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
Dec 23, 2016	2016_543561_0027	030792-16, 033249-16, 033685-16	Complaint

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

DARIA TRZOS (561), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 2, 6, 7, 8, 12, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Manager of the Behaviour Supports Ontario (BSO) and BSO staff member, registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), dietary aides and family member.

During the course of the inspection the Inspectors observed the provision of care, observed meal service, reviewed health records, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration
Reporting and Complaints

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, 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).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has 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 #001 was admitted to the home with a special device and was also treated for an infection on an identified date in 2016. The plan of care was reviewed and indicated that the physician had ordered an intervention after a specific number of weeks. Review of the progress notes indicated that the intervention was not implemented as indicated in the physician order. The registered staff #100 confirmed the physician order and did not know why it was not implemented as per order. The physician order was not followed and the care was not provided to the resident as specified in the order.

B) The plan of care for resident #001, identified that the physician had ordered treatment to be started on an identified date in 2016. The treatment was initiated; however, was not continued. This was confirmed by a registered staff #104. The oncoming shift registered staff #103 addressed the concern with the treatment and noted that the treatment had not been completed as ordered. Registered staff #103 indicated that it was an expectation that the treatment should have been monitored at a specified frequency. The

DOC confirmed that the treatment should have been given as prescribed. The treatment was not monitored and the resident did not receive treatment as indicated in the plan of care.

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. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Resident #001 was admitted to the home with a number of diagnoses. Resident's plan of care was reviewed and was noted to have a specified condition as per the Minimum Data Set (MDS) quarterly assessment in 2016. Review of the Medication Administration Record (MAR) for an identified month in 2016, indicated that resident was on scheduled treatment for management of resident's condition. Resident also had a treatment prescribed as needed (PRN) for the condition. The progress notes indicated that resident #001's health condition had been declining. The resident's Substitute Decision Maker (SDM) was called to advise about resident's condition and indicated to make the resident comfortable. The MAR was reviewed for an identified date in 2016 and indicated that the resident did not take their medications except for one which was given once that day for management of the resident's condition. None of the other scheduled and PRN medications for the management of resident's condition were administered that day. Registered staff #112 stated that they could not recall if resident had any symptoms of the condition, and that they were not the regular staff on the unit. There was no documentation in the health care records stating whether the resident had exhibited symptoms of the condition. The physician was not called until the day after and a new order for treatment was obtained. Resident was deemed palliative and passed away in the home two days later.
The licensee has failed to ensure that resident was reassessed and the plan of care revised when their needs changed on an identified date in 2016. [s. 6. (10) (b)]

3. The licensee has failed to ensure that, if the plan of care for resident was being revised because care set out in the plan had not been effective, the licensee failed to ensure that different approaches were considered in the revision of the plan of care.

Resident #001 was admitted to the home on an identified date in 2016. Review of the health care records and interviews with staff including registered staff, PSWs, BSO staff and the management in the home indicated that the resident had responsive behaviours

since the admission to the home. The physician prescribed medication to help with management of these behaviours. The resident's SDMs approved the treatment; however, decided that one of the medications was not effective and requested to have it discontinued. The health care records indicated that the medication was discontinued. The registered staff #100 and the ADOC reported that the resident's behaviours increased after the discontinuation of the medication. The registered staff #100 stated that the resident required constant attention, was getting up from the wheelchair which caused them to fall. They also stated that they recommended and requested that a specific intervention be implemented to manage the resident's behaviours. The progress notes indicated that the ADOC denied this intervention. Interview with the ADOC confirmed that this intervention was never tried. The Administrator confirmed that the intervention was not tried for this resident.
The licensee has failed to ensure that other approaches were considered and tried in the revision of the plan of care for the resident. [s. 6. (11) (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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, and to ensure that different approaches are considered in the revision of the plan of care if care set out in the plan is not effective, to be implemented voluntarily.

WN #2: 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 were documented.

The review of the health care records for resident #001 indicated that the resident was prescribed a specified treatment. The progress notes and the interview with the registered staff #104 stated that the treatment was started on an identified date in 2016. The registered staff #103 confirmed that due to the problem the treatment had not been administered as prescribed. The interview with the registered staff #104 confirmed the same. The home's relevant policy directed staff to monitor the treatment. The health records were reviewed and confirmed that the information related to the treatment was not recorded in the flow sheet.
The licensee has failed to enure that actions taken with respect to a resident, including assessments, reassessments, interventions and resident’s responses to interventions were documented. [s. 30. (2)]

Issued on this 2nd day of February, 2017

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

Original report signed by the inspector.