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 sions 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
Apr 11, 2016	2016_343585_0004	005013-16	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

LEAH CURLE (585), CYNTHIA DITOMASSO (528)

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 18, 19, 22, 23, 24, 25, 26, 29, March 1, 2, 3 and 4, 2016.

Concurrent with the Resident Quality Inspection (RQI), 10 additional inspections were completed, including two complaints: log #017714-15 related to nutrition and pain and #026657-15 related to skin and wound, infection prevention and control and housekeeping, and eight critical incident system (CIS) inspections: log #009898-15 and #028209-15 related to transferring and positioning, #011762-15, #004123-16 and #005918-16 related to abuse, #026392-15 related to falls, #032475-15 related to unexpected death with unknown cause and #004250-16 related to medications.

During the course of the inspection, the inspector(s) spoke with residents, families, registered nursing staff, personal support workers (PSWs), dietary staff, housekeeping staff, laundry staff, the resident assessment instrument (RAI) coordinator, food service manager (FSM), environmental services coordinator (ESC), business manager, Registered Dietitian (RD), Director of Care (DOC), Assistant Director of Care (ADOC) and Administrator.

During the course of the inspection, the inspector(s) observed care and services provided to residents, reviewed records including but not limited to resident clinical health records, staff files and training records, the complaints log, therapeutic menus, meeting minutes, policies and procedures, program evaluations as well as CIS investigation records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
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
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **5 VPC(s)**
- **1 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 failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A) On an unspecified date in May 2015, personal support worker (PSW) #128 assisted resident #043 off the toilet; however, in the middle of the transfer the resident slid and fell, resulting in an injury. Review of the resident's plan of care identified that they were at risk for falls and required a two person transfer. Review of the home's investigation notes and interview with PSW #128 confirmed that since no one was available to assist, they attempted to transfer the resident with one staff, not two, as required in the resident's plan of care. PSW #128 confirmed that they did not safely transfer the resident with two staff when they assisted the resident off the toilet.

B) On an unspecified date in October 2015, PSW #103 provided continence care to resident #042. Later that day, the resident displayed signs of pain, which increased as the day progressed. The resident was diagnosed with an injury and sent to hospital for treatment. Review of the resident's plan of care identified that they required total assistance of two staff with care, including but not limited to continence care. Review of the home's investigation notes identified that PSW #103 provided continence care that day without a second staff member. PSW #103 identified that they were aware the resident required two staff total assistance for safe transferring and positioning but did not wait for the second PSW to provide care. PSW #102 also confirmed that the resident required two staff total assistance for safe transferring and positioning and when they went to assist PSW #103, they had already completed care for the resident. PSW #103 did not provide safe positioning techniques when providing continence care to resident #042. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

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 failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) On unspecified dates in February and March 2016, resident #006 was observed with a positioning device applied. The resident demonstrated they were able to release the device independently. Review of their written plan of care did not include the device. Registered staff #100 confirmed the resident used the device and was able to release it independently; however, it was not included in their written plan of care.

B) In July 2015, the Bed System Assessment for resident #003 identified that they used bed rails daily for positioning assistance. Review of the written plan of care did not include the use of the bed rails daily until a second assessment was completed in February 2016. Interview with the Resident Assessment Instrument (RAI) coordinator confirmed that the resident used bed rails daily since 2014; however, the written plan of care did not include the daily use of bed rails until February 2016.

C) A Minimum Data Set (MDS) and Resident Assessment Protocol (RAP) assessment completed in March 2015 identified that resident #014 had a history of falling and was at high risk for falls related to cognition and impaired mobility. In May 2015, the resident had a fall and it was identified at that time that they required frequent monitoring. In August 2015, the resident had a second fall resulting in an injury. According to a post falls note, the resident had a falls intervention in place at the time of the fall. Review of the written plan of care did not identify that the resident was at a high risk for falls or include any falls prevention interventions staff were to use until after the resident was injured in August 2015. Interview with Director of Care (DOC) #001 confirmed that the written plan of care did not include the resident's ongoing risk for falls and falls interventions until August 2015. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

In October 2015, a MDS assessment completed for resident #006 noted their care needs for transfers changed from requiring supervision from one staff to extensive assistance with one to two staff. In March 2016, the resident's written plan of care stated they required two staff assistance with transfers; however, a transfer logo observed at their bedside stated they were a supervised independent transfer. PSW #101 reported the resident typically required person staff assistance with transfers but on occasion, required two staff. DOC #001 reported that the resident required one to two staff for transfers and the plan of care and bedside transfer logo did not provide clear direction to staff. [s. 6. (1) (c)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A) In August 2015, a MDS assessment completed for resident #016 indicated they required supervision with eating. In November 2015, the resident's MDS assessment

indicated they required limited assistance with eating. Review of Point of Care (POC) documentation completed by PSWs during the November 2015 review period revealed they required supervision with eating. Interview with the RAI coordinator confirmed the assessments of the resident were inconsistent and did not complement each other.

B) In October 2015, the MDS assessment for resident #012 identified that they had an infection. Review of the plan of care including but not limited to registered staff and physician assessments from that quarter, did not include any indication that the resident had been diagnosed with an infection. Interview with DOC #001 confirmed the MDS assessment completed in October 2015 incorrectly coded resident #012 with having an infection and the MDS assessment was not consistent with the assessments completed by registered nurses and the physician.

C) In June and September 2015, MDS assessments completed for resident #003 identified that they used bed rails daily. Documentation of an interdisciplinary conference in November 2015 also identified that the resident used bed rails daily; however, a MDS assessment from December 2015 indicated the resident used bed rails less than daily. Interview with registered staff #113 confirmed that the coding of bed rails in December 2015 was an error, the resident continued to use the bed rails daily and the December 2015 MDS assessment did not complement the two previous MDS assessments or the progress notes completed by registered staff.

D) In June and September 2015, MDS assessments completed for resident #003 identified they had an increase in responsive behaviours compared to the previous MDS assessment; however, no change in behavioural symptoms was coded. Interview with registered staff #113 reported that in June and September 2015, responsive behaviours increased; however, no change was coded on the corresponding MDS assessments. Registered staff #113 confirmed the assessments were not consistent with and did not complement each other.

E) On an unspecified date in January 2016, resident #041 started a treatment related to an unspecified type of infection as documented by registered staff. Registered staff documented an assessment indicating the resident had an elevated temperature. The physician documented that the resident was receiving treatment for a different type of infection than what was noted by registered staff. Registered staff assessed the resident again and documented the resident was receiving the treatment for different condition. Interview with DOC #001 confirmed that the documented assessments of the resident, completed by both registered staff and the physician were not consistent with and did not

complement each other, in relation to the cause of infection.

F) Resident #011's plan of care stated they were totally incontinent of bowel. In July 2015, the resident's MDS assessment identified they were usually continent of bowel; however, POC documentation indicated the resident was incontinent of bowel during the review period. In October 2015, their MDS assessment identified they were usually continent of bowel; however, POC documentation noted they were incontinent of bowel during the review period. In January 2016, the resident was coded usually continent of bowel; however, POC documentation revealed the resident was identified as frequently incontinent of bowel during the review period. PSW #124 and registered staff #126 reported the resident experienced bowel incontinence some, but not all of the time. The RAI coordinator confirmed the MDS assessments, POC documentation and plan of care were not consistent with or complemented each other.

G) Resident #041's plan of care identified they had a medical device. In June 2015, the resident's clinical record indicated they had problems with the device, as documented by the nurse practitioner (NP), physician and registered staff. The resident was transferred to the hospital due to ongoing issues, as confirmed by DOC #001. Review of the hospital documentation, identified that the home reported two to three weeks difficulties which did not resolve with treatments; however, interview with the NP confirmed that there had been ongoing issues greater than two to three weeks. The assessments completed by the treating practitioners and the assessments completed by the physician at the hospital were not consistent with each other, related to how long the symptoms occurred. [s. 6. (4) (a)]

4. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #020's plan of care stated they were to receive a texture modified diet. Review of progress notes revealed that on an unspecified date in 2015, the resident was provided regular texture by registered staff #122. Interview with registered staff #122 reported the resident was to receive a texture modified diet; however, they provided regular texture as requested by an individual who was not a substitute decision maker (SDM). Registered staff #122 confirmed the care set out in the plan was not provided to the resident as specified in the plan.

B) Resident #020 was identified with a history of choking. A progress note from an unidentified date in 2015 revealed that the resident was on a list to be assessed related

to their condition and if there was any change in condition to call the coordinator. On an unidentified date in 2015 following the progress note, the resident experienced a choking episode. Interview with registered staff #123 confirmed they provided treatment; however, did not contact the coordinator after the episode.

On a later unspecified date in 2015, the resident experienced another choking episode, at which time the coordinator was notified. DOC #001 reported the coordinator should have been contacted after the first choking episode following the progress note; however, confirmed they were not contacted until after the second episode.

C) In September 2015, weekly weights were ordered for resident #015. Review of the plan of care identified that weekly weights were not completed one week in September 2015 and two weeks in October 2015. A progress note from the physician at the end of October 2015 identified that the resident had ongoing and worsening symptoms, documented that weekly weights were not completed for over two weeks prior to their visit and weekly weights were ordered again. From end of October 2015 to end of December 2015, weekly weights were not completed for four weeks. Interview with DOC #001 confirmed that weights were not completed consistently as ordered by the physician. [s. 6. (7)]

5. The licensee failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed or the care set out in the plan was no longer necessary.

Resident #011's plan of care outlined direction to staff for toileting. PSW #124, #126 and registered staff #125 all reported the toileting plan of care had changed and registered staff confirmed the plan of care was not revised when the care set out in the plan was no longer necessary. [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 and ensuring that staff and others involved in different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 failed to ensure that where the Act or Regulations required, the plan, policy, protocol, procedure, strategy or system in place was complied with.

A) The home's procedure for administering medications through an unspecified type of administration device directed staff to follow Nursing Clinical Skills available online by the American Society for Parenteral Nutrition. The procedure directed that the administration device be discarded after each use.

Resident #046's plan of care identified they received medications daily through a medical device. On an unspecified day in February 2016, a medication administration device was unmarked and observed to have white flaky debris with some liquid in it. Interview with registered staff #122 identified that the device was not dated but was changed daily, as

required by the home. Interview with night nurse staff #110 identified that they did not change the device and it was the responsibility of the day shift nurse to replace it. Interview with DOC #001 identified that the process of administering medications was a clean procedure and the home directed staff to discard the device daily; however, staff had not followed the home's direction.

B) The home's policy, "Leave of Absence with Medication: LTC-CA-WQ-200-06-06", last revised May 2012, directed staff that if controlled or counted drugs are to be sent with a resident on a leave of absence (LOA):

i. "two registered staff must witness and count the release of the controlled (counted) medication for a leave",
ii. "both nurses must initial the form indicating the amount of medication released and update the individual narcotic count sheet as well as the unit count sheet",
iii. "staff are to complete the Leave of Absence with Medication form in the resident's chart for completion upon resident return", and
iv. "upon return the registered staff responsibilities will include but not limited to count all medication, discard unused medications, two registered staff to sign for wasted controlled substances, notify the DOC of any discrepancies".

On an unspecified date in 2016, resident #045 was provided with medications, including but not limited to, controlled substances for a LOA. The resident returned to the home from the LOA early, with medications; however, one tablet of controlled medication was missing. Interview with registered staff #125 confirmed that when the resident left, the controlled medication was not counted with two registered staff and the Leave of Absence with Medication form was not placed in the resident's chart. Upon the resident's return, the home's investigation notes, including a signed statement by registered staff #108, confirmed that registered staff #120 did not discard the extra medications that the resident returned to the home with, and the registered staff member did not immediately report the discrepancy to the management team. Both registered staff #125 and #120 did not follow the home's policy for Leave of Absence with Medication, as confirmed by DOC #001.

C) The home's policy, "LTC-CA-WQ-200-02-25", revised November 2014, indicated that registered staff were responsible to record all nutrition and hydration provided to the resident on an intake record. The record required staff to document the amount as well as the resident's tolerance to the intake.

Resident #041 had an unspecified plan of care related to their nutrition and hydration requirements. On an unspecified date in October 2015, treatment was initiated after the resident demonstrated symptoms of dehydration. Review of the resident's medication administration record (MAR) revealed they received their nutrition and hydration requirements on the unspecified dates; however, as per the home's policy, documentation on the intake record to supplement the MAR was incomplete prior to the initiation of treatment for symptoms of dehydration. Incomplete documentation was identified on additional dates between September to December 2015, which was confirmed by DOC #001.

D) The home's policy, "Nutritional Screening and Assessment, Policy No: LTC-CA-WQ-300-05-02", revised January 2015, stated upon identifying a need for a nutrition intervention, the health professional will complete a dietary referral progress note, reasons for referral may include difficulty chewing/swallowing.

Resident #020 had a history of choking as confirmed by the Registered Dietitian (RD). Review of progress notes revealed that on an unspecified date in 2015, the resident experienced a choking episode while eating. Later in 2015, the resident experienced another choking episode while eating, after which time the RD reassessed and changed their diet texture. The RD confirmed they should have received a referral to reassess the resident following the earlier choking incident in 2015.
[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 and ensuring that 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 will ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The home's policy, "Resident Abuse – Abuse Prevention Program – Whistle Blowing Protection, Policy No: LTC-CA-ALL-100-05-02", revised October 9, 2014, stated "physical abuse means any behaviour exhibited towards a resident, which is or may be perceived as physical force that may or does cause injury, or inflicts pain or discomfort for the resident. Such behaviour is included, but not limited to: hitting and handling in a rough manner. Abuse reporting is mandatory, all staff are required to report any abuse, suspected abuse or allegations of abuse immediately to their respective supervisor."

A) On an unspecified date in 2015, a critical incident system (CIS) report was submitted to the Ministry Health and Long-Term Care regarding allegations of staff to resident abuse. According to the report, on an unspecified date in 2015, PSW #129 hit resident #011 while providing care and was witnessed by PSW #130.

In an interview with PSW #129, they confirmed that they provided care to resident #011 on the unspecified date in 2015. In an interview with PSW #130, they confirmed they observed the interaction between PSW #129 and resident #011. PSW #130 stated they did not report the incident; however, should have as per the home's policy.

According to the home's investigation notes, resident #011 reported the incident to registered staff #100. Registered staff #100's statement indicated they completed an incident report, informed the charge nurse and left messages with the DOC and Administrator the day the resident made them aware of the alleged incident.

On March 4, 2016, the Administrator reported allegations of abuse were not substantiated; however, confirmed the home failed to follow their abuse policy to report allegations of abuse immediately to their respective supervisor.

B) On an unspecified date in February 2016, resident #006 reported they experienced pain during care, which was reported immediately to the Administrator. On an unspecified date in March 2016, PSW #101 reported they were aware of the resident reporting to colleagues that staff were rough with them and stated the resident had also informed them directly. PSW #101 stated they reported the information to registered staff; however, on March 4, 2016, the Administrator stated in an interview they had not received any reports or allegations of rough care to resident #006 prior to what was reported by the inspector in February 2016, and confirmed the home's abuse policy was not followed.
[s. 20. (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 and ensuring that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

In June 2015, documentation indicated resident #041 had a new area of altered skin integrity. Review of progress notes revealed altered skin integrity persisted; however, weekly skin assessments were not consistently completed and the resident was subsequently transferred to hospital. Registered staff #100 identified that the skin and wound team was involved with pressure ulcers stage two or greater, or wounds with complex dressings and that the team did not assess the area weekly. Interview with DOC #001 confirmed that weekly wound assessments were not consistently completed for the resident when the altered skin integrity persisted. [s. 50. (2)(b)(iv)]

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 and ensuring that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that on every shift symptoms which indicated the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and symptoms were recorded and immediate action was taken as required.

A) A physician note from the end of October 2015 revealed that an assessment was ordered for resident #015 after they demonstrated symptoms of an infection. The infection was confirmed and the resident started treatment. Review of the plan of care did not include monitoring and recording of symptoms by registered staff until the treatment started, however, the physician note indicated symptoms had been present several days prior. Interview with DOC #001 confirmed that monitoring and recording of symptoms did not occur when symptoms were first identified.

B) On an unspecified date in January 2016, resident #041 demonstrated signs of infection and started treatment. The resident continued to have an elevated temperature. The physician assessed and documented the resident had two more days of treatment, registered staff to monitor temperature, if symptoms persist to call family and send to the hospital. After the physician's note, the resident's clinical record did not reveal consistent monitoring of the resident's temperature. Five days after the physician's note, registered staff documented symptoms of elevated temperature, notified the SDM and the resident was sent to hospital. Interview with DOC #001 confirmed that registered staff did not monitor or document assessment of the resident every shift as required in the resident's plan of care, related to infection. [s. 229. (5)]

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 and ensuring that on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #7: 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 failed to ensure that the home was equipped with a resident-staff communication and response system was available in every area accessible by residents.

On February 18, 2016, during the initial tour of the home, a resident-staff communication and response system was not observed in the snoezelen room located on the first floor. Interview with the Administrator confirmed the room was used by residents and did not contain a communication and response system. [s. 17. (1) (e)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that planned menu items were offered and available at each meal.

i. On February 22, 2016, puree chicken salad sandwich was on the planned menu for lunch. The therapeutic menu indicated that a #10 scoop was to be used. During an observation in the mohawk trail dining room, a #12 scoop was used, which was a smaller portion, as confirmed by dietary staff #124.

ii. On March 3, 2016, minced broccoli and puree sweet potato were on the planned menu for lunch. The therapeutic menu indicated that a #10 scoop was to be used for the broccoli and a #8 scoop for the sweet potato. During the meal observation in the mohawk trail dining room, #12 scoops were used for both menu items, which was a smaller portion, as confirmed by dietary staff #124.

Interview with the Food Service Manager (FSM) confirmed the planned menu items were not offered as directed in the home's therapeutic menu.

iii. On two unspecified dates in February 2016, it was observed that resident #044 did not receive milk with their meal. Interview with dietary staff #129 confirmed milk was not offered to the resident. Interview with the FSM confirmed that milk was on the daily planned menu and should have been offered to the resident. [s. 71. (4)]

WN #9: 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for cleaning of the home, including, resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces.

Review of the home's procedure "Dust Mopping and Damp Mopping, NESM.D.20.01", dated February 2011, directed staff to dust mop in the direction of the door paying close attention to corners, under beds and heating units, move small furniture as needed in order to mop complete floor area.

On February 25, 2016, debris was noted on the floor in resident #048's room under the bed, in front of the dresser, between the chair and a small side table. On February 28, 2016, the debris between the chair and side table remained on the floor.

Housekeeping staff #128 reported that daily cleaning of resident rooms included mopping of the floors. Interview with Environmental Services Coordinator (ESC) confirmed the home's procedure for daily resident room cleaning was to include, but not limited to, dusting and damp mopping. [s. 87. (2) (a) (i)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

i. In February 2016, resident #013 reported they had two clothing items missing since approximately December 2015. PSW #128 reported they were aware of the resident's missing items and conducted a search, however the items were not located.

ii. In February 2016, resident #007 reported they had missing clothing items since an unspecified date in February 2016. PSW #125 reported they were aware of the resident's missing items and the home's expectation was to conduct a search of the items and complete a missing clothing form.

The ESC reported staff were expected to complete a Missing Clothing Report Form when any clothing item was reported missing and all forms be submitted to the ESC. The ESC confirmed forms were not completed for the missing items reported by resident #007 and #013. [s. 89. (1) (a) (iv)]

Issued on this 4th day of May, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LEAH CURLE (585), CYNTHIA DITOMASSO (528)
Inspection No. / No de l'inspection :	2016_343585_0004
Log No. / Registre no:	005013-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 11, 2016
Licensee / Titulaire de permis :	LIUNA LOCAL 837 NURSING HOME(ANCASTER) CORPORATION 44 HUGHSON STREET SOUTH, HAMILTON, ON, L8N-2A7
LTC Home / Foyer de SLD :	REGINA GARDENS 536 UPPER PARADISE ROAD, HAMILTON, ON, L9C-5E3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ashley Miller

To LIUNA LOCAL 837 NURSING HOME(ANCASTER) CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must ensure that:

A. Staff use safe positioning techniques when assisting resident #042 with continence care, safe transferring techniques when assisting resident #043 with toileting; and safe transferring and positioning devices or techniques when assisting all residents with toileting and/or continence care.

B. Ensure that all front line staff are educated regarding safe transferring and positioning, including but not limited to, how resident's care needs are assessed (including safety considerations), the responsibility to comply with the plan of care, and what to do if they disagree with the plan of care.

Grounds / Motifs :

1. The non-compliance issued was determined to have a severity of 'actual harm/risk' with a scope of 'isolated'. Non-compliance was previously issued in an unrelated area.

2. On an unspecified date in May 2015, personal support worker (PSW) #128 assisted resident #043 off the toilet; however, in the middle of the transfer the resident slid and fell, resulting in an injury. Review of the resident's plan of care identified that they were at risk for falls and required a two person transfer. Review of the home's investigation notes and interview with PSW #128 confirmed that since no one was available to assist, they attempted to transfer the resident with one staff, not two, as required in the resident's plan of care. PSW #128 confirmed that they did not safely transfer the resident with two staff when they assisted the resident off the toilet.

3. On an unspecified date in October 2015, PSW #103 provided continence care to resident #042. Later that day, the resident displayed signs of pain, which increased as the day progressed. The resident was diagnosed with an injury and sent to hospital for treatment. Review of the resident's plan of care identified that they required total assistance of two staff with care, including but not limited to continence care. Review of the home's investigation notes identified that PSW #103 provided continence care that day without a second staff member. PSW #103 identified that they were aware the resident required two staff total assistance for safe transferring and positioning but did not wait for the second PSW to provide care. PSW #102 also confirmed that the resident required two staff total assistance for safe transferring and positioning and when they went to assist PSW #103, they had already completed care for the resident. PSW #103 did not provide safe positioning techniques when providing continence care to resident #042.
(528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 11th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Leah Curle

Service Area Office /
Bureau régional de services : Hamilton Service Area Office