personal Support Worker, Resident, Social Worker, ADOC; Resident
 Record Review; Resident Observation.

The following Inspection Protocol was used in part or in whole during this inspection:
 Responsive Behaviours

2 Findings of Non-Compliance were found during this inspection. The following action was taken:
 2 WN
 2 VPC

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigences prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

i

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of corrective Action/Plan de redressement
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

WN #1:

The Licensee has failed to comply with: LTCHA, 2007, S.O. 2007, c.8, s.6(1)(c)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Findings:

The written plan of care for an identified resident did not include behaviours which have been exhibited by the resident. Clear directions were not provided to staff.

Inspector ID #: 170

Additional Required Actions:

VPC - pursuant to *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 corrective action relating to care plans providing clear directions to staff, to be implemented voluntarily.

WN #2:

The Licensee has failed to comply with: O. Reg. 79/10, s. 53(1)2
Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours: Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

Findings:

Written strategies which provide techniques and interventions which could prevent or minimize an identified resident's behaviours have not been completed for all behaviours exhibited by the resident.

Inspector ID #: 170

Additional Required Actions:


VPC – pursuant to *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 corrective action to ensure written strategies are developed to meet the needs of residents with responsive behaviours, to be implemented voluntarily.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigences prévue le paragraph 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

Signature of Licensee of Designated Representative Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. 
Title:	Date of Report (if different from date(s) of inspection). September 7, 2010