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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 7, 2014	2014_214146_0002	H-000105-14	Resident Quality Inspection

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

BARBARA NAYKALYK-HUNT (146), CAROL POLCZ (156), LESLEY EDWARDS (506), ROSEANNE WESTERN (508), THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 21, 22, 23, 24, 27, 28, 29, 30, 31, February 4, 2014.

This RQI inspection was conducted concurrently with Critical Incident inspection H-000775-13. The findings are included in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Physician, Resident Assessment Instrument (RAI) coordinator, Environmental Manager, Registered Dietitian (RD), Food Services Manager (FSM), registered staff, Social Worker, physiotherapy staff, personal support workers (PSW's), hairdressing staff, housekeeping staff, recreation staff, residents and family members.

During the course of the inspection, the inspector(s) toured the home; observed residents in dining area and care areas; reviewed policies and procedures; resident health records; the home's internal investigation notes and staff schedules.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the following rights of residents were fully respected and promoted: 5. Every resident has the right to live in a safe and clean environment.
In January 2014 an inspector observed resident #040 sitting alone in the hair salon. The hair salon is located in an area of the home where residents do not reside, therefore staff do not monitor the area. On this occasion there were no other persons in the hallway or in the nearby rooms.
The resident was visibly upset and anxious and started to cry when the inspector came into the room. There was no call bell system available or accessible to the resident. Four to five minutes later, the hairdresser returned to the salon with another resident. The hairdresser confirmed that resident #040 had been left unattended while she went to porter the next resident. The hairdresser confirmed that residents are left alone in the hair salon routinely. Resident #040 had a chair alarm clipped to clothes and it was confirmed by the health record and the DOC that this resident is at risk for falls. The DOC and the Administrator confirmed that residents should not be left unattended in this isolated area of the home. [s. 3. (1) 5.]

2. The licensee did not ensure that the following rights of residents were fully respected and promoted: 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. In January 2014 between 1130 and 1200 hours registered staff administered treatments to residents #259 and #012

while they were located in a resident care area hallway. [s. 3. (1) 8.]

3. The licensee did not ensure that the following rights of residents were fully respected and promoted: 9. Every resident has the right to have his or her participation in decision-making respected.
(A) In January 2014, resident #259 told staff that the resident was upset that some personal items had been removed from the resident's room. Staff indicated to resident that the items were removed and stored in the locked medication room; resident could request access at any time. The Administrator met with the resident to review the rational for safe storage of substances. Resident voiced concern that the personal items were removed without discussion with the resident; that the resident had not been involved in the decision. This information was confirmed by the DOC.
(B) Resident #001 had reported in November 2013 to the home a belief that an identified staff person had abused the resident. The resident had told the home that the resident did not want the identified staff person providing personal care any more. The resident repeated this request in an interview with an inspector in January 2014 because the identified person was still providing personal care to the resident. In an interview on January 29, 2014, the DOC confirmed that the identified staff person was still working with the resident but not alone. The resident's decision-making was not respected. [s. 3. (1) 9.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 following rights of residents are fully respected and promoted: 9. every resident has the right to have his or her participation in decision-making respected, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home had a dining and snack service that included, at a minimum, the following elements: providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortable and independently as possible.
(A) During the observed meal in January 21, 2014, resident #030 was observed requiring assistance with eating. The resident was served the meal but the resident did not receive assistance to eat until 16 minutes later. The care plan for this resident indicated that the resident required total assistance in eating from beginning to end of meal by one staff.
(B) Another resident #031 was picking at the lunch and had eaten very little. The resident was not encouraged until the very end of the meal service and then the lunch was taken away with less than 25% of the meal consumed. The care plan for this resident indicated the resident required intermittent/limited assistance with eating.
(C) During the observed meal in January 2014, at one table there were three residents all requiring feeding. One staff was assisting two residents and the third resident #167 did not receive assistance. The soup was in front of the resident but assistance was not provided for 15 minutes until another staff came to assist. The care plan for this resident indicated that the resident required one staff to provide total assistance with eating. A PSW was interviewed and indicated that the resident can eat on own occasionally but staff need to get the resident started. This assistance was not provided during the observed meal.
It was confirmed by staff during interview that residents #167, #030 and #031 required assistance in eating.
(D) Residents #246 and #032 were sitting at another table and both required assistance. Soup was served and the residents did not receive assistance until 15 minutes later. The care plan for resident #032 indicated that the resident required limited to total assistance and encouragement. Staff confirmed during interview that both residents required assistance with eating which was not provided. [s. 73. (1) 9.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of 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:

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

Findings/Faits saillants :

1. The License did not ensure the policy and procedures in the home were being complied with.
(A) The home's Clinical Nursing Services manual policy for falls (policy number LTCE-CNS-G-10) indicated that the home is to use a Decision Tree to determine which assessments are to be completed post fall. During a review of residents #200, #225 and #193, the Decision Tree indicated that the Morse Fall Risk Assessment was to be completed post fall. The DOC confirmed that the home is not always completing the Morse Fall Risk as per the facility policy.
(B) The home's Clinical Nursing Services manual policy for Skin and Wound (policy number LTCE-CNS-I-3) indicated that residents with altered skin integrity and current wound care will have their pain assessed weekly with wound care assessments. This is not being completed consistently with three out of three residents with altered skin integrity and was confirmed by the DOC.
(C) The home's Nutrition and Hospitality Services manual policy for Hydration (policy number NHS-X-17) indicated that a referral will be made to the RD if a resident's intake is 1000 millilitres of fluid or less for three consecutive days. During a review of resident #263, the resident did not consume the minimum of 1000 millilitres (eight glasses per day) as per the daily food and fluid intake record for twelve days in October; nine days in November; ten days in December; and seven days in January 2014. The RD confirmed that there was no referral sent during these dates as identified.
(D) During a review of resident #035, the resident did not consume the minimum of 1000 millilitres (eight glasses per day) as per the daily food and fluid intake record on 22 days in January 2014. The RD confirmed that there was no referral sent during these dates as identified.
(E) During a review of resident #215 the resident did not consume their minimum of 1000 millilitres (eight glasses per day) as per the daily food and fluid intake record on nine days in January 2014. The RD confirmed that there was no referral sent during these dates as identified. [s. 8. (1)]

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 where the Act or the Regulation requires the licensee of a long term care home to have, institute or otherwise put in place any plan, policy, procedure, strategy or system, the licensee is required to ensure that the plan, policy, procedure, strategy or system, (b) is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The Licensee did not ensure that the plan of care included communication abilities for resident #179. The MDS Resident Assessment Protocol (RAP) indicated that the resident had communication difficulties and the care plan had been reviewed with goals and interventions noted as effective. A plan of care was not in place to address resident's communication difficulties nor was this addressed in the kardex. The DOC confirmed that this information should be provided to the staff in the plan of care and the kardex. [s. 26. (3) 3.]

2. The Licensee did not ensure that the plan of care addressed vision needs for resident #230. The MDS RAP indicated that the resident had a visual function disturbance and the care plan had been reviewed with goals and interventions documented . A plan of care was not in place to address resident's visual disturbances as indicated in the RAP or addressed in the resident's kardex. The DOC confirmed that this information should be in the resident's plan of care and the kardex. [s. 26. (3) 4.]

3. The licensee did not ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 10. Health conditions, including allergies, pain, risk of falls and other special needs.
(A) Resident #200's plan of care did not address the resident's fall risk after the resident sustained a fall in January 2014. The DOC confirmed that after a resident falls it is the expectation that the plan of care should address the fall risk and provide interventions for staff to implement and to minimize fall risk.
(B) In January 2014, an inspector observed a specific treatment sign on a resident's door. Interviews with various staff yielded conflicting reasons for the treatment. The care plan and kardex were silent and did not address this resident's special need. This information was confirmed by the health record and staff interviews. [s. 26. (3) 10.]

4. The licensee did not ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences.
(A) During an interview with resident #263 in January 2014, it was noted that the resident indicated unusual sleep needs and preferences. Two PSW's interviewed confirmed the resident's statement. The plan of care and kardex did not identify sleep patterns and preferences for this resident.
(B) Ten plans of care were reviewed and ten out of ten did not address the residents' sleep patterns or preferences. [s. 26. (3) 21.]

5. The plan of care was not based on, at minimum, an interdisciplinary assessment of the following with respect to the resident:
22. Cultural, spiritual and religious preferences.
The plan of care and kardex for resident #215 did not reflect cultural food preferences. The resident indicated a cultural preference for a certain food. The plan of care, the kardex and the serving notes in the dining room did not address this preference nor did the home provide the food as requested. This information was confirmed by the health record and the resident's family. [s. 26. (3) 22.]

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 the plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 3. communication abilities, including hearing and language; 4. vision; 10. health conditions, including allergies, pain, risk of falls and other special needs; 21. sleep patterns and preferences; and 22. cultural, spiritual and religious preferences and age-related needs and preferences, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The Licensee did not ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were assessed at least weekly by a member of the registered nursing staff.
(A) Resident #179 was identified to have impaired skin integrity. The areas of altered skin integrity were not assessed at least weekly by a member of the registered staff. In a twelve week period, three weekly assessments were not done.
(B) Resident #230 was identified to have impaired skin integrity. The area of altered skin integrity was not assessed at least weekly by a member of the registered staff. In a twelve week period, five weekly assessments were not done.
C) Resident #200 was identified to have impaired skin integrity. The areas of altered skin integrity were not assessed weekly by a member of the registered staff. A wound assessment was completed in December 2013 and the resident did not have another weekly wound assessment for 23 days.
This information was confirmed by the health record. [s. 50. (2) (b) (iv)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are assessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee did not ensure that staff and others involved in different aspects of care of the resident collaborate with each other in the assessment of a resident so that their assessments were integrated, consistent with and complement each other.
(A) The assessments of resident #215's hearing capacity were inconsistent between staff and others involved in different aspects of care. The resident's assessments were not consistent with each other.
(B) The current care plan indicated that resident #230 had a certain impairment of the skin. The impairment was assessed differently in different parts of the health record, even when assessed on the same date.
(C) Resident #193's falls assessments conflicted with each other even though assessed in same time frame. [s. 6. (4) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that, (a) the home, furnishings and equipment were kept clean and sanitary.
(A)In January 2014, it was observed that:
(i) the green wing back chair in a family room was stained on the seat and the right arm;
(ii) a tabletop sitting on the floor was soiled and stained;
(iii) a family room had white flooring that was very scuffed with black marks and the wooden table had scratched and coating/finish missing in spots;
(iv) 5 winged back chairs in another family room had soiling on the fabric armrests.
(B)In January 2014, in a lounge area it was observed that arm chair legs on 2 chairs observed to be damaged with stain and lacquer scraped away; kitchen table in the lounge has several areas where finish has been scratched and removed; dryer lint catcher has excess lint inside.
(C)In January 2014 in a lounge, it was observed that there were bird feces dried to the top of the end table from a nearby bird cage. [s. 15. (2) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The Licensee did not ensure that the resident-staff communication and response system was easily seen, accessed and used by resident, staff and visitors at all times.

(A)In January 2014, bathroom call bell cords in two rooms were observed to be wrapped tightly around the grab bar beside the toilet so that the bell did not ring when the cord was pulled.
(B) In January 2014 the bathroom call bell cord in three rooms broke when pulled. Staff confirmed that call bell cord breaks when pulled.
The communication and response system was not able to be used by residents in the above rooms. [s. 17. (1) (a)]

WN #9: 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:

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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee did not immediately report the alleged abuse of a resident by a staff person.
Resident #001 reported to the home in November 2013 that a staff person had allegedly slapped the resident. The home reported the alleged abuse to the Director via critical incident report submitted four days later. This information was confirmed by the critical incident documentation. [s. 24. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee did not ensure that strategies were developed and implemented to meet the needs of those residents with compromised communication and verbalization skills, residents with cognitive impairment and residents who cannot communicate in the languages used in the home.
(A) In January 2014 three staff working with resident #236 were asked about communication strategies used for the resident. Two staff of three interviewed stated that they did not implement interventions as documented in the residents plan of care to communicate with the resident even though communication was identified as an issue with this resident. This information was confirmed by staff and the health record. [s. 43.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The nutrition care and hydration program did not include the implementation of interventions to mitigate and manage the identified risks related to nutrition care and dietary services and hydration.
(A) In January 2014 the inspector noted that resident #263 appeared dehydrated. The RD had seen the resident. It was noted in the daily flow sheet on 11 different dates that the resident had complained of thirst. This resident was noted to have consumed less than eight glasses per day on ten days in December and eight days in the first three weeks of January 2014. The nutrition care plan for this resident indicated that hydration would be maintained according to individual assessed needs. The hydration needs were not identified on the care plan. Interventions related to hydration and identified risks were not identified. This information was confirmed by the health record and the RD. [s. 68. (2) (c)]

2. The licensee did not ensure that resident weights were taken monthly. The weight for resident #263 was done in October 2013 and not again until December 2013, at which time there was a 13.3 kg weight loss. As confirmed with the RD and Nursing Unit Clerk on January 24, 2014 resident #263 did not have a weight taken for the month of November, 2013. [s. 68. (2) (e) (i)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. Planned menu items were not offered and available at each meal and snack.
(A) During the observed meal in January 2014, resident #263 was noted in the serving notes to receive a supplement, however, this was not provided. It was confirmed with the dietary aide that the resident was not provided with the supplement.
(B) During the observed meal in January 2014 resident #033 was to be provided with a special diet. The special diet was not available for the second choice at point of service as confirmed with the dietary aide. [s. 71. (4)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. All food and fluids were not prepared, stored, and served using methods which preserve taste, nutritive value, appearance and food quality.
During the observed meal in January 2014, resident #034 had a tray prepared as the resident was not in the dining room. The plate of food containing cold lettuce salad and hamburger (hot) on a bun was put in the servery fridge. 20 minutes later, the tray was prepared: hamburger on a bun and salad, soup, fruit dessert along with juice and coffee. Before the PSW took the tray to the resident's room, she heated the food in the microwave. 11 minutes later, the PSW was observed taking the tray back to the servery with the soup eaten and hamburger untouched. The hamburger was probed at 111 degrees F which was below safe food temperatures. Food quality was compromised. [s. 72. (3) (a)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee did not ensure that staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities.
The residents' hairdresser stated that she had not received prevention of abuse training. This information was confirmed by the administrator. [s. 76. (2) 3.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection and control program.
(A) In January 2014 it was observed that there were items in the tub room, such as an electric razor, a used hairbrush, and skin lotion that were not labeled. It was confirmed by staff that they did not know who these items belonged to.
(B) A scrub brush used to clean resident shower equipment was observed on four different dates in January hanging on the shower grab bar in the shower room. The bristles of the brush were lying on the grab bar used by residents inside the shower. It was confirmed by staff that the brush was used to clean commodes in the shower room after each use.
(C) In January 2014 a shared bathroom was observed to have two used combs, a used toothbrush and a denture cup all unlabeled. A urine collection bag was observed hanging from the grab bar in shared bathroom. [s. 229. (4)]

Issued on this 12th day of February, 2014

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

BARBARA NAYKALYK-Hunt.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : BARBARA NAYKALYK-HUNT (146), CAROL POLCZ (156), LESLEY EDWARDS (506), ROSEANNE WESTERN (508), THERESA MCMILLAN (526)

Inspection No. / No de l'inspection : 2014_214146_0002

Log No. / Registre no: H-000105-14

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Feb 7, 2014

Licensee / Titulaire de permis : LIUNA LOCAL 837 NURSING HOME(ANCASTER) CORPORATION
44 HUGHSON STREET SOUTH, HAMILTON, ON, L8N-2A7

LTC Home / Foyer de SLD : REGINA GARDENS
536 UPPER PARADISE ROAD, HAMILTON, ON, L9C-5E3

ANDREA LOFT

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur :

To LIUNA LOCAL 837 NURSING HOME(ANCASTER) CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee will ensure that the following rights of resident #040 and all residents are fully respected and promoted: every resident has the right to live in a safe and clean environment. The licensee will cease the practice of leaving residents alone and unattended in the hair salon located in a non-residential wing of the home not routinely monitored by staff.

Grounds / Motifs :

1. Previously issued 04/27/2011 s.3(1)1 as a WN.
The licensee failed to ensure that the following rights of residents were fully respected and promoted: every resident has the right to live in a safe and clean environment.
In January 2014 an inspector observed resident # 040 sitting alone in the hair salon.
The hair salon is located in an area of the home where no residents reside, therefore staff do not monitor the area. On this occasion there were no other persons in the hallway or in the nearby rooms. The resident was visibly anxious and started crying when the inspector entered the room. There was no call bell system available or accessible to the resident. Four to five minutes later, the hairdresser returned to the salon with another resident. The hairdresser confirmed that resident # 040 had been left unattended while she went to porter the next resident. The hairdresser confirmed that residents are left alone in the hair salon routinely. Resident # 040 had a chair alarm clipped on clothes and it was confirmed by the health record and the Director of Care that this resident is at risk for falls. The DOC and the Administrator confirmed that their expectation was that residents should not be left unattended in this isolated area of the home and would address the issue immediately. (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall develop , implement and submit a plan to ensure that residents in the Mohawk Trail dining room and all residents are provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. The plan is to be submitted to Carol Polcz by end of business day March 7, 2014 by mail at 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7 or by e-mail to Carol.Polcz@ontario.ca.

Grounds / Motifs :

1. Previously issued 2010-10-19 as a VPC and 2011-04-27 as a WN.
Residents were not provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible
(A) During the observed meal in January 2014, resident #030 was observed requiring assistance with eating. The resident was served the meal but did not receive assistance until 16 minutes later. The care plan for this resident indicated that the resident required total assistance in eating from beginning to end of meal by one staff.
(B) During the observed meal in January 2014 resident #031 was picking at the lunch and had eaten very little. The resident was not encouraged until the very end of the meal service and then the lunch was taken away with less than 25% of the meal consumed. The care plan for this resident indicated the resident required intermittent/limited assistance with eating.
(C) During the observed meal in January 2014, at one table there were three residents all requiring feeding. One staff was assisting two residents and the third resident #167 did not receive assistance. The soup was in front of the resident but assistance was not provided for 15 minutes until another staff came to assist. The care plan for this resident indicated that the resident required one staff to provide total assistance with eating. A PSW was interviewed and indicated that the resident can eat on own occasionally but staff or family need to get the resident started. This assistance was not provided during the observed meal.
It was confirmed by staff during interview that residents #167, #030 and #031 required assistance in eating.
(D) Residents #246 and #032 were sitting at another table and both required assistance. Soup was served and the residents did not receive assistance until 15 minutes later. The care plan for resident #246 indicated that the resident required extensive assistance of one staff as the resident will refuse to eat and will just sit and stare at the food. The care plan for resident #032 indicated that the resident required limited to total assistance and encouragement. Staff confirmed during interview that both residents required assistance with eating which was not provided.
(156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 07, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 7th day of February, 2014

Signature of Inspector / Signature de l'inspecteur : BARBARA NAYKALYK-HUNT

Name of Inspector / Nom de l'inspecteur : BARBARA NAYKALYK-HUNT

Service Area Office / Bureau régional de services : Hamilton Service Area Office