Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: January 5, 2023	
Inspection Number: 2022-1338-0002	
Inspection Type: Critical Incident System	
Licensee: Liuna Local 837 Nursing Home (Hamilton) Corporation	
Long Term Care Home and City: Queen's Garden, Hamilton	
Lead Inspector Emma Volpatti (740883)	**Inspector Digital Signature** Emma Volpatti Digitally signed by Emma Volpatti Date: 2023.01.06 12:08:53 -05'00'
Additional Inspector(s) Yuliya Fedotova (632) was on-site during this inspection	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): December 12-14, 16, 19-21, 2022

The following intake(s) were inspected:

- Intake #00013741: Critical Incident System (CIS) report number 2853-000020-22 regarding falls prevention and management.
- The following intake(s) were completed in this inspection: Intake #00003020, CI# 2853-000014-21; Intake #00003486, CI#2853-000016-21; Intake #00003494, CI: 2853-000012-22; Intake #00005110, CI#2853-000002-22; Intake #00006084, CI#2853-000005-22 and Intake #00006976, CI#2853-000011-22 were all related to falls.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

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)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs were no longer necessary related to medication use.

Rationale and Summary

A resident's plan of care stated that they were receiving a specific medication and staff were to use extra precautions during care. Review of the resident's medication orders showed that the physician had discontinued this medication on a specified date. The Infection Prevention and Control (IPAC) lead confirmed that the plan of care should have been revised when the medication was discontinued.

On a day in December 2022, the resident's plan of care was revised to reflect that the care needs had changed in relation to medication use.

There was no risk to the resident as they did not require additional precautions since the medication had been discontinued.

Sources: a resident's medication orders, interview with the IPAC lead, a resident's plan of care. **[740883]**

Date Remedy Implemented: December 19, 2022

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

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

A) The licensee failed to ensure that the IPAC Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes, indicated under section 6.1 that the licensee shall make personal protective equipment available and accessible to staff and residents, appropriate to their role and level of risk.

On December 12, 2022, Long Term Care Home (LTCH) inspector observed eight resident rooms under additional precautions. The personal protective equipment (PPE) storage cart for each room was either missing the required type of gloves needed for those precautions and/or gowns. The home's policy stated that an adequate supply of PPE shall be maintained in a readily accessible manner to the location.

Three Registered Practical Nurses (RPNs) and a Personal Support Worker (PSW) acknowledged that some of the rooms were missing the required type of gloves and/or gowns.

On December 19, 2022, gowns and/or the required type of gloves were observed to be available for the eight resident rooms.

There was minimal risk to the residents when the required type of gloves and/or gowns were not accessible to the staff.

Sources: Interviews with RPNs and a PSW, the home's policy, IPAC Standard for Long-Term Care Homes (April 2022). **[740883]**

B) The licensee failed to ensure that the IPAC Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (e) point-of-care signage indicating that enhanced IPAC control measures are in place.

On December 16, 2022, LTCH Inspector observed a resident's room. There was additional precaution signage at the entrance to the room stating the resident required droplet contact precautions.

The resident's plan of care indicated that they required contact precautions. Interview with an RPN confirmed that the resident did not require droplet contact precautions but required only contact precautions.

On December 19, 2022, LTCH inspector observed the resident's room with contact precaution signage present on the door.

There was no risk to the resident as they required less precautions than the signage present.

Sources: Observations of a resident's room, a resident's plan of care, interview with an RPN**. [740883]**

Date Remedy Implemented: December 19, 2022

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 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 all staff participated in the implementation of the infection prevention and control program.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that all staff participate in the implementation of the Infection Prevention and Control program.

Specifically, staff did not comply with their policy, which was included in the licensee's Infection Prevention and Control program.

Rationale and Summary

On an identified date, a resident was transferred to the hospital. Upon return to the home on a later date, the resident was not provided a specified test. The home's policy stated that upon return from a hospital stay longer than 12 hours in length, a resident should undergo a specified test.

The IPAC lead confirmed that the resident was not tested after returning from the hospital.

Failure to test the resident put them at risk of an undetected change in condition and other residents at risk of the same.

Sources: Interview with the IPAC lead, the resident's census record, the home's policy.
[740883]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM
NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection are recorded and that immediate action is taken to reduce transmission, isolate residents and place them in cohorts as required.

Rationale and Summary

On an identified date, a resident began to display signs and symptoms of an infection. The physician ordered for the resident's symptoms to be monitored once daily. Five days later, the physician ordered a medication for the resident to be administered once a day for seven days.

The home's policy stated that any resident who has symptoms of an infection must have their symptoms recorded daily on a specific tracking sheet. Interview with an RPN confirmed that

there was no tracking sheet recording the resident's symptoms during the course of their infection.

The IPAC lead confirmed the expectation is that staff complete the daily tracking sheet when a resident has an infection.

Failure to record the resident's symptoms every shift put the resident at risk of worsening symptoms being undetected.

Sources: Interview with the IPAC lead and staff, the homes policy. **[740883]**

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM
NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that the IPAC Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) additional PPE requirements including appropriate selection and application.

On a date in December 2022, the LTCH inspector observed an RPN begin to enter a resident's room that was under contact precautions. The RPN completed hand hygiene, put on gloves and then a gown. The RPN confirmed that they were going into the resident's room to administer medication through a specified route.

The home's policy references a best practice document which states the recommended steps for putting on personal protective equipment (PPE) is to perform hand hygiene, put on a gown and then put on gloves.

Failing to put on PPE in the correct order posed a risk of spreading infection to other residents.

Sources: Observations of an RPN, the home's policy. **[740883]**

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)

The licensee failed to ensure that the falls prevention and management program provided for assessment and re-assessment tools.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the Falls Prevention and Management program provided for assessment and re-assessment tools.

Specifically, staff did not comply with their policy which indicated that for any fall that is unwitnessed, head injury routine (HIR) must be completed for 48 hours. This policy was included in the licensee's Falls Prevention and Management program.

Rationale and Summary

A resident had four unwitnessed falls since their admission to the home.

Upon review of the resident's clinical records, there were HIR forms started for each of the four unwitnessed falls, but they were not fully completed as per the instructions on the form. The Director of Care (DOC) confirmed the expectation is that HIR is completed fully for any unwitnessed fall, and that HIR was not fully completed for 48 hours for any of the four unwitnessed falls that the resident had.

Failing to fully complete the HIR forms for the resident when they fell posed a risk of not identifying a possible head injury.

Sources: Interview with the DOC, the homes policy, the resident's clinical records. **[740883]**

COMPLIANCE ORDER CO #001: PLAN OF CARE

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. The Licensee shall complete audits of a specified resident every shift for two weeks to ensure that the plan of care is followed in relation to two fall prevention interventions; and
2. Complete random audits for three months following the completion of the two-week audit, at a frequency decided by the home of the specified resident to ensure that the plan of care is followed in relation to two fall prevention interventions; and
3. Keep a record of the audits for the LTCH inspector to review.

Grounds

The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

A) On a date in December, 2022, the LTCH inspector observed a resident in the dining room. The resident did not have a specified intervention in place. Upon review of the resident's plan of care, it was indicated that the resident was a high risk for falls. Their fall prevention interventions stated they were to have a specified intervention in place.

A Registered Nurse (RN) confirmed that the resident was to have a specified intervention in place.

Sources: Interview with an RN, the resident's plan of care, observations of the resident. **[740883]**

B) A Critical Incident (CI) report was submitted to the Director regarding a resident fall with injury resulting in a transfer to hospital.

Review of a resident's clinical record indicated that on an identified date, the resident had a fall. Upon assessment by an RN, it was determined the resident required further medical attention

and was subsequently transferred to the hospital. The resident sustained an injury and required surgical intervention.

At the time of the resident's fall, their plan of care indicated they were to have a specified intervention applied at all times for injury prevention. The DOC confirmed they conducted an investigation into the fall and determined through staff interviews that the specified intervention was not in place at the time of the resident's fall.

An RN acknowledged that part of the resident's fall interventions included a specified intervention, and when they assessed the resident after they fell, they did not have the specified intervention applied.

Failing to follow the resident's plan of care in relation to fall interventions, posed a significant impact on the resident when the fall resulted in an injury.

Sources: CI report #2853-000020-22, interview with the DOC and staff, the resident's plan of care. **[740883]**

This order must be complied with by: January 26, 2023

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

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.