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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 27, 2015	2015_349590_0017	008959-15 & 008548-15	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

ALICIA MARLATT (590)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 21 & 22, 2015.

Two complaints were conducted concurrently during this inspection and were related to resident care needs.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Care, two family members, one resident, two Registered Nurses, a Registered Practical Nurse and two Health Care Aides.
During the course of the inspection, the inspector(s) reviewed two resident clinical records and the homes policies on Nutrition and Hydration and Resident Fall Prevention and Management.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure they fully respected and promoted the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Resident #2 was identified as a nutritional risk and required extra fluids to prevent dehydration. The resident has a history of poor oral intake. Resident #2's plan of care was reflective of her extra fluid needs.
Review of Resident #2's clinical record reveals that food and fluid intake records were incomplete. The Inspector was unable to locate the record titled "Push Fluid Record", which documents extra fluids taken by the resident. The Director of Resident Care confirmed there are no "Push Fluid Records" to indicate that the staff monitored or encouraged oral intake for Resident #2. [s. 3. (1) 4.]

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 they fully respected and promoted the resident's right to be cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: 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 licensee has failed to ensure that any policy put in place is complied with.

In an interview with Resident #1's family member, they indicated they were not made aware of a previous fall.
Review of the homes Post Fall Incident Report revealed that Resident #1's POA was not notified when the resident fell previously.
Review of the homes policy titled "Falls - Resident Fall Prevention and Management Program" dated July 2001 and revised on February 2015, outlines the roles and responsibilities of the Registered Staff and includes the notification of the POA or Substitute Decision Maker of the fall incident.
Interviews with two Registered Staff members reveal that it is the responsibility of the Registered staff to notify the POA of falls.
Interview with the Director of Resident Care confirmed Resident #1's POA was not notified of the previous fall and that the homes expectation is that POA's are notified when residents fall as per the homes policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any policy put in place is complied with.

Resident #2 was assessed as a moderate nutritional risk.
The homes policy titled "Nutrition and Hydration Program" dated May 2008 and last revised in June 2012, outlines the procedure for documenting each residents food and fluid intake and is as follows: "The assigned HCA/PSW or other appropriate personnel, when serving in each dining room & assigned tables as well as snack cart will be responsible to complete the food and fluid flow documentation at the end of every meal/snack for their assigned shift" and also "The Food and Fluid documentation for each resident will be completed in the computerized system".
Review of Resident #2's food and fluid intake records reveal that the resident's intake was not documented for two days.
Interview with a Health Care Aide revealed that the Health Care Aides are responsible for documenting residents food and fluid intakes in the computer system.
The Director of Resident Care confirmed Resident #2's food and fluid intake should be documented as she is a nutritional risk. [s. 8. (1) (a),s. 8. (1) (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 that any policy put in place is complied with, to be implemented voluntarily.

Issued on this 27th day of May, 2015

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

Original report signed by the inspector.