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
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Original Public Report

Report Issue Date: April 15, 2024
Inspection Number: 2024-1338-0002
Inspection Type: Complaint Critical Incident
Licensee: Liuna Local 837 Nursing Home (Hamilton) Corporation
Long Term Care Home and City: Queen's Garden, Hamilton

Lead Inspector	**Inspector Digital Signature**
Barbara Grohmann (720920)	Barbara Grohmann 2024.04.17 09:29:55 -04'00'

Additional Inspector(s)
Brittany Wood (000763)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 21, 22, 25-28, 2024 and April 2-4, 2024.

The following intakes were completed in this complaint inspection:

- Intake: #00109772 was related to concerns regarding toileting, transferring, and allegations of financial abuse; and,
- Intake: #00111170 was related to concerns regarding 1:1 supervision and falls prevention and management.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00100645 [CI 2853-000021-23] was related to unresponsive hypoglycemia,

- Intake: #00106391 [CI 2853-000003-24/2853-000004-24] was related to allegations of financial abuse and neglect,
- Intake: #00107264 [CI 2853-000005-24] was related allegations of neglect; and,
- Intake: #00108501 [CI 2853-000007-24] was related to falls prevention and management.

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

Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

A. The licensee has failed to ensure that a resident received the care consistent with their needs related to a change in condition.

Rationale and Summary

A nurse practitioner (NP), in consultation with the resident, ordered medication to be administered once a week for four weeks. After that time, the weekly dose would increase. Two days later, after the dose was increased, the resident began feeling unwell. Personal support workers (PSW) reported to the registered staff episodes of vomiting on several occasions.

At the same time, the resident's food and fluid intake declined and they experienced increased lethargy. A Registered Practical Nurse (RPN) took the resident's vitals twice in the morning, but they were never checked again during the rest of the day and night despite the resident's change in condition. A CI report documented that the NP and/or on-call physician were not contacted for direction.

The home's investigation determined that the registered staff working during the day, evening and night shifts did not re-assess the resident, including rechecking their vitals, or reach out to the charge RN, NP or on-call physician for assistance or direction.

The administrator acknowledged that this situation may have been avoided or identified earlier had the RPNs reassessed the resident appropriately, and/or contacted the NP or on-call doctor.

Failure to properly re-assess the resident when their condition changed and/or request direction/assistance from the charge RN, NP or on-call doctor may have resulted in a delay in treatment.

Sources: resident's clinical records, CI 2853-000021-23, Medication Product Monograph (revised March 2024), Diabetes Canada, Investigation notes, Blood

Glucose Monitoring Policy (LTC-CA-BC-ON-200-03-01, June 2023); and interview with the Administrator. [720920]

B. The licensee has failed to ensure that a resident received the care consistent with their needs related to 1:1 supervision.

Rationale and Summary
A resident was identified as a high fall risk. Supervision was initiated as an intervention for falls prevention and responsive behaviours.

When the resident had a fall, the PSW scheduled to provide the supervision acknowledged that did not stay close to the resident, nor were they present when the resident fell. They explained that they stood back and watched them from a distance.

The administrator acknowledged that the PSW was not present when the resident fell and was often not in a position to re-direct the resident away from other residents or situations which may have triggered behaviours. They explained that they expected the 1:1 to be within arms-reach of the resident at all times during their shift.

Failure to provide the care in accordance with the resident's needs may have contributed to their fall.

Sources: resident's clinical records, home's investigation notes; interviews with the administrator and other staff. [720920]

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from financial abuse.

O. Reg. 246/22 s. 2 defined financial abuse as, "any misappropriation or misuse of a resident's money or property".

Rationale and Summary
A PSW removed property from a resident's room to store in their own home. The resident's substitute decision maker (SDM) expressed their concern regarding missing property to the Administrator. The home's investigation notes indicated that the PSW confirmed taking the property to store in their home, which was returned to the resident after the investigation.

The home's policy for Prevention of Abuse and Neglect, indicated "abuse includes any action or inaction that involves the misuse of power and/or betrayal of trust, respect or intimacy by a person against a resident" The policy also defined financial abuse as "any misappropriation or misuse of a resident's money or property."

The PSW did not notify the resident's family or leadership of the home that they were storing the property in their own home. The administrator acknowledged that financial abuse took place in this incident.

Failure to protect the resident from financial abuse could lead to harm to the resident's sense of well-being, dignity, or self-worth.

Sources: Investigation notes, Prevention of abuse and neglect policy (revised March 2022) and interview with Administrator. [000763]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that a resident was assessed after a fall.

In accordance with O. Reg. 246/22 s. 11 (1)(b), the licensee is required to ensure that there is a falls prevention program which included assessing a resident post fall and must be complied with.

Specifically, staff did not comply with the policy "Resident Falls Prevention Program", which was included in the licensee's Falls Prevention Program.

Rationale and Summary
The home's fall policy stated that in the event of a fall, registered staff were to assess the resident for any possible injury or negative outcome. It also specified that the resident was not to be moved off the floor until a head-to-to assessment had

been completed by the registered staff and the decision to move the resident would be based on the assessment of injury.

A resident had a witnessed fall. When staff attended to the resident, they were moving their legs and attempted to get up on their own. During the home's investigation into the fall, the RN admitted to not completing a head-to-toe assessment while the resident was on the floor, stating that they assumed the resident was not injured as they were moving their legs without any expression of pain.

A few weeks later, the resident was sent to the hospital following increased pain and decreased mobility where an injury was identified.

The administrator acknowledged that the RN did not complete a proper head to toe assessment for injury while the resident was on the floor. They agreed that even though the resident was moving their legs, by not completing an assessment, the RN could not safely assume, nor had any way of ensuring, that the resident was uninjured.

Failure to assess the resident as per the home's fall policy may have resulted in an injury going unnoticed, delaying treatment.

Sources: resident's clinical records, Resident Falls Prevention Program (LTC-CA-WQ-200-07-08, June 2022), home's Investigation Notes; observations; interviews with the Administrator and other staff. [720920]

WRITTEN NOTIFICATION: Administration of Drugs

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

Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that no drug was administered to a resident unless the drug has been prescribed for the resident.

Rationale and Summary
A PSW alerted the RPN that a resident was not their usual self. The RPN assessed the resident and found them to require urgent care. They contacted the charge RN, who also assessed the resident and determined that urgent action was needed. While awaiting the paramedics, the RN administered medication to the resident that was typically used to treat that type of condition.

The home's policy directed registered staff to use that medication under specific clinical conditions. However, a physician/nurse practitioner's order was required, must be resident specific and on the resident chart.

A review of resident's electronic physician's orders showed that there was no order for that medication when it was administered.

The administrator verified that the medication was administered to the resident without a prescription.

Failure to ensure that a drug was prescribed prior to its administration had the potential for a resident to receive an inappropriate drug.

Sources: resident's clinical records, Hypoglycemia and Glucagon Policy (LTC-CA-BC-0-200-03-04, June 2023); interviews with the Administrator and other staff. [720920]

WRITTEN NOTIFICATION: Administration of Drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A resident was prescribed two medications to be administered together, every three hours as needed (PRN); however, registered staff were not to exceed a specific number of doses in 24 hours.

A review of the resident's electronic medical administration records (eMAR) showed that over three days, the PRN medications were not administered according to the prescriber's directions for use.

The administrator acknowledged that registered staff had not followed the prescriber's directions for use regarding the PRN medications.

Failure to follow the prescribers directions for use may have resulted in the resident

experiencing increased side effects from the medications.

Sources: resident's clinical records, Medication Product Monographs (January 2018 and, March 2017); interviews with the Administrator and other staff. [720920]