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
Oct 27, Nov 3, 2014	2014_256517_0042	001799-14	Complaint

Licensee/Titulaire de permis

MERITAS CARE CORPORATION
567 VICTORIA AVENUE, WINDSOR, ON, N9A-4N1

Long-Term Care Home/Foyer de soins de longue durée

REGENCY PARK LONG TERM CARE HOME
567 VICTORIA AVENUE, WINDSOR, ON, N9A-4N1

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

PATRICIA VENTURA (517)

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): August 22, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, one Registered Nurse and two Registered Practical Nurses.

During the course of the inspection, the inspector(s) reviewed the home's Nutrition and Hydration program and one resident health record.

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 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed as evidenced by:

Health record review for a resident for assistance needed with eating and drinking revealed the resident required assistance with drinking and eating [redacted]. The resident was assessed to be at high nutritional risk and had significant weight loss in the last 3 months.

The resident's most recent written plan of care indicated the resident required supervision, oversight or cue to finish eating and drinking and required no physical assistance with eating and drinking.

The Administrator and the Director of Care verified the resident's written plan of care should reflect the resident's current needs. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the resident care conferences as evidenced by:

Health record review revealed a resident did not receive a care conference from admission to discharge. On admission the Power of Attorney (POA) signed a document indicating the POA would attend a care conference for the resident at a scheduled later date. The home did not contact the Power of Attorney to confirm attendance for the care conference. The POA stated she forgot the date the care conference was scheduled for and did not attend, as a result the care conference was canceled.

The POA informed the home of her availability to attend a care conference for the resident on another date. The home scheduled the care conference for the date requested but failed to notify the POA. The POA did not attend the care conference, as a result the care conference was canceled.

The Director of Care confirmed the expectation was that the Power of Attorney was given an opportunity to participate fully in the resident care conferences and verified the POA was not contacted to confirm attendance for the first scheduled care conference and was not notified of the second scheduled care conference. [s. 27. (1) (b)]

Issued on this 27th day of October, 2014

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