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
May 1, 2017	2017_322156_0005	002222-17	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

CAROL POLCZ (156)

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): February 14, 15, 16, March 2, April 5, 6, 2017

CIS 10124-16 inspection related to transferring and positioning was conducted simultaneously.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Nursing Unit Clerk, registered nursing staff, personal support worker (PSW) staff, residents and families.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **1 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.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).

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 the care set out in the plan of care was provided to the resident as specified in the plan.

i) The plan of care for resident #001 indicated that the resident had an intervention as a falls prevention strategy. The resident was observed on April 6, 2017; however, the intervention was not in place as confirmed with registered staff #200. Care set out in the plan of care was not provided to the resident as specified in the plan.

ii) The plan of care for resident #001 indicated that the resident's skin was very fragile. Staff were instructed not to use an identified intervention; however, staff reported that they needed something for the resident because of their fragile skin and needed to turn and reposition the resident while in bed. Interview with the DOC confirmed that the intervention should not be used. Care set out in the plan was not provided to the resident as specified in the plan.

iii) The plan of care for resident #001 indicated that as a falls prevention strategy, staff were to ensure that an identified intervention was in place. The resident was observed on April 5, 2017; however, the intervention was not in place as confirmed with staff #101. On April 6, 2017, the resident was again observed with the intervention not in place as confirmed with staff #106. Care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

2. The licensee 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 changed or care set out in the plan was no longer necessary.

A) i) The plan of care for resident #001 indicated that the resident was to receive an identified intervention at breakfast and lunch. During the observed lunch meal on April 6, 2017, it was noted that the resident did not receive the intervention. Registered staff #200 confirmed that the intervention was only to be provided at breakfast as per family request. Interview with the family, confirmed that the intervention was changed to breakfast only. The plan of care was not reviewed and revised when the resident's care needs had changed or care set out in the plan was no longer necessary.
ii) The plan of care for resident #001 indicated on the annual care conference notes, that the resident continued to use an identified intervention for safety. Interview with staff #101 and family of the resident, confirmed that the intervention noted in the care conference notes, was no longer used. The plan of care was not reviewed and revised when the resident's care needs had changed or care set out in the plan was no longer necessary.

B) The plan of care for resident #003 indicated that as a falls prevention strategy, the resident was to have identified interventions in place. Observation of the resident and interview with staff #101 on April 6, 2017, confirmed that the resident had these interventions in place a few months ago. It was confirmed that the resident no longer required these interventions and that the plan of care was not reviewed and revised when the resident's care needs had changed or 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 to ensure that the care set out in the plan of care was provided to the resident as specified in the plan and 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 changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

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Issued on this 2nd day of May, 2017

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

Original report signed by the inspector.