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

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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
Sep 25, Oct 29, 2015	2015_216144_0046	022579-15	Resident Quality Inspection

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

CAROLEE MILLINER (144), ALISON FALKINGHAM (518), NATALIE MORONEY (610)

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): August 31, September 1, 2, 3, 4, 2015

During the course of the inspection, the inspector(s) spoke with 40+ residents, six family members, the Administrator, Director of Care (DOC) , Food Service Manager (FSM), Ward Clerk, one maintenance staff, two Registered Nurses (RN's), seven Registered Practical Nurses (RPN's), six Personal Support Workers (PSW's), one Activation Aide, two Housekeeping Aides and two Personal Support Worker students.

During the course of the inspection, the Inspector(s) toured all resident home areas, medication rooms, observed dining service, medication administration, provision of care, recreation activites, resident/staff interactions, infection prevention and control practices, reviewed resident clinical records, posting of required information, meeting minutes related to the inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **6 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. 6. Plan of care

Specifically failed to comply with the following:

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

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).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

A) One identified resident required a new prescription medication.
B) A second medication the resident was receiving resulted in changes to the resident's skin integrity.
C) The resident was then diagnosed with a condition requiring oral and topical treatment.
D) Review of the resident's care plan revealed there was no documented goals or interventions for nursing staff to follow related to the resident's impaired skin integrity.
E) Three registered staff members confirmed the plan of care did not provide direction to staff related to their skin conditions.
F) The DOC confirmed her expectation that a skin care focus should have been included in this resident's care plan to set out and provide clear directions to staff and others who

provide direct care to resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A) During stage one of the Resident Quality Inspection (RQI), one Inspector observed one resident's bed equipped with two bilateral quarter length bed rails in the up position. The resident was not observed in the bed with the bed rails elevated.
B) The Inspector then observed the resident in the lounge area in a tilt wheelchair with a seat belt.
C) Review of the Point Click Care (PCC) documentation system revealed the Bed Rail/Restraint/Entrapment Assessment and Consent was completed and showed that the resident did not use a tilt wheelchair, bed rails and seat belt as Personal Assistive Safety Devices. (PASD).
D) The resident's Minimum Data Set (MDS) assessment, section J.4 indicated the resident did not use PASD's and restraints.
E) The resident care plan indicated that the resident used a seat belt and tilt wheelchair chair as a PASD. Further review of the documentation showed that the bilateral bed rails were not part of the plan of care.
F) Interviews with two nurses and two PSW's confirmed that the resident used a tilt wheelchair for positioning and was not able to change position without staff assistance. The interviews further revealed the resident was not able to remove the seat belt on their own and the bed rails were used for repositioning.
G) Further review of the resident's clinical record confirmed that the resident did not have a current order for the seat belt to be used as a restraint or PASD. As of the date of this inspection, no further assessment had been completed.
H) The home's policy "Restraints Program (Minimizing)" reviewed May 2015, indicates that a restraint or PASD may be considered in collaboration with the interdisciplinary team after alternatives have been considered and or trialed, informed consent obtained and a restraint ordered by a physician or Registered Nurse Extended Class (RNEC). The policy furthermore indicates that prior to the use of bed rails, a restraint assessment/consent or a bed rail assessment/entrapment consent will be completed and that if a restraint is required, the physician order shall include what restraining device is being ordered and instructions relating to the order. The restraint or PASD will be reviewed by the physician or RNEC at least quarterly or more frequent as needed.
I) The DOC confirmed that the resident should have had consent for the use of the bed rails and that the bed rails should be part of the plan of care and an assessment

completed on both the tilt wheelchair and the bed rails. The DOC agreed that the seat belt is no longer being used as a PASD and that a reassessment of the seat belt as a restraining device should have been completed and an order obtained by the physician with instructions for use of the restraint.
J) The DOC acknowledged the licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
A) The current bed rail/restraint assessment for one resident identified that the resident did not require bed side rails.
B) The quarterly assessment identified that the resident is at risk for falls.
C) The written plan of care includes directives for the resident's bed to be positioned at the lowest height from the floor and that a bed and chair alarm be used.
D) Inspector #144 observed that two bed side rails were in the elevated position when the resident was in bed, a bed alarm was not installed on the bed and that the bed was not positioned at the lowest point from the floor.
At this time, one registered staff shared that the resident directs staff to put their side rails up, a bed alarm wasn't needed and the the bed height should be as close to the floor as possible.
E) The Inspector on a different day, observed that two bed side rails were in the elevated position when the resident was in bed, a bed alarm was not installed on the bed and the bed was not positioned at the lowest point to the floor.
F) One nursing staff advised that the resident needed one bed side rail up when in bed, a bed alarm was not required and the bed should be positioned high enough off the floor to accommodate tray service.
On this same date, a second staff shared that the resident used two bed side rails, did not require a bed alarm and that the bed should be positioned as close to the floor as possible.
One registered staff on this same date, confirmed the resident used two bed side rails, should have the bed alarm on the bed and that the bed height should be very close to the floor.
G) The resident on interview shared that staff put their bed side rails up without direction from them.
H) The Administrator and one RPN confirmed that staff have not followed the resident plan of care as specified in the plan. [s. 6. (7)]

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 plan of care sets out clear directions to staff and others who provide direct care to the resident, 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 the policy and procedure put in place for call bells was complied with.

A) The home's Call Bells Policy, reviewed June 2013, directs that "All nursing staff have the responsibility to respond to all call bells promptly to ensure resident safety and comfort."
B) At 1400 hours on September 3, 2014, two Inspectors observed two key pad security boxes next to the the north stairwell door leading to the outside of the building. One key pad box was emitting a green light and the second, a red light.
C) Inspector #610 in the presence of maintenance personnel opened the exit door in the north stairwell without placing the key pad security system on bypass. Inspector #144 proceeded to the call bell system anunciator panel located in the main lounge on the first floor and waited for three and one half minutes for staff to respond to the audible and visual alarm. Staff did not respond within this time frame and the alarm silenced without being turned off by staff or the Inspector.
D) At 1410 hours on September 3, 2014, Inspector #144 in the presence of maintenance personnel used the key pad security system to open the door to the outside of the building in the west stair well. Inspector #610 proceeded to the call bell system anunciator panel located in the main lounge on the first floor and waited for three minutes for staff to respond to the audible and visual alarm. Staff did not respond within this time frame and the alarm silenced without being turned off by staff or the Inspector.
E) Two registered staff confirmed the alarm sound for doors leading to the outside of the building do not differ from call bell alarms for resident rooms and that all nursing personnel carry pagers that notify them of activated alarms. The nurses also confirmed that nursing staff are responsible for responding to alarms leading to the outside of the home as well as resident room alarms and that the alarms display on the staff pagers.
F) Both registered staff further confirmed that the batteries for the Charge Nurses pager were not working on this date.
G) The Administrator confirmed that the home's Call Bell policy includes staff's prompt response to alarms on doors leading to the outside of the building, that all nursing staff carry pagers that alert them to activated alarms and that staff should have responded to both alarms.
H)The Administrator on interview advised of her awareness of the discrepancy with the doors leading to the outside of the building for the past two to three months as the home was in the process of integrating wander guard bracelets into their fire safety system. [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 the policy and procedure put in place for call bells was complied with, to be implemented voluntarily.

WN #3: 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 has failed to discuss the plan of care and any other matters of importance to the resident and his or her Substitute Decision Maker (SDM) annually, and that a record is kept of the date, the participants and the results of the conferences.

A) Interview with one resident's spouse revealed that the spouse had not been invited to care conferences since admission of the resident to the home.
B) Review of the resident clinical record indicated that a multidisciplinary care conference assessment was opened in Point Click Care (PCC) in 2014 and the care conference was booked.
D) The care conference assessment for 2014 did not include documentation of any participants attending the conference. Dietary and activity staff completed the summary portion of the assessment and signed it. There was no nursing or physician summary

and no indication that annual consents were signed. Review of the progress notes for these dates did not indicate that the conference had been canceled and or rescheduled.
E) Further review of the clinical record revealed that a care conference had been booked for 2015 and that a multidisciplinary care conference assessment had been opened in PCC. There was no documentation in the PCC program of attendance of staff or the Power of Attorney (POA) at the conference and no dietary, activation and physician summary. There was no indication that annual consents had been signed however, there was a nursing summary completed and signed by a registered staff member.
F) Review of the progress notes indicate that a phone call was made to the POA to reschedule the 2015 care conference. There was no further follow up documentation in the progress notes regarding the 2015 care conference.
G) Interviews with the Ward Clerk and two registered staff confirmed that the care conference assessments for 2014 and 2015 were incomplete and that the conferences did not occur.
H) The policy regarding Multi-Disciplinary Team Conferences: Plan of Care Review last revised September 2014, indicated that a multidisciplinary team will meet on a regular schedule with participation from all departments if able, and a Substitute Decision Maker (SDM) and /or POA and, if these persons are unable to attend, the conference can be conducted over the telephone. If the SDM and/or POA is unable to attend or are a no show, the team will continue with the care conference and the POA will have a telephone messages left and all attempts to contact the POA will be documented on all shifts for two days.
I) The DOC confirmed the above multidisciplinary care conferences for this resident did not occur and that the documentation in these assessments was incomplete. The DOC further stated it is her expectation that multidisciplinary care conferences occur annually and that the summaries within the assessments are completed by each discipline prior to the care conference. [s. 27. (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 the plan of care and any other matters of importance to the resident and his or her SDM annually, and that a record is kept of the date, the participants and the results of the conferences, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that restraint plan of care included the consent by the resident or if the resident is incapable, by SDM.

A) During stage one of the RQI, one Inspector observed a resident with bilateral quarter length bed rails in the up position. The resident was not observed in the bed.
B) The Inspector observed the resident in a wheelchair that was tilted. The resident was wearing a seat belt.
C) A review of the PCC documentation showed that the resident had a physician's order for a seat belt to be used as a PASD.
D) An interview with two nurses and two PSW's revealed that the resident was not able to undo the seat belt or change position without staff assistance and that staff complete the task of releasing the seat belt, repositioning, visual checks at least hourly and document in Point of Care (POC).
E) The home's policy on Minimizing Restraints Program directs nursing staff to obtain and record informed consent that includes the risks and benefits of alternative treatment options as well as risks and benefits related to the restraint.
F) Review of the resident's clinical record and POC showed that the resident did not give consent to use a seat belt, tilt wheelchair or bed rails.
G) The DOC confirmed that the resident should have gave consent for use of bed rails and tilt wheelchair which were being used as a PASD. The DOC also confirmed that the seat belt was being used as a restraint and required consent from the resident's Public Trustee. [s. 31. (2) 5.]

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 restraint plan of care included the consent by the resident or if the resident is incapable, by the SDM, 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 has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, be reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

A) One resident developed impaired skin integrity that was documented on the home's Skin Condition Monitoring Tool.
The wound was assessed by the physician and treatment started.
Documentation continued on the Skin Condition Monitoring Tool weekly until an identified date when the area was assessed by nursing personnel as being resolved.
B) On two occasions, Inspector #518 observed the resident with a dressing over the impaired skin area. Interview with three registered staff revealed that they were either unaware of the dressing, unaware of the impaired skin integrity or believed it was a protective dressing to cover the impaired area of the skin.
A registered staff member removed the dressing and revealed a healing area of impaired skin. There was no documentation of the healing area on a Skin Condition Monitoring Tool.
C) The home's Skin Care Management Program last revised December 2014, directs registered staff to assess the compromised skin condition and/or wound on a weekly basis unless otherwise indicated by the physician.
D) The DOC confirmed it was her expectation that all alterations in a residents skin integrity be reassessed on a weekly basis using the Skin Condition Monitoring Tool. [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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, be reassessed 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 O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee did not ensure unused/discontinued narcotics were stored in an area or medication cart that is used exclusively for drugs and drug related supplies.

A) During a review of the narcotic medication storage system, one RN indicated that the unused/discontinued narcotic box was located in the DOC's office.
B) Interview with the DOC and observation confirmed the presence of a locked metal box in an unlocked filing cupboard in the DOC's office containing unused/discontinued narcotic medication.
C) The DOC confirmed unused/discontinued narcotic medication was stored in her office under one lock but that the office door was locked when she was not present. The DOC further confirmed other Managers of the home have key access to her office therefore, the unued/discontinued narcotic medications are not double locked at all times. [s. 129. (1) (a)]

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 unused/discontinued narcotics were stored in an area or medication cart that is used exclusively for drugs and drug related supplies, to be implemented voluntarily.

Issued on this 29th day of October, 2015

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

Original report signed by the inspector.