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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jan 4, 2017	2016_380593_0033	027443-16	Resident Quality Inspection

Licensee/Titulaire de permis

MERITAS CARE CORPORATION
567 VICTORIA AVENUE WINDSOR ON N9A 4N1

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

REGENCY PARK LONG TERM CARE HOME
567 VICTORIA AVENUE WINDSOR ON N9A 4N1

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

GILLIAN CHAMBERLIN (593), SUSAN LUI (178)

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): November 21 - 25, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nursing Staff, Activation Staff, Maintenance Staff, Personal Support Workers (PSW), residents and family members.

The inspectors observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records, observed a medication pass and reviewed licensee policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for residents #001 and #003 set out the planned care for the residents.

During the inspection, resident's #001 and #003 were observed in bed with a single bed rail in use.

Inspector #593 reviewed the current plan of care for residents #001 and #003 and was unable to locate any documentation related to the use of bed rails for these residents.

A review of the Bedrail/Restraint/Entrapment and Consent assessment for resident #001, documented that no bed rail was required for this resident.

During an interview with Inspector #593, November 22, 2016, RN #102 reported that resident #001 has a bed rail up for safety. RN #102 further indicated that there was no documentation related to the use of bed rails for this resident and that this documentation should be located in the physician's orders and the care plan.

During an interview with Inspector #593, November 23, 2016, PSW #101 reported that resident #001 used the bed rail for support.

A review of the Bedrail/Restraint/Entrapment and Consent assessment for resident #003, documented that no bed rail was required for this resident.

During an interview with Inspector #593, November 22, 2016, RPN #105 reported that resident #003 used the bed rail for support.

During an interview with Inspector #593, November 23, 2016, RPN #104 reported that resident #003 used the bed rail for support.

During an interview with Inspector #593, November 23, 2016, RPN #100 indicated that she completed the Bedrail/Restraint/Entrapment assessments for residents #001 and #003. The RPN further indicated that she obtains the information for the assessments from a variety of places but usually from the physician's orders as any resident using one or two bed rails have an order from the physician for their use. RPN #100 further indicated that there was no physicians order for the use of bed rails for resident's #001 and #003, which is why the completed assessments did not indicate their use.

During an interview with Inspector #593, November 23, 2016, the ADOC reported that the expectation of the home was that a physician's order should be obtained for the use of bed rails regardless of whether it was one rail or two. This order is then set up in the electronic medication administration record (eMAR) and a check for registered staff to sign off once per day or once per shift depending upon the use of the bed rails. The ADOC indicated that there was no documentation for the use of the bedrails for resident #001. The ADOC also indicated that there was no documentation for the use of bed rails for resident #003. In addition to the physician's orders and eMAR, the ADOC reported that this information should also be documented in the care plan. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

A review of resident #009's health care record found that the resident recently sustained an injury which had decreased the resident's mobility.

On November 21 and 23, 2016, resident #009 was observed in bed by Inspector #178 with one partial bed rail in use. During an interview on November 23, 2016, resident #009 stated that they always have this bed rail in use, to keep them from falling out of bed, and to assist them to turn in bed.

During an interview with Inspector #178 on November 23, 2016, PSW #109 stated that resident #009 always has a single partial bed rail in use, and that since the resident returned from hospital after their recent injury, the resident has been requesting that the other partial bed rail be used as well. PSW #109 stated that information regarding the resident's use of bed rails can be found in the Kardex. A review of resident #009's Kardex with PSW #109 revealed no information indicating use of bed rails for the resident.

During an interview with Inspector #178 on November 23, 2016, PSW #108 stated that since the resident's recent injury, resident #009 always uses two partial bed rails while in bed at night. PSW #108 stated that the resident is restless during the night, and the PSW is afraid that the resident will fall out of bed if the rails are not in use. PSW #108 stated that a resident's use of bed rails would be recorded in the care plan.

During an interview with Inspector #178 on November 23, 2016, RPN #104 stated that resident #009 always uses one partial bed rail, and that since the resident's recent injury, the resident has sometimes used two partial bed rails while in bed. RPN #104 stated that the use of bed rails, whether for restraint or for positioning, should be documented in the resident's plan of care. The inspector reviewed resident #009's plan of care with registered staff #104, however the registered staff was unable to locate any documentation indicating the use of bed rails for resident #009.

During an interview on November 23, 2016, the ADOC stated that the use of bed rails for resident #009 should appear in the resident's plan of care, and when bed rails are used it should be documented on the resident's electronic Medication Administration Record (eMAR). The ADOC confirmed that neither has been done for resident #009. [s. 6. (1) (a)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Review of the resident's plan of care by Inspector #178 for continence revealed an intervention stating that the resident wears a specific product each shift.

During an interview with RPN #100 on November 24, 2016, she indicated that a specific product was trialed for the resident, but that they do not like to wear a product and refuses to do so. RPN #100 stated that the resident does not wear a specific product, but

this has not been updated on the written plan of care.

During an interview with the DOC on November 25, 2016, she indicated that the registered staff should have revised the resident’s plan of care when their care needs changed. [s. 6. (10) (b)]

4. The licensee has failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change.

A review of resident #009's health care record by Inspector #178 found that the resident has had a recent change in condition, resulting in decreased mobility.

During an interview with Inspector #178 on November 23, 2016, resident #009 stated that they recently sustained an injury. The resident stated that prior to the injury, they would use the washroom independently, but since the injury, they require assistance from staff to take them to the washroom.

During an interview with Inspector #178 on November 23, 2016, PSW #109 confirmed that prior to resident #009's injury, the resident would use the toilet independently. Since the resident’s injury, the staff needs to assist the resident.

Review of resident #009’s health record by Inspector #178 revealed that their plan of care states that the resident does not require physical assistance for toileting.

During an interview on November 23, 2016, RPN #104 indicated that resident #009 sustained an injury recently. Since the injury, resident #009 has required physical assistance to use the toilet. RPN #104 indicated that the plan of care for resident #009 has not been revised to reflect the resident’s increased need for assistance for ambulating and toileting.

During an interview on November 25, 2016, the DOC indicated that the registered staff should have revised resident #009’s written plan of care when the resident’s care needs changed. [s. 6. (10) (b)]

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 ensuring that the written plan of care for all residents sets out the planned care for each resident and that the resident is assessed and the plan of care reviewed and revised at least every six months and at any other time when the residents care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as per O. Reg 79/10 s. 8 (1) (b), that any required plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

As per O. Reg 79/10 s. 48 (1), every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

A review of resident #021's health care record by Inspector #178 found that the resident has a history of skin impairment and currently the resident has altered skin integrity to multiple areas on their body.

During an interview with Inspector #178 on November 24, 2016, RPN #100 indicated that the resident has multiple areas of skin impairment, and that these areas are being treated by registered staff. RPN #100 stated that it is the home's process for registered staff to assess residents with impaired skin integrity weekly using a skin assessment tool. RPN #100 explained that for pressure ulcers, the staff complete the Pressure Ulcer Scale for Healing (PUSH) tool, and for other areas of skin impairment, such as skin tears, the Skin Condition Monitoring Tool. RPN #100 stated that the weekly assessments would be documented on whatever skin assessment tool the staff was using.

The inspector reviewed the home's Skin Care Management Program (policy unnumbered), created January 2014, revised December 2014. The policy states that the a specific tool is to be used to reassess altered skin integrity weekly and the reassessment documented on the tool.

Review of resident #021's health record by Inspector #178 revealed that one area of altered skin integrity was first documented several months earlier. The resident's record does not contain weekly assessments of this altered skin integrity using the specific tool as required in the home's written Skin Care Management Program. Review of the resident's record indicates that during the weeks between the initial documentation of the altered skin integrity and the time of this inspection, the resident's altered skin integrity was assessed six times, and these assessments were not completed using the specific tool as documented in the policy.

The resident's other areas of altered skin integrity were first documented several weeks earlier. The resident's record does not contain weekly assessments of the altered skin integrity using the tool as required in the home's written Skin Care Management Program. Review of resident #021's health care record by Inspector #593 indicates that during the weeks between the initial documentation of the altered skin integrity and the time of this inspection, the resident's altered skin integrity was not assessed weekly and these assessments were not completed using the specific tool as documented in the policy.

During an interview with the DOC on November 25, 2016, she indicated that it is the home's policy that altered skin integrity is reassessed weekly and with change in condition, using a specific tool, and the assessment is to be documented on this tool. The DOC indicated that the specific tool was not used to assess and document resident #021's altered skin integrty at least weekly, and that the staff did not follow the home's skin care management policy in this case. [s. 8. (1) (a),s. 8. (1) (b)]

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 ensuring that the home's required skin care management program is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and that those doors are kept closed and locked when they are not being supervised by staff.

During the initial tour of the home on November 21, 2016, at approximately 1130 hours, Inspector #178 observed in the home's basement, that the double doors leading to the hallway which houses the maintenance room and staff locker room, were closed but not locked. These double doors are directly beside the elevator, which is accessible to, and used by, staff, families and residents. No staff was present supervising the double doors. The inspector entered the identified hallway and observed a hand saw on top of a table outside the locked maintenance room. No residents or staff members were present in the hallway at the time. The door to the staff room was propped open, and no staff was present. Approximately forty-five minutes later, at 1208h, the inspector observed the saw still present on the table in the hallway. The saw was not being used. No residents were present. A member of the housekeeping staff and the home's maintenance employee were both present. When the inspector inquired about the saw, the maintenance employee explained that the saw was present because he had been using it earlier, and immediately removed and secured the saw.

During an interview with Inspector #178 on November 23, 2016, the Administrator confirmed that the hallway housing the maintenance and staff locker rooms is not a residential area, and that the doors leading to the hallway are not kept locked. The Administrator indicated that there is nothing preventing a resident from accessing the hallway where items which could be dangerous to a resident may be found.

During and interview with Inspector #178 on November 24, 2016, the home's maintenance staff #115 indicated that the double doors leading to the hallway containing the maintenance room and staff locker room, are not equipped with a lock. [s. 9. (1) 2.]

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 ensuring that the double doors in the basement leading to the maintenance area and other non-residential areas are equipped with locks and kept locked when not being supervised by a staff member, to be implemented voluntarily.

WN #4: 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 failed to 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.

Resident #021 was known to have a history of skin impairment.

Review of resident #021's medical record by Inspector #178 revealed that the resident had multiple areas of skin impairment on their body.

During an interview with Inspector #178, RPN #100 on November 24, 2016 indicated that the resident had multiple areas of skin impairment, and that these areas were being treated by registered staff.

Review of resident #021's medical record by Inspector #178 revealed that a specific area of skin impairment was first documented several months earlier. Since that date, only six skin assessments had been documented of resident #021's altered skin integrity. The resident's other areas of altered skin integrity were first documented several weeks earlier and since this date skin assessments had not been completed weekly.

Review of resident #021's treatment administration record (TAR) by Inspector #178 indicated that the resident's altered skin integrity had been treated at least twice weekly since it was discovered several months earlier. The TAR indicated that the resident's other areas of altered skin integrity had been treated daily since discovery.

During an interview with Inspector #178 on November 24, 2016, RPN #100 indicated that she assesses the resident's altered skin integrity each time treatment is provided, which is daily for one of the areas and every three days for the other area, however these assessments were not documented. RPN #100 further indicated that assessment of the resident's altered skin integrity was only documented once weekly on Mondays, which was the day designated for skin assessment on resident #021's floor. RPN #100 indicated that all assessments of the resident's altered skin integrity had not been documented.

During an interview with Inspector #178 on November 25, 2016, the DOC indicated that the staff had not documented all of resident #021's skin assessments. [s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment.

During an interview with Inspector #178 on November 24, 2016, PSW #101 indicated that resident #001 uses the bathroom independently, but is incontinent regularly. PSW #101 stated that the resident uses a specific product in case of incontinence.

During an interview with Inspector #178 on November 24, 2016, RN #114 indicated that resident #001 has a history of a specific condition, and when the resident receives treatment for this condition, this can cause them to be incontinent. RN #114 further indicated that the nursing staff are currently working with the medical staff in an effort to balance the resident's treatments without causing incontinence.

A review of resident #001's medical record by Inspector #178 revealed that the resident was first assessed as being incontinent several months earlier. Review of the resident's plan of care revealed no written plan of care for incontinence. RN #114 indicated on November 24, 2016, that there is no written plan of care for incontinence for resident #001.

During an interview with Inspector #178 on November 25, 2016, the DOC indicated that a plan of care for incontinence should be documented in resident #001's care plan. [s. 51. (2) (b)]

Issued on this 4th day of January, 2017

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

Original report signed by the inspector.