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
Telephone: (800) 461-7137

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 10, 2023
Original Report Issue Date: May 2, 2023
Inspection Number: 2023-1338-0003 (A1)
Inspection Type: Complaint Follow up
Licensee: Liuna Local 837 Nursing Home (Hamilton) Corporation
Long Term Care Home and City: Queen's Garden, Hamilton

Amended By	**Director who Amended Digital Signature**
Phyllis Hiltz-Bontje (129)	

AMENDED INSPECTION SUMMARY

This report has been amended to:
This Public Inspection report has been revised to reflect the Licensee Report. This inspection 2023_1338_0003 was completed on April 3, 2023.

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Lead Inspector Phyllis Hiltz-Bontje (129)	**Additional Inspector(s)**
Amended By Phyllis Hiltz-Bontje (129)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
This Public Inspection report has been revised to reflect the Licensee Report. This inspection 2023_1338_0003 was completed on April 3, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 13-17, 20- 23, 27-31, April 3, 2023.

The following intake(s) were inspected:

- Intake: #00005770 - Complainant related to Pest control.
- Intake: #00015213 - Complainant related to wound care, assessments, bathing, Physician visits and notifying the Substitute Decision Maker.
- Intake: #00017582 - Follow-up related to FLTCA, 2021, s. 6 (7) from inspection #2022-1338-0002 - Compliance Due Date of January 26, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1338-0002 related to FLTCA, 2021, s. 6 (7) inspected by Phyllis Hiltz-Bontje (129)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure the Substitute Decision Maker (SDM) designated by a resident was given the opportunity to participate fully in the development and implementation of the residents' plan of care when the SDM was not notified of a change in the residents' health status.

Rational and Summary

A resident designated a family member to act as their SDM for care and finances, as well as their Emergency Contact #1, Next of Kin, and Designated Essential Visitor.

The residents' clinical record indicated the resident began to feel unwell and over the course of the

following 14 days the residents' condition continued to worsen and the resident was transferred to hospital for treatment.

The resident, their SDM and the clinical record confirmed staff had not contacted the SDM when the residents' health condition worsened. The SDM verified that the first time they were made aware that the residents' health had worsened was 14 days after the resident began to feel unwell and several hours after the resident had been transferred to hospital.

The Director of Care (DOC) confirmed they had not provided information to staff related to the circumstances under which staff should communicate with a residents' SDM.

Sources: A residents' clinical progress notes and interviews with the resident, the SDM and the DOC. [129]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure wound care was provided to a resident as directed in the resident's plan of care.

Rational and Summary

A residents' plan of care, specifically the electronic Treatment Administration Record (TAR) directed that over two months in 2022, staff were to provide a specified treatment to an identified wound. The TAR also directed that staff were to change the dressing on specific days and as necessary.

A review of the TAR for the first month indicated the specific treatment had not been provided on two occasions.

A review of the TAR for the second month indicated the specific treatment had not been provided on one occasion.

The licensee's "Wound Care Treatment" policy directed; "completion of wound care treatments are to be documented on the Treatment Administration records".

The Wound Care Lead indicated they did not complete audits of wound care provided to the resident and was not aware that the wound care identified in the plan of care had not been provided to the resident.

There was an increased risk that the residents' wound may worsen when staff did not consistently provide the treatments identified in the residents' plan of care.

Sources: A residents' Treatment Administration Records, Licensee's "Wound Care Treatment" policy and an interview with the Skin and Wound lead.
[129]

WRITTEN NOTIFICATION: Required Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.

The licensee failed to ensure the required skin and wound program was fully implemented when staff failed to comply with the program policies and procedures when caring for a residents' wounds.

In accordance with O. Reg 246/22, s. 34 (1) 1, the long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation: there must be a written description of the program that includes relevant policies and procedures.

In accordance with O. Reg. 246/22, s 11 (1) (b) 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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative, or system, is complied with.

Rational and Summary
Staff did not fully implement the licensee's skin and wound care program when they did not comply with the "Skin Care Program Overview" policy.

a) The licensee's "Skin Care Program Overview" policy directed; "the focus of the skin care program was on promoting skin integrity, which included weekly assessment of areas of altered skin integrity".

A residents' clinical record, and information provided by the resident indicated that they had altered skin on two areas of their body and subsequently developed multiple additional areas of altered skin integrity.

Staff did not comply with the policy direction to complete weekly assessments when they did not initiate or complete weekly skin assessments for the resident on eight occasions over four months.

The Skin and Wound Program lead confirmed they expected skin assessments that had been initiated would have been completed and all residents who demonstrated altered skin integrity would be assessed weekly until the area had healed. They acknowledged that weekly skin assessments had not been completed for the resident.

b) The "Skin Care Program Overview" policy directed that registered staff would complete a risk assessment using the ONT-Pressure Sore Risk assessment in Point Click Care following any readmission from hospital, or with any newly identified alteration to skin integrity.

A resident returned from hospital in 2022, with multiple areas of altered skin integrity.

Staff did not comply with this policy direction when they did not initiate a pressure sore risk assessment when the resident returned from hospital.

The Skin and Wound Program lead confirmed that staff had not completed a pressure sore risk assessment for the resident when they returned from hospital.

c) The policy directed, "residents with a total score of 16 or less on a pressure sore risk assessment were at risk for developing pressure ulcers and would have a preventative skin care plan developed".

At the time of the inspection a RN confirmed a pressure sore risk assessment had not been completed as per the policy. The RN completed a pressure sore risk assessment for the resident, which resulted in an outcome score of 15. The residents' plan of care and the RN confirmed that a preventative skin care plan had not been developed for the resident.

Sources: A residents' skin and wound assessments, a pressure sore risk assessment, Licensee's Skin Care Program Overview policy, and an interview with a RN.
[129]

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that when a resident demonstrated altered skin integrity the resident was reassessed at least weekly by a member of the registered nursing staff.

A residents' plan of care indicated they had an area of altered skin integrity. A review of weekly skin assessments in the residents' electronic record indicated that over two months the required weekly skin assessments had not been completed on four occasions.

The resident's clinical notes indicated the resident subsequently developed additional areas of altered skin integrity and over following two months, weekly skin assessments had not been completed on three occasions.

A Registered Nurse (RN) confirmed that registered staff had not initiated or completed weekly skin and wound assessments for this resident.

Sources: a Residents' skin and wound assessments records**,** and an interview with a RN.
[129]

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a)

The licensee failed to ensure that as part of the organized program of housekeeping under clause 19 (1) of the Act, procedures were implemented for cleaning of the home; specifically, the serveries and the kitchen.

Rationale and Summary

Multiple serveries were noted to be unclean.

The "Chartwell Retirement Residences Environmental Services Manual" identified that all cleaning in the kitchen, other than the floors will be performed by dietary staff.

Cleaning schedules provided by the Food and Nutrition Manager (FNM) indicated that cleaning of the serveries and the kitchen had not been completed as required.

The Environmental/Maintenance Supervisor (EMS) and the FNM who toured a home area servery with the inspector, acknowledged the unclean condition of the servery.

The FNM acknowledged that the daily and deep cleaning tasks for the serveries and the kitchen had not been completed as required.

Pest control service records indicated they visited the home three times over a two-month period and on all three occasions recommended that "the kitchen be deep cleaned with a bleach additive to remove possible cockroach attractions".

Failure to implement procedures for cleaning of the kitchen and the serveries increased the risk of pest infestations which, may jeopardize the health and wellbeing of residents.

Sources: Direct observation, "Chartwell Retirement Residences Environmental Services Manual", cleaning procedures and schedules, cleaning records for serveries and the kitchen, and interviews with FNM and EMS.
[129]

COMPLIANCE ORDER CO #001 Infection Prevention and Control Program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 102 (8) [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:
1. The type of staff retraining required related to contact precautions and direct care, the name of the

person responsible for the retraining and when the retraining will be completed.

2. The person responsible for monitoring that staff wear appropriate PPE when providing direct care to the resident #001 who required additional contact precautions and how the monitoring will be documented.

3. The person responsible to implement and document an action plan if monitoring demonstrated staff have not complied with the policy; and

4. Actions taken to address sustainability once the home has been successful in ensuring compliance with the use of Personal Protective Equipment (PPE) when providing direct care to a resident who requires additional contact precautions.

Please submit the written plan for achieving compliance for inspection #2023_1338_0003 to Phyllis Hiltz-Bontje, LTC Homes Inspector, MLTC, by email to hamiltondistrict.mltc@ontario.ca by May 9, 2023.

Please ensure that the submitted written plan does not contain any PI/PHI.

This plan shall be implemented by the compliance due date of; July 30, 2023.

Grounds
The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program related to the use of Personal Protective Equipment (PPE).

Rational and Summary

All staff did not participate in the implementation of the IPAC program when Personal Support Workers (PSW) did not don gowns prior to providing personal care to a resident.

The licensee's IPAC program directed that any resident who had been diagnosed with or was suspected of having an illness requiring the use of contact precautions, that staff were to immediately implement the additional precautions, including the use of gloves and gowns, as well as following routine precautions.

A "Contact Precaution" sign posted on the resident's door indicated that when providing direct care to the resident staff where required to don a gown.

Gowns were noted to be available in an IPAC cart that was in in place outside the resident's room.

Both PSWs confirmed they had not donned gowns when they provided direct care to the resident.

The Administrator confirmed that it was the expectation that when PSWs provided personal care for a resident who required additional contact precautions, they would don gowns as well as use gloves and masks.

Sources: Observations of the residents' room and the actions of PSWs , Licensee Policy "Routine Practices and Additional Practices", as well as interviews with two PSWs and the Administrator. [129]

This order must be complied with by July 30, 2023

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.