Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London Service Area Office
130 Dufferin Ave, 4th Floor
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Original Public Report

Report Issue Date September 8, 2022
Inspection Number 2022_1251_0001
Inspection Type
☐ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☒ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Universal Care Canada Inc.

Long-Term Care Home and City
Regency Park Long Term Care Home
Windsor Ontario

Lead Inspector
Debra Churcher #670

Debra Churcher
2022.09.08 07:45:06
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Choose an item.

Additional Inspector(s)
Cassandra Taylor #725
Julie D'Alessandro #739
Inspector #740915 Jennifer Bertolin and Inspector #740895 Andrea Dickenson were also present for this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 9, 10, 11, 12 and 15, 2022.

The following intake(s) were inspected:

- Log# 015100-22 related to a Proactive Compliance Inspection.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Personal Support Services
- Prevention of Abuse and Neglect
- Quality Improvement

- Residents' and Family Councils
- Resident Dignity, Choice and Privacy
- Safe and Secure Home
- Skin and Wound Prevention and Management

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable. There were findings of non-compliance.

NON-COMPLIANCE REMEDIED-DINING

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 S. 79. (1). 1.

The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements, communication of the seven-day and daily menus to residents.

Rationale and Summary
During the dining observation on August 9, 2022, the posted menu on the first floor was cream of potato soup; choice one was salami and cheese sandwich, tomato country style salad and watermelon wedge for dessert and choice two was macaroni and cheese casserole, chefs salad and tapioca pudding for dessert.

During the observation no country tomato salad was served instead it was country potato salad and for dessert yogurt and mix melon of cantaloupe and honeydew were served.

During an interview with a Dietary Aide and the Dietary Manager, both indicated that when a menu item was not available or needs to be switched out, communication needs to be placed on the menu for the residents to be aware. The menus were updated during subsequent meals for resident awareness.

Sources
Lunch dining observation and staff interviews with both a Dietary Aide and the Dietary Manager.

Date Remedy Implemented: August 10, 2022.
[#725]

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NON-COMPLIANCE REMEDIED-INFECTION PREVENTION AND CONTROL

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#002 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 102. 2. (b)

The licensee has failed to ensure that they implemented, any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary
IPAC Standard 10.1 stated, “The licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.”

Public Health Ontario Fact Sheet Titled, Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes stated “do not use expired product. Be sure to note product expiration date when selecting product.”

During the initial tour of the home on August 9, 2022, Aloe Med ABHR pumps were observed on the medication carts on all three floors which had an expiration date of October 2020.

During an interview with the Acting Director of Care(ADOC) they stated that the Aloe Med ABHR pumps were being refilled with another product however, they were unable to verify that the product being used to refill the pumps was not expired due to no longer having the original packaging for that product in the home.

On August 10, 2022, an observation was completed of ABHR on the medication carts on all three floors which had been replaced with a Spectrum ABHR pump with an expiry date of November 2022.

Sources
Observations and interview with the ADOC.

Date Remedy Implemented: August 10, 2022.

[739]

WRITTEN NOTIFICATION- AIR TEMPERATURE

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 24. (1)

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary
Review of the homes temperature log showed the following temperatures in the home to be below 22 degrees Celsius;
August 1, 2022, 1pm a resident room temperature was 21.7
August 3, 2022, 5 pm a resident room temperature was 21.9
August 4, 2022, 5pm a resident room temperature was 21.5, a subsequent resident room temperature was 21.9, first floor lounge 21.6.
August 5, 2022, 7am a resident room temperature was 21.4, 2nd floor lounge temperature 21.7.
August 6, 2022, 7am common area first floor (nurses desk) temperature 21.8
August 6, 2022, 5pm a resident room temperature was 19, first floor nurses desk temperature 19, second floor lounge temperature 19.8 and third floor lounge temperature 20.
August 7, 2022, 7am a resident room temperature was 21.4, first floor lounge temperature 21.9, third floor lounge 21.8
August 7, 2022, 1pm second floor lounge temperature 21.9.
August 8, 2022, 7am a resident room temperature was 21.4
All temperatures were measured in degrees Celsius.

During an interview with a resident they stated there were times when they were cold.

During an interview with another resident they stated there were times they found the home cold, especially at night and in the mornings.

During an interview with the Acting Director of Care (ADOC) they stated that if the temperature was below 22 degrees Celsius it would be the expectation that the Registered Nurse (RN) on duty would adjust the thermostat and retake the temperature.

The home's Hot Weather Prevention an Illness Management policy stated "The home will ensure that the indoor ambient air temperature is maintained at a minimum of 22 degrees Celsius."

Sources
Temperature logs, interviews with two residents and the ADOC and the homes Hot Weather Prevention an Illness Management policy.

[#670]

WRITTEN NOTIFICATION-AIR TEMPERATURE

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 24. (3).

The licensee has failed to ensure that the temperature required to be measured under subsection (2) was documented at least once every morning, once every afternoon between 12 pm and 5 pm and once every evening or night.

Rationale and Summary
Review of the homes temperature logs show that temperatures were to be taken at 7 am, 1pm and 5pm in two resident rooms, and a common area on each floor. This inspector was unable to locate temperatures for the following dates and times;
-July 31, 2022, at 5pm.
-August 2, 2022, at 1 pm and 5pm.
-August 6, 2022, at 1pm in all areas except one resident bedroom.
-August 7, 2022, at 5pm.
-August 8, 2022, at 5pm.

During an interview with the Acting Director of Care (ADOC) they stated that they have had some difficulty getting the temperatures completed specifically when they had agency staff working.

The home's Hot Weather Prevention and Illness Management policy stated, "The ambient air temperature must be measured and documented in writing, there times per day, once in the morning, once in the afternoon between 12:00pm-5:00 pm and once in the evening/night. These temperature records must be kept in writing for at least one year."

Sources
The homes temperature logs, interview with the ADOC and the homes Hot Weather Prevention and Illness Management policy.

[#670]

WRITTEN NOTIFICATION-CONTINUOUS QUALITY IMPROVEMENT

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 168. (6). (a)

The licensee has failed to ensure the interim report prepared under subsection (5) was published on the home's website RegencyParkLTC.ca.

Rationale and Summary
This Inspector was unable to locate the Continuous Quality Improvement (CQI) Interim Report on the homes' website.

During an interview with the Acting Director of Care (ADOC) and the Corporate Director of Senior Living (CDSL) they confirmed the homes website was RegencyParkLTC.ca and that the Interim CQI report was not posted.

Sources
The homes website RegencyParkLTC.ca and interview with ADOC and CDSL.

[#670]

WRITTEN NOTIFICATION-MEDICATION DESTRUCTION

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 148. (2). 1.

The licensee has failed to ensure that drugs that were to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that were available for administration to a resident, until the destruction and disposal occurs.

Rationale and Summary
This Inspector observed a pail in the second floor medication room 75 percent full of medications. There was a large hole in the top of the pail with a screw top that was removable and the pail was not secured.

During an interview with the Acting Director of Care (ADOC) they stated that non-controlled medications that were to be destroyed would be stored in a pail in each medication room. ADOC acknowledged that while they did not recall there ever being a issue in the home the medications in the pail could be removed.

The homes' Non-controlled Medication Destruction policy stated, "The home ensures that medication is destroyed and disposed of, they are stored safely and securely within the home."

Sources
Observation of the non-controlled medication for destruction storage pail, interview with ADOC and the homes' Non-controlled Medication Destruction policy.

WRITTEN NOTIFICATION- MEDICATION DESTRUCTION

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 148. (2). 2.

The licensee has failed to ensure that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs.

Rationale and Summary
During an interview with a Registered Practical Nurse (RPN) they stated that if a controlled substance was discontinued they would give it to the Acting Director of Care (ADOC) for destruction and if the ADOC was not in the building they would keep the controlled substance

in the locked controlled substance drawer in the medication cart with the current medications and continue to count the medications until the ADOC was back in the building.

During an interview with the Acting Director of Care (ADOC) they stated that controlled medications that were to be destroyed would remain in the locked drawer in the medication cart until they were in the building to remove them. The ADOC acknowledged that if they were not in the building, controlled substances to be disposed of would be stored with controlled substances available for administration to residents.

The homes' Narcotic and Controlled Medication Destruction policy stated, "Any Narcotic or Controlled substance to be disposed of must be stored separately from any medication available for administration to a resident."

Sources
Interview with the ADOC and an RPN and the homes' Narcotic and Controlled Medication Destruction policy.

[#670]

WRITTEN NOTIFICATION-MEDICATION DESTRUCTION

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 148. (3). (b)

The licensee has failed to ensure that drugs were destroyed by a team acting together and composed of, in every other case, one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing and Personal Care.

Rationale and Summary
During an interview with a Registered Practical Nurse (RPN) they stated that when they were putting medications into the non-controlled substance destruction pail they do this alone and a second person was not required.

During an interview with the Acting Director of Care (ADOC) they stated that staff place non-controlled medications that were to be destroyed in the destruction pail and do not complete this with two persons.

The homes' Non-controlled Medication Destruction policy stated, "Medication destruction is completed by the DOC or DOC designate (e.g. Registered Nurse) and another staff member appointed by the DOC (e.g. ward clerk, personal support worker or environmental services worker)."

Sources
Interview with the ADOC and an RPN and the homes' Non-controlled Medication Destruction policy.

[#670]

WRITTEN NOTIFICATION-DINING

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.79. (1). 9.

The licensee failed to ensure that a resident was in the correct position for dining.

Rationale and Summary
During a dining observation a resident was observed being fed in a specific position.

The home's policy, Eating Assistance, NUR 03-01-12, last revised August 11, 2022, documented that for "dining and snack service Proper techniques to assist residents with eating, including safe positioning of residents that require assistance."

The Dietary Manager indicated that residents were required to be in a proper position for eating and confirmed a specific resident was not care planned to be in the specific position they were observed in for dining and the resident was removed from the incorrect position.

Sources
Observation, the home's policy and staff interview with the Dietary Manager.

[#725]

WRITTEN NOTIFICATION-INFECTION PREVENTION AND CONTROL

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102. (8)

The licensee failed to ensure that a PSW participated in the IPAC program

Rationale and Summary
During an observation a Personal Support Worker (PSW) was observed walking out of a room that required specific IPAC precautions, without Personal Protective Equipment (PPE) on and the afternoon snack cart. The PSW indicated that they would follow the IPAC additional precaution signage and that they did not see it in this case.

During an interview with the Acting Director of Care (ADOC) they indicated it is the expectation of all staff to follow the IPAC program and designated signage to use the appropriate PPE.

Sources
Observation and staff interviews with a PSW and the ADOC.

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