Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Ottawa Service Area Office

347 Preston St., 4th Floor
Ottawa ON K1S 3J4
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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
Bureau régional de services de Ottawa

347, rue Preston, 4iém étage
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Ontario

February 24, 2011

Ms. Katherine Jackson
Administrator
Wynfield (The)
451 Woodmount Drive
Oshawa ON L1G 8E3

Dear Ms. Jackson:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted on January 20, 2011 under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Ottawa Service Area Office, Performance Improvement and Compliance Branch.

Sincerely

Kathleen Smith

for Wendy Berry
LTC Home Inspector – Environmental Health

c President, Resident's Council
President, Family Council

Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

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	Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public
Date of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
January 20, 2011	2011_102_2885_20Jan082516	Complaint Log # O-003084

Licensee/Titulaire
Regency LTC Operating Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive, Suite 700
Mississauga, Ontario L5R 4H1 Fax # 905 501 4711

Long-Term Care Home/Foyer de soins de longue durée
The Wynfield
451 Woodmount Drive
Oshawa, Ontario L1G 8E3 Fax # 905 579 4902

Name of Inspector(s)/Nom de l'inspecteur(s)
Wendy Berry (102)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to maintenance, housekeeping and odour control. An issue related to privacy was dealt with during the inspection.

During the course of the inspection, the inspector spoke with: the Acting Administrator, 1 Assistant Director of Care, Nursing Consultant, Environmental Services Manager, Maintenance person, 1 housekeeper, several Personal Support Workers, and several residents.

During the course of the inspection, the inspector: looked at the condition of carpets and floor coverings in 2 main floor resident home areas, reviewed the carpet maintenance schedule and equipment used, checked and reviewed the operation of the air make up and exhaust system in the 2 main floor resident home areas, reviewed the maintenance log in the McLaughlin Bay home area, reviewed Resident and Family Council meeting minutes for 2009 and 2010, reviewed documentation related to the repair of the heat recovery units. Sliding doors leading into ensuite washrooms in residents' rooms were examined.

The following Inspection Protocols were used during this inspection: Accommodation Services-Housekeeping, Accommodation Services-Maintenance. Ad Hoc notes were also used.

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

2 WN

1 VPC

NON- COMPLIANCE / (Non-respectés)	
Definitions/Définitions **WN** – Written Notifications/Avis écrit **VPC** – Voluntary Plan of Correction/Plan de redressement volontaire **DR** – Director Referral/Régisseur envoyé **CO** – Compliance Order/Ordres de conformité **WAO** – Work and Activity Order/Ordres: travaux et activités	
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'exigence 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.

WN #1: The Licensee has failed to comply with O. Reg. 79/10, 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):

2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety , security or well-being of residents for a period greater than six hours.

Findings: The Director was not informed within one business day of the occurrence of a breakdown of major equipment in the home.

1. On January 20, 2011 the ventilation system on the west side of the long term care home was not functioning at the time of this complaint inspection. The exhaust ventilation system was checked in several residents' washrooms in the McLaughlin Bay resident home area (RHA) and lacked suction. The make up diffusers in the RHA corridor lacked air movement.
2. The Environmental Services Manager for The Wynfield informed the Inspector that the heat recovery unit (HRU # 1) which controls the ventilation system was determined to be malfunctioning on December 23, 2010 and was shut down.
3. The Acting Administrator confirmed that the Director had not been informed of this breakdown of major equipment. A written report had not been submitted as of the time of inspection.

Note: A contractor was on site repairing the HRU at the time of inspection.

Inspector ID #:	102

WN #2: The Licensee has failed to comply with the Long Term Care Homes Act, 2007, c. 8, s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
Findings: Privacy is not being afforded to residents in treatment and in caring for his or her personal needs. 17 of 19 ensuite washroom doors that were checked in the McLaughlin Bay and Lynde Creek resident home areas could not be closed so as to prevent a view from the vestibule in the bedroom into the washroom. 15 of the 19 doors that were checked had gaps of 1 to 2 inches allowing an easy view into the washrooms. One washroom door could not be closed at all due to being off of its track (room 113); one washroom door was misaligned on its track causing it to remain open approximately 10 inches.
Inspector ID #: 102
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 that all doors leading to all residents' washrooms throughout the long term care home are adjusted so that there is no view into the washroom when the door is in the closed position, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee 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:**	**Date of Report:** (if different from date(s) of inspection). February 04, 2011