Ontario

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

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: October 17, 2023	
Inspection Number: 2023-1338-0005	
Inspection Type: Critical Incident Follow up	
Licensee: Liuna Local 837 Nursing Home (Hamilton) Corporation	
Long Term Care Home and City: Queen's Garden, Hamilton	
Lead Inspector Phyllis Hiltz-Bontje (129)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 15, 16, 17, 18, 21, 22, 23, 24, 25, 28, and September 1, 2023.

The following intake(s) were inspected:

- Intake: #00087117 -Follow-up #: 1 - IPAC, O. Reg. 246/22 - s. 102 (8), Inspection #2023-1338-0003 (A1), CDD: July 30, 2023.
- Intake: #00090062 -2853-000007-23 - Resident fall resulting in injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1338-0003 related to O. Reg. 246/22, s. 102 (8) inspected by Phyllis Hiltz-Bontje (129)

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

Infection Prevention and Control
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Minimizing Restraining

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 33 (1) (b)

The licensee has failed to ensure staff complied with the Licensees written policy to minimize the restraining of residents when all other alternatives to the use of a physical restraint where not considered prior to implementing a physical restraint for a resident.

Rational and Summary

The Fixing Long-Term Care Act requires the licensee to have a written policy to minimize the restraining of residents and requires the licensee to comply with the directions included in the policy.

The licensee's current policy, "Physical Restraint", last revised December 2017, directed: "the right to freedom of movement should only be infringed upon when all other alternatives have been considered and found to be ineffective and in all cases, the application of a physical restraint is the decision of last resort, and only after all other options have been exhausted".

The licensees restraint assessment form directed staff to document all alternatives to use of a restraint that were trialed and found to not be effective.

The three restraint assessments that had been completed for the resident, indicated that no alternatives to the use of a restraint were considered before the implementation and the ongoing use of a restraint

for the resident.

The DOC confirmed the restraint assessments completed for the resident identified that no alternatives to the use of the restraint were considered or trialed prior to the implementation of the restraint.

Sources: Licensee's "Physical Restraint" policy # LTC-CA-WQ-200-07-19, restraint assessments completed on 11/03/22, 02/13/23 and 05/06/23 and an interview with the DOC.
[129]

WRITTEN NOTIFICATION: Required Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure staff fully implement the required Falls Prevention and Management Program when they failed to ensure staff complied with the Head Injury Routine protocol included in the program.

In accordance with O. Reg. 11 (1) (b) where the license is required to have a program, policy or protocol they are to ensure the program, policy or protocol is complied with.

Rationale and Summary

The licensee's required Falls Prevention Program directed: "when a resident has fallen, head injury routine/neurological assessment will be initiated for 48 hours if there is a suspected head injury or an unwitnessed fall.

A Critical Incident Report submitted by the home, indicated that a Personal Support Worker (PSW) found the resident sitting on the floor, the restraint was undone and the resident had sustained a head injury.

In accordance with the licensee's Head Injury Routine (HIR) protocol, staff were to continue to complete the protocol every four hours for 24 hours after the fall and then every 12 hours until 48 hours after the fall.

The DOC and a Head Injury Flow Sheet confirmed staff had not complied with the HIR protocol when they did not complete the assessments as directed in the policy.

Sources: Critical Incident System Report #2853-000007-23, licensee policy "Resident Fall Prevention Program, Head Injury Routine Flow Sheet and an interview with the DOC.
[129]

WRITTEN NOTIFICATION: Requirements related to restraining by a physical device

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 4.

The licensee has failed to ensure staff removed a residents' physical restraint and repositioned the resident every two hours when the restraint was in use.

Rationale and Summary

The residents' plan of care directed staff where to use a restraint both during the day and at night.

A Point of Care (POC) Audit Report indicated staff had not removed the residents' restraint and reposition them every two hours, multiple times over several months.

A PSW said they provided care to the resident during the evening shift prior to the residents' fall and also on the following night shift. The PSW confirmed they did not reposition the resident every two hours, because a family member told them not to disturb the resident.

Following a review of the POC Report, the DOC confirmed the resident did not have the restraint released and was not repositioned every two hours while a restraint was in use.

The resident was placed at risk for alterations in the integrity of their skin when staff did not release the restraint and reposition the resident every two hours.

Sources: The residents' plan of care, Point of Care Audit Report and interviews with a PSW and the DOC.
[129]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

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NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 7.

The licensee has failed to ensure that staff documented every release of the restraint and every repositioning of a resident, while the resident was restrained.

Rational and Summary

The residents' care plan included a task that directed staff to release the restraint and reposition the resident every two hours, and the computerized clinical record included an electronic documentation form for staff to document every release and repositioning of the resident.

A Documentation Report generated from the residents' computerized clinical record over a 14 day period the period, confirmed that staff had not documented every two hour release of the restraint and repositioning of the resident when the report identified many staff who worked nights had documented that the every two hour task had occurred all at the same time at the end of their shift. Other PSW staff had documented they performed this task several hours after the appointed time for the task to have been completed.

The DOC confirmed that PSW staff had not documented that the resident had the restraint released and was repositioned every two hours.

Sources: The residents' care plan, Point Click Care Documentation Survey Report and an interview with the DOC.
[129]

COMPLIANCE ORDER CO #001 Plan of Care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
-Review and revise the residents' plan of care and ensure care plan strategies are put in place to manage the identified risk that the resident could undo their restraint and fall.

-Educate registered staff who work on the identified home area on the relationship between resident

assessments, the development of a plan of care, specifically, the need to address any risks identified during an assessment in the care plan.

-Document the education, including the names of the staff who attended the education, the dates the training was provided and the name staff member who provided the education.

Grounds
The licensee has failed to ensure that the care set out in a resident plan of care was based on the restraint assessments completed.

Three restraint assessments completed for the resident, identified that the resident "unbuckles the restraint" and exhibited behaviours that included agitation. Following the first restraint assessment completed, staff obtained a Physician's order for the use of restraint and the two subsequent restraint assessments identified that the use of the restraint was ongoing.

The residents' plan of care directed that the resident was to use a restraint both during the day and during the night.

The resident was observed to have a restraint in use on August 18, 2023 and on August 21, 2023.

Staff were alerted to attend the resident and found the resident on the floor in their room. A PSW attended the resident and said the restraint was undone and the resident was injured.

The PSW who regularly provided care to the resident, including just prior to the fall, confirmed that the restraint could be opened by pushing the red button on the restraint closure mechanism. They indicated they felt the resident could accidentally release the restraint because they were often agitated and they often moved their hands around and over the push button release mechanism on the restraint.

The DOC said they were aware that the three restraint assessments indicated the resident "unbuckles the restraint", they were aware of the potential risk that the resident may open the the restraint and fall, and confirmed that no actions were taken to manage the risk that the resident may fall.

The failure of staff to manage the assessed risk that the resident could open the restraint and fall, may have contributed to the resident falling and sustaining injuries.

Sources: The residents' plan of care, observations of the resident, Restraint Assessments, and interviews with the PSW and the DOC.
[129]

This order must be complied with by November 8, 2023

COMPLIANCE ORDER CO #002 Requirements related to restraining by a physical device

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 119 (1) 2.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
-Review all specifically identified restraints used in the home to ensure the devices are well maintained and working properly.

-Educate all PSW staff who work on the identified home area, related to how to monitor that the identified restraints are working properly and what actions they are to take if they suspect a restraint is not functioning properly or if they feel the device is not safe for the resident the to use.

-Document the education provided to PSWs, including the names of the staff who attended the training, the dates the training was provided and the name of staff member who provided the education.

-Develop and implement a process for registered staff to regularly monitor the functionality of the identified restraints in use and ensure there is a documented record maintained of this monitoring.

Grounds
The licensee failed to ensure a physical restraint that was used to restrain a resident, was well maintained.

The Residents' plan of care directed that the resident was to use a restraint both during the day and at night.

Interview notes made by the DOC, identified a PSW told them a restraint used for the resident was difficult to open during the evening prior to the residents' fall, they did not report the malfunction to registered staff and verified it was the same restraint that was in use when the resident fell the following shift.

The PSW told the Inspector, "the residents' restraint was "difficult to open", "they had tried to put it in

but it was not going in" and a family member had asked them what was wrong with the restraint.

Staff identified that when they attended the resident at the time of the fall, they observed the restraint to be open.

Sources: The residents' plan of care, DOC interview notes and an interview with a PSW.
[129]

This order must be complied with by November 8, 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.