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: May 05, 2023	
Inspection Number: 2023-1406-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Liuna Local 837 Nursing Home (Ancaster) Corporation	
Long Term Care Home and City: Regina Gardens, Hamilton	
Lead Inspector Olive Mameza Nenzeko (C205)	**Inspector Digital Signature**
Additional Inspector(s) Tracey Delisle (741863) Stephany Kulis (000766) Bernadette Susnik (120)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
March 31, 2023, April 3-6, 11-14, 17, 2023.

Inspector (120), Bernadette Susnik, participated in this inspection offsite.
Inspector (000766), Stephany Kulis, shadowed this inspection from March 31,2023 to April 07, 2023.

The following intake(s) were inspected in this complaint inspection:

- Intake #00014156 complaint related to resident charges.
- Intake #00015763 complaint and Intake #00015917/CI #2922-000036-22 related to safe and secure home and responsive behaviours.

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake #00008666/CI #2922-000026-22 related to resident care and support services and Prevention of abuse and neglect.
- Intake #00019623/CI #2922-000004-23 related to falls prevention and management.

The following intake (s) were completed in this inspection: Intake #00010832/CI #2922-000029-22 and Intake#00017906/CI #2922-000001-23 related to an injury with a significant change in condition.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management
Resident Charges and Trust Accounts

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control (IPAC)

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the infection prevention and control program required under subsection 23(1) of the Act complied with any standard or protocol issued by the Director.

Rationale and summary
The IPAC Standard for Long-Term Care Homes, dated April 2022, stated under section 9.1 (f) that additional precautions were to be followed in the IPAC program which included the proper use of PPE including the appropriate selection and application of PPE.

A resident's room door had Droplet Contact Precautions signage posted which included eye protection as required Personal Protective Equipment (PPE). The resident's written plan of care stated that droplet contact precautions were required. A staff member was observed entering the room and providing direct care to the resident with no eye protection on. The Administrator and the IPAC Director confirmed that staff are expected to wear eye protection when providing care to a resident on droplet contact precautions.

Staff's failure to choose and apply appropriate PPE while entering a resident's room with additional precautions in place increased the risk of infectious disease transmission.

Sources: Observation of resident's room, Interview with Administrator and IPAC Director, resident's clinical records.

[C205]

WRITTEN NOTIFICATION: Late Reporting

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 1.

The licensee has failed to inform the Director no later than one business day after a resident went missing for less than three hours and returned to the home with no injury or adverse change in condition.

Rationale and Summary
A resident went missing on a specific date for less than three hours and returned to the Long Term Care (LTC) home with no injury or adverse change in condition.

A Critical Incident System (CIS) Report# 2922-000036-22 was not submitted to the Ministry of Long-Term Care (MLTC) within one business day after the resident went missing. The Administrator confirmed during an interview that the incident was reported late.

Sources: CIS#2922-000036-22, Interview with the Administrator.

[C205]

COMPLIANCE ORDER CO #001 Doors in a Home

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.

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

The licensee shall prepare, submit, and implement a plan to ensure that all doors to the outside of the home, specifically the door that leads to the adult community support program space is kept locked.

The plan shall include but is not limited to:

1. How the door between the LTC Home and the adult community support program building will be monitored to ensure that residents cannot leave the LTC Home until such time as the door is secured with a lock.
2. When a lock for the second door will be purchased and installed.

Please submit the written plan for achieving compliance for inspection# 2023-1406-0002 to Olive Mameza Nenzeko, LTC Homes Inspector, MLTC, by email to hamiltondistrict.mltc@ontario.ca by April 26, 2023.

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

Grounds

The licensee has failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to were kept locked.

Two doors to which residents had access to and were located between the long-term

care home and an adult community support program space (not part of the licensed long-term care home and considered to be outside of the home) were found unlocked by the inspectors on two specific dates.
A resident was able to exit the home via one of the two doors noted above. The resident was returned to the home by staff without injury less than an hour later. The elopement was reported to the Ministry via the Critical Incident System.

On a specific date, the Administrator was advised by Inspectors that the two doors leading from the long-term care home to the adult community support program space were unlocked and that would allow residents access to the street. The same day, one of the two doors was equipped with a double-sided dead bolt key lock. The second door to the program space, which had an exit sign above it indicating that it was a designated fire exit, remained unlocked. According to the local fire Inspector, the door could not be kept locked using a conventional key lock but could be secured using a magnetic access control system. At the time Inspectors exited the home after completing the inspection, the Administrator indicated that they were actively trying to determine which option was appropriate to secure the door in consultation with the fire department.

Failure to ensure that doors leading to the outside of the home were kept locked, and to which residents had access, resulted in an unsecure environment, allowing a resident to exit the home and posing potential risk to other residents.

Sources: Observation of the exit doors, Interview with the Administrator and Fire Inspector.

[C205] [120]

This order must be complied with by May 19, 2023

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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.