Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 22, 24, 25, 28, 29, 30, 31, Jun 4, 28, 2012	2012_064167_0018	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

MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Director of Care, the Administrator, registered staff and personal support worker staff on the unit, the maintenance supervisor and the identified resident related to complaint # H-000277-12.

During the course of the inspection, the inspector(s) conducted a review of the clinical records for identified residents, conducted a tour and observed care on the identified resident's unit, reviewed the home's policies and procedures related to Skin and Wound Management, Critical Incident Reporting, Medication Administration and Pain Management.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that resident #001 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when their care needs changed or care set out in the plan of care was no longer necessary. [s.6(10)b]

a) A progress note on the resident's health file in 2012 indicated that the resident was to receive analgesic medication prior to a treatment in order to decrease the pain experienced by the resident. The progress note also stated that the instructions would be communicated to other staff on the 12 hour report.
- The documentation in the progress notes indicated that resident #001 was observed to be in pain during the identified treatment on at least eight occasions over a three month period in 2012.
- The plan of care for was not revised to include the need to administer medication prior to the treatment and a review of the treatment administration records did not indicate that the resident received this intervention on a regular basis prior to the treatment.
b)The progress notes that resident # 001 indicated that they displayed a number of responsive behaviours.
The care plan was not reviewed and revised to include these behaviours.
c) The document that the home refers to as the care plan was not reviewed and revised to include the use of a specific positioning device to be used when the resident was in their wheelchair. This new intervention was noted in a progress note completed by the Director of Care and was consented to by the resident's Substitute Decision Maker.
d) It was noted that the physician wrote an order to keep the resident's treatment area dry.
The care plan was not updated to include interventions to be put in place to prevent the treatment area from becoming wet during their shower.
Personal support worker staff and registered staff interviewed were aware of the need to keep the resident's treatment area dry during their shower and did indicate that there were interventions in place to prevent the area from becoming wet.
2. The plan of care did not provide clear direction to staff who provide direct care to the resident. [s.6(1)c]

a) It was noted that the signs posted in the resident # 001's room, information provided in the resident's health file and directions on the resident's care plan related to positioning of the resident provided inconsistent direction to staff who provide care.
b) A sign was posted in the resident's room to direct staff related to transferring activities. The posted sign and the transfer logo in the resident's room provided inconsistent information related to the type of transfer to be used for the resident.
- It was noted that the document that the home refers to as the care plan indicated the the type of transfer to be used.
- The Director of Care confirmed that this care plan contained the correct information related to transfer.
The plan of care for resident #001 did not provide clear direction to staff related to the type of transfer to be used for the resident.

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 plans of care for residents are reviewed and revised at any time when the residents' care needs change and that the written plan of care provides clear direction to staff and other who provide direct care to the resident., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee did not report immediately to the Director an incident of abuse that occurred in 2012 when there was reasonable grounds to suspect that the abuse had occurred. [s. 24(1)2]
An incident of abuse occurred at the home involving two residents.
The home did not report this incident to the ministry immediately as required. The home reported this incident to the Ministry six weeks later when it was brought to their attention by the inspector.

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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where the Act or Regulation requires that the home have a policy or protocol in place that the policy or protocol is complied with. [O.Reg.79/10 s. 8(1)b]

During the inspection in 2012, it was noted that there was a pill on the floor beside resident #001's bed. The pill was appeared to be a medication that was ordered for resident # 001. The pill was shown to the Director of Care and the Consultant. The Director of Care indicated that the pill appeared to be the resident's medication.
- A review of the physician's orders and the Medication Administration Record (MAR) revealed that the identified medication was to be given twice daily to resident # 001.
It was noted on the MAR that the identified medication was signed as given at 0800 and 1700 each day throughout the the time frame reviewed. The medication was noted to have been administered that morning.
- A review of the home's policy related to Medication Administration (NURS-VII-18 REG. 131) directs registered staff to: Observe the resident taking all of the medication with water provided- never leave medication at the side of the bed, on table in the dining room, at resident's side - always ensure that they take the medication.

Registered staff at the home did not follow the home's policy and procedure related to medication administration as the resident was not observed taking their medication.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident's SDM (Substitute Decision Maker) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.
[s.97(1)b]

An incident of abuse took place between two residents at the home. The SDM for resident #002 was notified of the incident. The SDM for resident #001 was not notified until six weeks after the incident took place when it was brought to the attention of the home that the SDM for resident #001 may not have been notified of the incident. The Director of Care confirmed that the SDM for resident #001 had not been informed of the incident.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following subsections:

s. 88. (1) As part of organized programs of housekeeping and maintenance services under clauses 15 (1) (a) and (c) of the Act, every licensee of a long-term care home shall ensure that an organized preventive pest control program using the services of a licensed pest controller is in place at the home, including records indicating the dates of visits and actions taken. O. Reg. 79/10, s. 88 (1).

Findings/Faits saillants :

1. The licensee did not ensure that an organized preventive pest control program using the services of a licensed pest controller is in place at the home, including records indicating the dates of visits and actions taken.

The home has a contract with a licensed pest control company, however the company was not contacted when insect activity was identified on two separate occasions in 2012. Staff at the home attempted to control the insects, however the interventions put in place were not preventative.
- Ants were identified in a resident's room by a visitor in March 2012. The visitor reported the ants to the administrator who in turn verbally directed the maintenance person to follow-up on the issue. The maintenance person placed ant traps in the room as an intervention but did not report the ant activity to their contracted pest control technician. On March 28, 2012, staff identified ants in room 241 and recorded the information in the maintenance request log. The maintenance person made a notation in the log that he placed ant traps in the room. The information was not forwarded to the pest control operator for further investigation.
- Interview with the pest control operator on May 29, 2012 confirmed that he was not aware of any ant activity in the home. His service reports and that of other technicians between January and May 16, 2012 indicate that there was no insect activity in the home. The technicians visit common areas such as storage areas, delivery areas, kitchens, mechanical rooms, dining areas etc., but not resident rooms. The technicians rely on information from staff of the home regarding pest issues in resident rooms. The technician reported that their response to ant activity would be different than the interventions taken. A preventive component would have been considered such as applying a pesticide product around the perimeter of the building, which has not been done to date.

Issued on this 5th day of July, 2012

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

Marilyn Low