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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 24, 2016	2016_178624_0006	004041-16	Resident Quality Inspection

Licensee/Titulaire de permis

PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
1090 MORAND STREET WINDSOR ON N9G 1J6

Long-Term Care Home/Foyer de soins de longue durée

REGENCY MANOR NURSING HOME, DIVISION OF PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
66 DORSET STREET EAST PORT HOPE ON L1A 1E3

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

BAIYE OROCK (624), CHANTAL LAFRENIERE (194), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 11, 12, 16, 17, 18, 19, 22 and 23 of 2016

The following intakes were completed during this RQI: Log # 001526-16-Complaint related to discharge of a resident, log#028820-15-critical incident related to a fall, and log # 004599-16- anonymous complaint related to insufficient staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC),Program Manager, Restorative Care Coordinator, Environmental Service Supervisor (ESS), Resident Service Coordinator (RSC), RAI Coordinator, CCAC Senior Manager, Hairdresser, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Residents, Family members and the President of the Resident Council. A tour of the building was completed and the following observations were made during the course of the inspection: dining experience, medication administration, infection control practices and staff-resident interaction during the provision of care. Documentation review was also completed for relevant policies and procedures, resident and family council minutes, licensee internal investigations related to falls, staffing plan and staff schedules.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Admission and Discharge
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting resident #037 with transfers.

The plan of care for resident #037 during the period of August 2015 indicated that resident #037 was at risk for falls and was to be transferred using a sit-to-stand lift with two staff assist. Review of the progress notes indicate that on the same month, resident fell during a transfer, sustaining an injury.
A review of the internal investigation completed by the home indicated that the PSW providing transfer assistance to resident, completed the transfer unassisted by another staff.

A review of the progress notes for resident #037 indicated that in November 2015, resident #037 sustained a second fall during a transfer resulting in injury. The licensee's internal investigation into the incident indicated that two PSWs, assisting resident with the transfer, did not sign off on the transfer equipment pre-start check list at the beginning of the shift. The home had the transfer equipment inspected by the supplier, who found no deficiency with the equipment. The home has since replaced the transfer sling used at the time, with one that has a locking type mechanism to minimize the risk of any further falls. [s. 36.]

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 by ensuring that staff use safe transferring and positioning devices or techniques when assisting residents with transfers, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 14, whereby the licensee did not ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall.

On February 11, 2016, during the tour of the resident care areas, it was noted that a grab bar was not located on the same wall as the faucet in the shower area of the SPA room located on the west wing of the second floor. Grab bars are noted to be located on adjacent and opposite walls of the faucet in the shower area.

Personal Support Workers indicated to an Inspector that the shower is being used to provide showers to residents.

The Environmental Service Supervisor indicated to the inspector no awareness that a grab bar is required on the same wall as the faucet wall. [s. 14.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 17 (1) (e), whereby the licensee did not ensure that a resident staff communication and response system is available in every area accessible by residents.

The hair salon located in the first floor, which is accessible to residents, was noted to have no resident-staff communication and response system.

On February 17, 2016, the hair dresser working in the Hair Salon indicated to the inspector being aware that there was no call bell or phone within the hair salon and she would yell for help in case of an emergency situation involving a resident.

The Environmental Service Supervisor indicated to the inspector no awareness that the Hair Salon did not have a resident-staff communication and response system. [s. 17. (1) (e)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 107. (3) 4, whereby the licensee did not ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Review of the health care record for resident #024 indicated on a certain date and time, the resident sustained a fall from a wheelchair. The resident was assessed by registered staff and was transferred to hospital for further assessment. Eight and a half hours later, the resident returned to the home with a diagnosis of an injury.

Interview with two registered staff members indicated to inspector that resident #024's condition had changed following the fall. The resident was on bed rest for eleven days, was immobile and required assistance by two staff when turning in bed and pain medication as needed prior to care.

Review of care plan in effect at time of the fall indicated that resident #024 required one staff to assist with transfer.

Review of clinical records and interview with the same registered staff members indicated that the resident transfer status was changed to two staff and was permitted to use wheelchair by the physiotherapist 11 days after the fall.

Interview with DOC indicated to inspector that a critical incident report was not submitted to the Director as the home did not consider the resident had a significant change in condition. [s. 107. (3) 4.]

2. Related to Log # 028820-15 pertaining to resident #019

Resident #019 had a fall at the home on a certain date and time when a door was opened, knocking the resident to the ground resulting in transfer to hospital. Resident was diagnosed with an injury and a significant change in condition.

The home was informed on the same date by the hospital that resident #019 would be admitted to the hospital related to the injuries sustained. The Director was notified of the incident involving resident #019, four days later. [s. 107. (3) 4.]

Issued on this 25th day of February, 2016

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

Original report signed by the inspector.