Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 13, 2020	2019_689586_0029	015859-19, 016314-19, 016856-19, 016857-19, 018517-19	Critical Incident System

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

JESSICA PALADINO (586)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 7, 8 and 9, 2020.

The following Critical Incident System (CIS) inspections were conducted concurrently:
015859-19 - Falls Prevention & Management;
016314-19 - Falls Prevention & Management; and,
018517-19 - Falls Prevention & Management.

The following Follow-up Inspections were completed concurrently:
016856-19 - Falls Prevention & Management; and,
016857-19 - Sufficient Staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Staff Educator, Programs and Support Services Manager, Resident Assessment Instrument (RAI) Coordinator, registered and non-registered staff and residents.

During the course of the inspection, the inspector(s) observed resident care and reviewed resident health records, internal investigation notes, training records, internal audits, employee records and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_689586_0014	586
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2019_689586_0015	586

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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided as per the plan.

Resident #003's documented plan of care indicated that they were at an identified risk level for falls and required the use of a specific intervention to mitigate falls.

According to CIS #2922-000007-19 submitted to the Director, resident #003 experienced a fall on an identified date in 2019, resulting in injury. Upon investigation by the home, it was discovered that Personal Support Workers (PSWs) #107 and #108 did not apply the specific intervention used to mitigate falls for the resident. This was confirmed by the staff through the home's internal investigation notes. The DOC and Administrator acknowledged that resident #003 was not provided care as per the plan of care.

Please note this area of non-compliance is further evidence to support the compliance order issued on August 28, 2019, during CIS inspection 2019_689586_0014 with a compliance due date of November 27, 2019. [s. 6. (7)]

Issued on this 13th day of January, 2020

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

Original report signed by the inspector.