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 13, 2015	2015_247508_0006	H-001049-14	Complaint

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

ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 31, April 1, 2015

LTC Homes Inspector toured the facility, observed provision of care, reviewed clinical records, relevant policies and procedures, maintenance log and interviewed staff.
This complaint inspection was conducted concurrently with inspection ~~#H-002424-15~~ #H-002428-15. la sep 21/15

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Personal Care Providers (PCP), Environmental Services Coordinator, residents and families

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for resident #100 who demonstrated responsive behaviours, actions were taken to respond to the needs of the resident including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A) Resident #100 was identified as having responsive behaviours which included being resistive to care. A review of the resident's clinical record indicated that goals and interventions had been developed and implemented to manage the resident's responsive behaviours.

The resident continued to demonstrate these responsive behaviours and continued to refuse care in November and December, 2014, and in January, 2015. The resident's clinical record indicated that during this period of time, the resident did not receive personal hygiene as per their plan of care as a result of the demonstrated behaviours. The resident's responsive behaviour plan of care including the interventions had not been reassessed from November, 2014, to January, 2015.

B) Resident #100 exhibited responsive behaviours which included being resistive to care. Interviews with the Personal Care Providers (PCP) and a review of the clinical records verified that resident #100 would refuse care intermittently and staff could not always provide all of their personal care as required.

The Director of Care (DOC) indicated during an interview that it is the home's expectation that when a resident is resistive to care and care is not provided to the resident, the PCP's must report this to the registered staff, the registered staff are required to document the information reported by the PCP's and any actions taken in the progress notes.

A review of the PCP's documentation in Point of Care (POC) for December, 2014, and January, 2015, indicated that resident #100 was resistive to care on seven separate occasions and did not receive all of their personal care. The registered staff did not document these occurrences, including the resident's responses or any interventions taken in the progress notes.

It was confirmed by the Director of Care the actions taken to respond to the needs of the resident including reassessments, interventions and the resident's responses to interventions had not been documented. [s. 53. (4) (c)]

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 for residents who demonstrate responsive behaviours, actions are taken to respond to the needs of the resident including assessments, reassessments and interventions and that the resident's responses to interventions are documented., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #100 received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

Resident #100 required total assistance with personal hygiene including oral care, twice daily. A review of the resident's clinical record indicated that the resident would refuse oral care intermittently due to responsive behaviours which included being resistive to care. A review of the Point of Care (POC) documentation for December, 2014, and January, 2015, indicated that in December, 2014, the resident did not receive oral care on five separate dates. In January, 2015, the resident did not receive oral care on nine separate dates. The documentation related to responsive behaviours did not indicate that the resident was resistive to care.

It was confirmed during interviews with staff on April 1, 2015, that the resident did not receive oral care in the morning and in the evening on these identified dates. [s. 34. (1) (a)]

Issued on this 29th day of May, 2015

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

Original report signed by the inspector.