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
Oct 4, 2021	2021_916168_0007	005831-20, 006243-20, 009807-20, 016581-20, 004951-21	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

LISA VINK (168), JENNIFER ALLEN (706480), YULIYA FEDOTOVA (632)

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): September 21, 22, 23 and 24, 2021.

This inspection was conducted for the following intakes:
005831-20 related to plan of care;
006243-20 related to falls prevention and management;
009807-20 related to prevention of abuse and neglect;
016581-20 related to prevention of abuse and neglect; and
004951-21 related to falls prevention and management.

This inspection was conducted concurrently with complaint inspection 2021_916168_0006.

During the course of the inspection, the inspector(s) spoke with the Administrator, former Administrator, the acting Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Social Services Worker, former PSWs, a family member and residents.

During the course of the inspection, the inspectors observed the provision of care and services, toured the home, reviewed records, including but not limited to, policies and procedures; human resource files; training records; investigative notes and clinical health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) 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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Regulation required the licensee of a long-term home to have, institute or otherwise put in place any procedure, that the procedure was complied with.

In accordance with Ontario Regulation 79/10 s. 48 (1) 1 and in reference to O. Reg s.30 (1) 1, the licensee was to ensure that in respect of the organized falls prevention and management program there was a written description of the program that included relevant procedures and that the procedures were complied with.

Specifically, staff did not comply with the home's Head Injury Routine, which required that any resident who might have sustained an injury to their head as a result of a fall or where the resident's head might have come in contact with a hard surface, head injury routine was to be initiated. The assessments were to be completed initially, then every 30 minutes for the first two hours, every hour for the next four hours, then every four hours until 24 hours post fall and then every eight hours until 48 hours post fall was reached.
Additionally, the Resident Falls Prevention Program, specified that head injury routine would be initiated if suspected head injury or unwitnessed fall, unless directed by the physician.

i. A resident sustained an unwitnessed fall.
A review of the clinical record identified the unwitnessed fall; however, it did not include a head injury routine, as required in the home's procedure.

Staff did not follow the home's procedure for unwitnessed falls when they failed to initiate and complete the required head injury routine.

Sources: Review of the progress notes and assessments of a resident, review of the Resident Falls Prevention Program and interviews with staff.

ii. A resident was being actively assessed according to the home's head injury routine due to a recent fall, when they sustained additional falls later that same day.
The registered staff continued to assess and monitor the resident utilizing the initial head injury routine; however, they did not re-initiate the assessments at the frequency of every 30 minutes for the first two hours and every hour for the next four hours for the additional falls.

Staff did not follow the home's procedure for Head Injury Routine when they failed to complete and re-initiate the required assessments as required.

Sources: Review of the progress notes and assessments of a resident, review of the Resident Falls Prevention Program and Head Injury Routine and interviews with staff. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Regulation requires the licensee of a long-term home to have, institute or otherwise put in place any procedure, that the procedure is complied with, to be implemented voluntarily.

WN #2: 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 failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

A resident had a plan of care in place which noted that staff were to provide care frequently at night.
On a specific date progress notes identified that the resident was found in a condition and with symptoms.
The Administrator identified that staff did not check the resident "frequently" during the night as identified in their plan, that they were checked twice during an identified period of time.
Additionally, the Job Routines noted that staff were to check residents were safe and comfortable on at least four specified occasions during the night and assist with toileting, personal care or positional changes as per care plan on at least three specified occasions during the night.
Care was not provided to the resident as set out in their plan of care.

Sources: A review of the plan of care and progress notes for a resident, a review of investigative notes and interviews with staff. [s. 6. (7)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse or neglect of a resident occurred or might have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A progress note identified that a resident was found in a condition with symptoms. The staff who recorded the note sent an email to the DOC related to their concerns with the care provided to the resident by a staff member that same day, which was forwarded to the Administrator by the DOC.
A review of Action Line Call log, four days later, included that the Administrator initiated an internal investigation and identified suspected neglect of a resident when they were not provided care as per the plan of care during a shift and had symptoms.
A Critical Incident System (CIS) report was submitted five days after the initial progress note for the allegation of neglect of a resident by staff.
The Director was not immediately notified by the Administrator who had reasonable grounds to suspect that neglect of a resident had occurred.

Sources: Review of CIS report, Action Line Call log, progress notes for a resident and investigative notes related to the allegation and interviews with staff. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the program related to resident hand hygiene.

During nourishment pass a staff member was observed to serve five residents a beverage without immediate prior assistance with hand hygiene.
The staff confirmed that they provided residents hand hygiene assistance prior to and following all meals, but that they had not provided the hand hygiene prior to the distribution of the nourishment.
The home's Hand Hygiene Program, identified that hand hygiene was to be performed before eating food, which was clarified to include beverages as well.

The failure to comply with the home's Hand Hygiene Program presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that might have been on their hands.

Sources: Observations of residents at nourishment time, review of Hand Hygiene Program, interviews with staff. [s. 229. (4)]

Issued on this 5th day of October, 2021

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

Original report signed by the inspector.