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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 19, 2019	2019_556168_0011	005125-19	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

LISA VINK (168)

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): May 16, 22, 23, 24, 29, 30, 31, June 3, 11, 12 and 13, 2019.

This inspection was conducted by Inspector Gillian Hunter #130.

This off site inspection was conducted related to log #005125-19 related to sufficient staffing.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC) and complainant.

During the course of this off site inspection, the inspector the reviewed relevant documents.

The following Inspection Protocols were used during this inspection:
Medication
Sufficient Staffing

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	Légende 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one Registered Nurse (RN) who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Ontario Regulation 79/10, section 45, allowed for exceptions for the requirement of one RN on duty and present at all times, under specific situations, for homes with less 129 beds and for small homes at hospitals.

Regina Gardens did not qualify for any exceptions as specified in the regulations.

Regina Gardens is a long term care home with a licensed capacity of 128 beds.

Interview with the Director of Care (DOC) identified that the home did not have a sufficient number of Registered Nurses within the staffing plan to fill all the shifts related to staffing events such as sick calls.
The DOC confirmed that the home consistently offered additional shifts to regular registered nurses to fill these vacant shifts; however, when the registered nurses employed by the home were unwilling or unable to work one or more of the required shifts the home would fill those shifts with registered nurses employed with an employment agency.
On request the home provided a list of shifts over a recent three month period of time in 2019, which identified there were five occasions, where there was no RN on duty at all times, who was a member of the regular nursing staff.

The DOC confirmed that the need to fill these RN shifts was not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2).

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff, present and on duty at all times. [s. 8. (3)] [s. 8. (3)]

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 there is at least one Registered Nurse (RN) who is an employee of the licensee and is a member of the regular nursing staff on duty and present at all times, to be implemented voluntarily.

Issued on this 19th day of June, 2019

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

Original report signed by the inspector.