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

Original Public Report

Report Issue Date: June 16, 2023
Inspection Number: 2023-1406-0003
Inspection Type: Follow up Critical Incident System
Licensee: Liuna Local 837 Nursing Home (Ancaster) Corporation
Long Term Care Home and City: Regina Gardens, Hamilton

Lead Inspector	**Inspector Digital Signature**
Dusty Stevenson (740739)	Dusty Stevenson Digitally signed by Dusty Stevenson Date: 2023.07.24 12:34:52 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 1-2, 6-8, 12, 2023
The inspection occurred offsite on the following date(s): June 9, 2023

The following intake(s) were inspected:

- Intake #00018901/Critical Incident (CI)#2922-000002-23 – related to Resident Care and Support Services
- Intake #00021685/CI#2922-000008-23 – related to Prevention of Abuse and Neglect
- Intake #00086572 - Follow-up to CO#001 from inspection# 2023-1406-0002 regarding O. Reg. 246/22, s. 12 (1) 1. i. Doors in a home, CDD: May 19, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1406-0002 related to O. Reg. 246/22, s. 12 (1) 1. i. inspected by Dusty Stevenson (740739)

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours

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.

The licensee failed to ensure that a resident was provided care and services that were consistent with their needs.

Rationale and Summary

On a day in January 2023 a resident sustained an injury. Staff #101 documented that they attempted to assess the injury however the resident appeared to show non-verbal signs of pain, so the assessment was not completed. The resident was provided pain medication and was allowed to sleep. Later that morning, staff #101 attempted to reassess the injury of the resident however the resident again exhibited non-verbal signs of pain and the assessment was not completed. Staff #101 endorsed the next shift nurse to contact the doctor regarding the injury.

Records indicated that following an assessment by staff #102 the resident was sent to hospital later that morning due to pain medications were ineffective, resident complained of pain, and change in signs and symptoms of the injury. The resident returned to the home with a confirmed injury.

Staff #101 indicated to the Inspector that they should have sent the resident to hospital when they could not complete the assessment.

The Administrator indicated that the expectation was staff #101 should have reported the incident right

away, properly assessed the resident and sent them to the hospital, as required.

As a result, the resident was not provided care and services consistent with their needs at the time of sustaining an injury that required further assessment and care.

Sources: resident's clinical records, interviews with staff #101, #102 and the Administrator

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WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care provided to a resident complied with the plan of care.

Rationale and Summary

A resident was admitted to the home on a day in January 2023. According to the resident's admission note they did not speak English, which could pose a barrier for communication. The admission notes also indicated that the resident was resistive to some care despite needing assistance. The plan of care directed staff on how to provide care including communicating with the resident during care.

On a day in January 2023 a staff member was assisting the resident with care when the resident sustained an injury. The resident was sent to hospital for further assessment and was found to have an injury.

When interviewed, the staff member indicated that they did not read the admission note for the resident, and therefore was not familiar with the resident's care needs.

The Administrator indicated that there was a plan of care in place for the resident and the staff member did not read the admission note for the resident before providing care; it was the expectation that staff read the admission note on new residents before providing care.

Failing to review the plan of care may have contributed to the resident's injury.

Sources: resident's clinical records, interviews with staff and the Administrator

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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to immediately report a suspected incident of abuse towards a resident.

Rationale and Summary

On a day in February 2023 an injury was identified on a specific part of the body of a resident. When asked what happened, the resident stated another resident with specific responsive behaviours did it. This incident was reported to the Director on the following day.

The Administrator indicated that incidents of alleged abuse should be reported immediately.

Sources: resident's clinical records, interview with staff and the Administrator, Critical Incident report 2922-000008-23

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WRITTEN NOTIFICATION: Pain management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee failed to ensure a resident received a pain assessment following an incident in which they experienced pain.

Rationale and Summary

On a day in January 2023 a resident sustained an injury to a specific part of the body. A staff member was not able to complete their range of motion assessment for the injury as the resident displayed non-verbal signs of pain during the assessment. Later that morning, the staff member attempted to reassess the resident and again was unable to complete their assessment as the resident complained of pain.

Records indicated that the resident was administered an analgesic that morning and it was found ineffective.

The staff member later indicated that they should have completed a pain assessment for the resident on the day the injury was sustained as the resident had experienced new pain.

The Administrator stated it was the expectation that a pain assessment was to be completed at the time of the incident.

As a result, the resident's pain was not appropriately assessed and documented.

Sources: resident's clinical records, interviews with staff and the Administrator

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