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
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Jan 10, 11, 12, 16, 17, 18, 23, 24, 26, 27, Feb 6, 16, 24, Mar 27, May 23, 2012	2012_122156_0001	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.

During the course of the inspection, the inspector(s) spoke with Administrator, Director Of Care (DOC), Registered Dietitian (RD), Registered staff, Personal Support Workers (PSW's)

During the course of the inspection, the inspector(s) reviewed clinical records of residents, observed meal service, reviewed policies. This inspection is related to Log #H-002081-11.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (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;
(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 there was a written plan of care for each resident that set out clear directions for staff and others who provide care to the resident. 1a)The plan of care for resident #2 did not provide clear direction to staff providing care. The resident had a physician's order for a fluid restriction of 1500ml/day, however, the plan of care was not individualized to provide direction for staff. Under the eating section of the plan, it indicated to provide the resident with diet and fluids per Registered Dietitian directive, see nutritional focus for specifics. However, nutritional focus did not provide specifics related to fluids as indicated.
1b)The plan of care for resident #3 did not provide clear direction to staff providing care. The diabetes focus in the plan indicated for Registered staff to complete capillary blood glucose (CBG) readings as ordered; abnormalities to be reported to medical doctor (MD) for further direction. During an interview, the Registered Dietitian stated that abnormalities for this resident would be greater than 10, a registered staff interviewed indicated abnormalities to be greater than 20 and the home policy indicated that when values were over 15, call MD. The plan of care did not identify what abnormalities for this resident would be and therefore, did not provide clear direction for staff providing care.
2. The licensee did not 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 change or care set out in the plan is no longer necessary.
2a)Resident #2 returned from hospital in 2011 and had an order for a 2g sodium/day diet, however, was receiving a regular diet. This was not reassessed by the Registered Dietitian and the plan was not reviewed and revised to include an individualized menu plan. The Registered Dietitian confirmed that there was no reassessment completed.
Resident #2 was not reassessed and the plan of care reviewed and revised when the resident's care needs changed. The resident returned from hospital in 2011 with a diagnosis of congested heart failure. The resident had a physician's order for 1500 ml fluid restriction however, Daily Food and Fluid Intake Records indicated the resident consumed 1500ml or greater on 9/13 days(69% of the time) for two weeks in 2011, 22/31 days (71% of the time) for one month in 2011 and 20/23 days (87%) for another month in 2011. The clinical record indicated that during this time, the resident was exhibiting signs of fluid retention and the physician increased the order for the diuretic. The reassessment was not completed by the Registered Dietitian in relation to fluid status until the following month when the Resident Assessment Protocol (RAP) was completed.
2b)Resident #3 was not reassessed and the plan of care reviewed and revised when the resident's care needs changed. The Registered Dietitian confirmed that usually when the resident's blood glucose values were above 10, it would be considered abnormal. The resident's blood glucose records on the Capillary Blood Glucose Monitoring sheet from November 1, 2011 - January 3, 2012 indicated that the resident's blood glucose had reached levels greater than 10 mmol/L on 8 of 12 occasions. Minimum Data Set (MDS) Nutrition Resident Assessment Protocol (RAP) Summary completed by the Registered Dietitian on January 3, 2012 did not include evaluation of the resident's blood sugars. The Registered Dietitian confirmed that the resident's diabetes was not evaluated and blood sugars should have been flagged for reassessment. She also confirmed that there was not a referral noted in the physician communication book for the physician to evaluate the blood glucose.
3. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
3a)The Physicians Order Review for resident #1 for October 1-December 31, 2011 indicated that HgA1C was to be taken every three months, however, this was not completed by the home; this was confirmed by the Nurse Manager on the floor. The last HgA1C was completed on August 18, 2011.
3b)The physician's order for resident #3 indicated for capillary blood glucose to be taken at alternate times once per week. The Capillary Blood Glucose Monitoring sheet for November 1, 2011 - January 17, 2012 did not indicate blood glucose was taken for the weeks of December 27, 2011 and January 17, 2012.
3c)A physician's order for resident #2 in September 2011 indicated for weights to be taken every two days. The Medication Administration Record (MAR) indicated that weights were not taken on September 27, 29 and October 8, 2011. A physician's order on November 30, 2011 directed staff to take weight tomorrow. The Medication Administration Record indicated that this was not completed until December 3, 2011. This was confirmed by the Director of Care.
The resident's monthly weight was not taken and recorded in the resident's clinical record for the month of September, 2011.
On September 20, 2011 the physician's order stated to call the MD if the blood glucose was greater than 20 mmol/L. On October 13, 2011, the blood glucose recorded on the Capillary Blood Glucose Monitoring sheet indicated a blood glucose of 20.6 at 1600. The MD was not called until the residents blood glucose reached 24.4 at 2000.
In September 2011 the physician's order stated blood glucose to be tested four times per day before meals and evening. Blood glucose was not taken and recorded on the Capillary Blood Glucose Monitoring sheet on September 21, 2011 at

2000; October 21, 2011 at 1200, and November 9, 2011 at 1600. The DOC confirmed that all blood glucose taken would be recorded on the Capillary Blood Glucose Monitoring sheet and confirmed that these entries were missing.

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 a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan and that the resident is 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee did not ensure that residents with weight changes that compromise the resident's health status were assessed using an interdisciplinary approach and that actions were taken and outcomes evaluated. Resident #2 returned from hospital with a diagnosis of congested heart failure and a physician's order for weights to be taken every two days. There were fluctuations in weight, for example, between a period of two days where there was a difference of 5kg recorded. However, an interdisciplinary approach was not taken as the Registered Dietitian confirmed she did not evaluate the weights taken every two days. The clinical record indicated that the homes' Registered Dietitian did not assess the weight change for six weeks in 2011 despite a decrease of 5.7kg.

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 residents with weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: any other weight change that compromises a resident's health status, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs
Specifically failed to comply with the following subsections:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licencee did not ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.
1a)The current physicians order for resident #1 written in 2009 for sliding scale Humulin R insulin was to inject per sliding scale: if capillary blood sugar was greater than 15, 2 units extra; greater than 20, 4 units extra; greater than 25, call MD. Blood glucose recorded on the Capillary Blood Glucose Monitoring sheet at 1600 on November 8, 2011 was 19.7, November 9, 2011 was 18.0, November 14, 2011 was 18, November 17, 2011 was 15.4, November 18, 2011 was 18.4, November 22, 2011 was 15.1, December 11, 2011 was 15.9 and January 15, 2011 was 17.1. Insulin was not administered on any of these occasions as ordered. This was confirmed in an interview with registered staff.
1b)The physicians order for resident #2 on September 20, 2011 indicated for staff to administer 10 units of sliding scale NPH insulin at 2000 when blood glucose level was between 15.1-20. Blood glucose recorded on the Capillary Blood Glucose Monitoring sheet for September 20 at 2000 was 19.9. The Medication Administration Record (MAR) indicated 5 units was provided instead of the 10 as ordered. The physicians order for this resident on September 20, 2011 for sliding scale Regular R insulin at 0800, 1200 and 1700 was as follows:
Below 4, call MD
4.1-10, 0 units
10.1-12, 2 units
12.1-14, 4 units
14.1-16, 6 units
16.1-18, 8 units
18.1-20, 10 units
Over 20, call MD
Blood glucose recorded on the Capillary Blood Glucose Monitoring sheet for October 23, 2011 at 1600 was 17.5. The MAR indicated the resident did not receive any insulin when 8 units were ordered.
Blood glucose recorded on the Capillary Blood Glucose Monitoring sheet for October 24, 2011 was 18.1 at 1600. The MAR indicated 8 units was provided instead of the 10 as ordered.
The physicians order for this resident on October 25, 2011 for sliding scale Regular R insulin at 0800, 1200 and 1700 was as follows:
Below 4, call MD
4.1-10, 0 units
10.1-12, 2 units
12.1-14, 4 units
14.1-16, 6 units
16.1-18, 8 units
18.1-24, 10 units
Over 24 call MD
Blood glucose recorded on the Capillary Blood Glucose Monitoring sheet for October 25, 2011 was 19.8 at 1600. The MAR indicated 8 units was provided instead of the 10 as ordered.
Blood glucose recorded on the Capillary Blood Glucose Monitoring sheet for October 26, 2011 was 9.9 at 1600. The MAR indicated 2 units was provided when 0 units were ordered.
Blood glucose recorded on the Capillary Blood Glucose Monitoring sheet for October 27, 2011 was 11.5 at 1200. The MAR indicated she did not receive any insulin when 2 units were ordered.
Blood glucose recorded on the Capillary Blood Glucose Monitoring sheet for October 28, 2011 was 11.9 at 1600. The MAR indicated she did not receive any insulin when 2 units were ordered.
Blood glucose recorded on the Capillary Blood Glucose Monitoring sheet for October 30, 2011 was 11.2 at 0800. The MAR indicated she did not receive any insulin when 2 units were ordered. Blood glucose recorded on the Capillary Blood Glucose Monitoring sheet was 8.2 at 1600. The MAR indicated 8 units were provided when none were ordered.

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 drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: 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 of the home did not ensure that the policies and procedures in place were complied with.
1.Diabetic Management Policy NUR-V-120 indicated that quarterly (Hemoglobin A1C) HbA1C testing was to be ordered through the lab unless otherwise ordered by the physician. Resident #1 did not have a quarterly HbA1C completed. The last lab value for HbA1C was on August 18, 2011. This was confirmed with the Nurse Manager on the floor. Resident #2 did not have a quarterly HbA1C completed. The last lab value for HbA1C was on August 18, 2011. This was confirmed by the Registered Nurse.
2.Dietary referral policy NHS-X-14 indicated that referrals were made to the Registered Dietitian/Food Service Manager using the dietary referral progress note when residents returned from hospital or when there had been a diet or texture change or uncontrolled blood sugars. A dietary referral was not initiated when resident #2 returned from hospital in 2011, or when there was a new diet order in 2011 and when the resident continued to exhibit uncontrolled blood sugars after return from hospital. This was confirmed during an interview with the Registered Dietitian.
3.Dietary availability policy NHS-X-24 indicated that any resident who required specialized diets would be assessed by the Registered Dietitian and an individual menu would be developed. In 2011, resident #2 had an order for 2g sodium/day diet however, an individual menu was not developed. This was confirmed during an interview with the Registered Dietitian.

Issued on this 11th day of July, 2012

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

Carol Roby, RD