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
May 20, 2015	2015_240506_0010	H-002396-15	Resident Quality Inspection

Licensee/Titulaire de permis

LIUNA LOCAL 837 NURSING HOME(ANCASTER) CORPORATION
44 HUGHSON STREET SOUTH HAMILTON ON L8N 2A7

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

REGINA GARDENS
536 UPPER PARADISE ROAD HAMILTON ON L9C 5E3

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

LESLEY EDWARDS (506), JESSICA PALADINO (586), MARILYN TONE (167)

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): May 4, 5, 6, 7, 8, 11, 12, 13 and 14, 2015.

The following inspections were conducted concurrently with this inspection-Complaint Inspections log numbers; H-001690-14, H-000331-14 and H-001756-14; Critical Incident Inspections log numbers-H-002045-15, H-000733-14, H-001202-14, H-001350-14, H-001374-14, H-001369-14, H-001411-14 and H-002088-15 and Follow up Inspections were also conducted with this inspection; H-000179-14 and H-000180-14

During the course of the inspection, the inspector(s) spoke with Administrator, Directors of Care (DOC's), Resident Assessment Instrument (RAI) coordinator, Environmental Manager, registered staff, Social Worker, Pharmacist, Physiotherapist, personal support workers (PSW's), housekeeping staff, dietary staff, recreation staff, residents and family members.

During the course of the inspection, the inspector(s) toured the home; observed residents in dining areas and care areas; reviewed policies and procedures; resident health records; the home's internal investigation notes and staff schedules.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_214146_0002	506
O.Reg 79/10 s. 73. (1)	CO #002	2014_214146_0002	586

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #015, #004 and #017 were treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity.

A) On an identified date in September 2014, PSW #1 allegedly refused to provide care to resident #015 as per the request of the resident. Resident #015 reportedly requested that PSW #1 use their own specific brand of soap when providing their care that morning. The resident also requested that their lotion be applied after being washed. PSW #1 indicated to the resident that they did use the specific brand of soap, but the resident told PSW #1 that they couldn't have used their soap because the soap was still dry. PSW #1 also indicated to PSW #2 that resident #015 asks for too much and they were not going to put the lotion on the resident. Resident #015 indicated during an interview with the home's Director of Social Services and a second interview with the Administrator, that they had felt rushed when PSW #1 provided their care that morning.

B) On an identified date in September 2014, PSW #1 reportedly told PSW #2 that PSW #3 was annoyed at them because they came in to work late. PSW #1 indicated to PSW #2 and the RPN working that day that they were going to confront PSW #3 related to this. PSW #2 and the RPN advised PSW #1 to wait until after their shift to discuss with PSW #3. PSW #1 reportedly did not listen to the advice and approached PSW #3 when they were transporting a resident and made a comment to PSW #3. This comment was made in front of resident #017. PSW #1 did not treat resident #017 with respect when speaking rudely to PSW #3 in front of resident #017.

C) During identified dates in September 2014, an RPN staff indicated that they observed PSW #1 transporting resident #004 with a shower chair with no clothing on and with no blanket covering the resident. When the RPN approached PSW #1 related to this concern, PSW #1 reportedly indicated that they were in a hurry. The home conducted an investigation into the identified incidents and PSW #1 received disciplinary action related to not respecting residents' rights.

Residents #015, #017 and #004 were not treated by PSW #1 with courtesy and respect and in a way that fully recognized their individuality and respected their dignity. [s. 3. (1) 1.]

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 residents are treated with courtesy, respect and dignity, to be implemented voluntarily.

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #019 as specified in their plan.

A review of resident #019's plan of care indicated that the resident was to have two staff members present for all care due to responsive behaviours as confirmed by the registered staff. On an identified date in March 2014, two staff members approached the resident who was ringing their call bell and was trying to climb out of their bed and was incontinent. One staff member left the room to gather supplies to complete morning care, while the other staff member initiated care for the resident. The resident became physically aggressive with the staff member and was grabbing the staff member with their hands and started kicking the staff member. While the staff member was trying to free themselves from the resident's grasp, the resident sustained an injury to their face. The staff member involved confirmed that they did not follow the resident's plan of care which required two staff members for all care due to responsive behaviours. [s. 6. (7)]

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 the care set out in the plan of care is provided to residents as specified in their plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) the home, furnishings and equipment were kept clean and sanitary.

On an identified date in May 2015, during the initial tour of the home, it was observed that:
i. Three wing back chairs in the Activity of Daily Living (ADL) room on Mohawk Trail were stained and soiled on the seats of the chairs and the arm rests.
ii. Four chairs in the hallway across from the nurses station on Mohawk Trail were all soiled and stained.
iii. In the family room on Mohawk trail three wing back chairs and two small chairs were stained and soiled.
iv. In the dining room on Mohawk trail several chairs were soiled with dried food particles on the seats, arm rests and legs.
v. One wing back chair in the ADL room on Cootes Paradise was stained and soiled on the seat of the chair and the arm rest.
vi. In the family room on Cootes Paradise a wing back chair was stained and soiled.
vii. In the family room on Chedoke Falls the couch and two wing back chairs were stained and soiled.
viii. In the family room on Mount Hope a black leather chair had tears in it.
ix. In the dining room on Mount Hope several chairs were soiled with dried food on the seats.
The Environmental Service Co-ordinator confirmed that the homes furnishings were not kept clean and sanitary. [s. 15. (2) (a)]

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 home furnishings are kept clean and sanitary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #009's seat belt was applied according to manufacturer's guidelines.

i. On identified dates in May 2015, resident #009 was noted to be wearing a front fastening seat belt that was loose fitting and not applied according to manufacturer's guidelines.
ii. Interview with the DOC on an identified date May 2015, confirmed that the seat belt was a restraint and that the resident could not remove the seat belt.
iii. The seat belt observed on identified dates in May 2015, was more than four inches from the resident's abdomen which was not in accordance with the manufacturer's guidelines. [s. 110. (1) 1.]

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 residents seat belts are applied according to manufacturer's guidelines, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s.44(7) whereby the licensee refused an applicant's admission to the home based on reasons that are not permitted within the legislation.

i. On an identified date in December 2014, a letter provided by the home to resident #100 and the Community Care Access Centre (CCAC), indicated that the home's reason for refusing the resident's admission was because the home did not have the necessary resources to meet the resident's needs. The letter also indicated that due to the CCAC information and other supporting information, it would be a challenge to manage the resident's responsive behaviours.
ii. During a review of the CCAC information, it was confirmed that there were no concerns about the risk of physical safety or property of other individuals from this resident.
iii. During an interview with the home's Social Worker, it was confirmed that the home did not have sufficient grounds for refusal of the resident for admission to the home, based on acceptable reasons permitted within the legislation. [s. 44. (7)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids, in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During identified dates in May, 2015, the wheelchairs of residents #001, #009, #101 and #108 were observed to be dirty.
i. Old food crumbs and dried spills were noted on the seat of the chairs, and covering the bottom base in and around the wheels, footrests, seat belts and headrests.
ii. The DOC confirmed that the wheelchairs were not cleaned as per the wheelchair cleaning schedule. [s. 87. (2) (b)]

Issued on this 20th day of May, 2015

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

Original report signed by the inspector.