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: December 20, 2023
Inspection Number: 2023-1406-0005
Inspection Type: Proactive Compliance Inspection
Licensee: Liuna Local 837 Nursing Home (Ancaster) Corporation
Long Term Care Home and City: Regina Gardens, Hamilton

Lead Inspector	**Inspector Digital Signature**
Klarizze Rozal (740765)	Klarizze Mae S Rozal Digitally signed by Klarizze Mae S Rozal Date: 2023.12.20 15:36:15 -05'00'

Additional Inspector(s) Carla Meyer (740860)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 6-8, 11-12, and 14, 2023

The following intake(s) were inspected:

- Intake: #00102837 - Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils

Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (l)
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(l) copies of the inspection reports from the past two years for the long-term care home;

The licensee has failed to ensure that a copy of the most recent inspection report was posted.

Rationale and Summary:
During the initial tour of the home, a binder titled Mandatory Postings was reviewed and a copy of the home's most recent inspection report that occurred was not posted, including the report that was issued in 2022. The last report found in the

binder was dated October 2021. This was acknowledged by the Administrator.

During the course of inspection, the Administrator informed and the inspector verified that the licensee had included a copy of the most recent inspection report in the Mandatory Postings binder.

Sources: Observations, record review of mandatory postings, and interview with the Administrator. [740860]

Date Remedy Implemented: December 7, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that their continuous quality improvement (CQI) initiative report contained the written record of the dates and how the results of their resident and family/caregiver experience surveys taken during the fiscal year were communicated to the residents and their families, Residents' Council, Family Council, and members of the staff of the home.

Rationale and Summary
The home's CQI initiative report included the home's Quality Improvement Plan (QIP) Narrative and Workplan. The report did not include the dates and how the results of

their resident and family/caregiver experience surveys taken during the fiscal year were communicated to the residents and their families, Residents' Council, Family Council, and members of the staff of the home. The Administrator acknowledged that the report did not include the dates and how the results were communicated. During the course of the inspection, the CQI initiative report was amended to include the dates and how the results of the surveys were communicated.

Sources: Initial and amended versions of the home's CQI initiative/QIP Narrative report, website, and interview with the Administrator.

Date Remedy Implemented: December 14, 2023 [740765]

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. v.
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that their CQI initiative report contained the written record of the dates and how the actions taken based on the results of their resident and family/caregiver experience surveys were communicated to the residents and their families, Residents' Council, Family Council, and members of the staff of the home.

Rationale and Summary
The home's CQI initiative report did not include how and when the actions taken

based on the home's results of their resident and family/caregiver experience surveys were communicated to the residents and their families, Residents' Council, Family Council, and members of the staff of the home. The Administrator acknowledged that the report did not include the dates and how the actions were communicated. During the course of the inspection, the CQI initiative report was amended to include the dates and the actions taken based on the results of the surveys were communicated.

Sources: Initial and amended versions of the home's CQI initiative/QIP Narrative report, website, and interview with the Administrator.

Date Remedy Implemented: December 14, 2023 [740765]

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (3)
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that a copy of the CQI initiative report was provided to the Residents' Council and Family Council.

Rationale and Summary
The home's Residents' and Family Council representatives stated they were not provided a copy of the home's CQI initiative report which included the QIP Narrative and Workplan. The Administrator acknowledged that they had discussed the report with the Residents' and Family Councils but could not recall when a copy of the CQI initiative report was provided to them. During the course of inspection, the Administrator stated they had provided the Council representatives with a copy of the amended CQI initiative report. The Family Council representative was sent an

electronic copy and the Residents' Council representative was provided and observed with a physical copy.

Sources: Website, observations, and interviews with a resident and a family member, and the Administrator.

Date Remedy Implemented: December 14, 2023 [740765]

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor's policy was posted.

Rationale and Summary
During the initial tour of the home, a binder titled Mandatory Postings was reviewed and no copies of the home's visitor's policy was found. This was confirmed by the Administrator who acknowledged that this would not be located at any other location in the home.

During the course of inspection, the Administrator informed the inspector which was verified that the licensee has included a copy of the most current visitor's policy in the Mandatory Postings binder.

By not posting the home's most current visitor's policy, the home's ability to

communicate require procedures to visitors were impacted.

Sources: Observations, review of mandatory postings, and interview with the Administrator. [740860]

Date Remedy Implemented: December 7, 2023

WRITTEN NOTIFICATION: Food Production

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 78 (7) (c)

s. 78 (7) The licensee shall ensure that the home has and that the staff of the home comply with,

(c) a cleaning schedule for the food production, servery and dishwashing areas.

The licensee has failed to ensure that the cleaning schedule for the food production, servery, and dishwashing areas on a resident home area (RHA) was complied with.

Rationale and Summary

The severy and high-touch surface cleaning schedules reviewed on a specified RHA from specified dates had no recorded documentation of completion. The Food and Nutrition Manager (FNM) acknowledged the cleaning schedules had no documentation and signatures of staff. The FNM explained the expectations for staff were to clean and complete the high-touch and servery cleaning schedules daily and to document and sign for their completion.

Failure to ensure the home's cleaning schedules in the servery were complied with, posed a risk to resident's food safety, sanitation, and infection control

Sources: A specified RHA Servery and High-Touch Cleaning Schedules, and

interview with the FNM. [740765]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure the home's dining service included food being served at a temperature that is both safe and palatable to residents.

In accordance with O. Reg. 246/22 s. 11 (1)(b), the licensee was required to ensure the home's Food Temperature Policy was implemented and complied with. Specifically, staff were required to record food temperatures of all menu items prior to meal service.

Rationale and Summary
The home's food temperature log on a specified RHA identified multiple missing records of food temperatures on different dates and shifts on specified dates. The FNM acknowledged the missing records and stated that food temperatures were to be measured and recorded prior meal services.

Failure to obtain food temperatures posed a risk that unsafe temperatures may not have been identified or corrected prior to meal service.

Sources: A specified RHA food temperature logs, Food Temperature Policy, and interview with the FNM. [740765]

WRITTEN NOTIFICATION: Medication Management System

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that protocols to ensure safe medication management was implemented. Specifically, a registered staff did not follow protocols by pre-pouring medications in advance for a resident prior to administration.

Rationale and Summary
On a specified date, during an observation of medication administration for a resident, a registered staff was observed to remove a clear plastic medication cup from one of the medication cart's drawer containing a white and green powder. The staff proceeded to take an empty medication pouch and compared the listed medication against the electronic medication record (eMAR). The staff confirmed that the content of the medication cup was the resident's medications and that it contained a controlled substance that the resident was scheduled to receive at that time. They also acknowledged that the medications were pre-poured as the resident's medications needed to be crushed. Furthermore, it was observed that the narcotic count sheet for the resident was signed off that the controlled substance was administered prior to the medication being given to the resident.

The DOC acknowledged as per the home's policy and medication administration

process, pre-pouring of medications was not best practice, and that the narcotic count sheet should have been signed once the medication was administered to the resident.

The home's policy titled, Medication Administration, instructed the following, "Do not pre-pour medication - pour one, give one, sign for one - then move on to another resident" and, "Do not pre-pour medication for administration later."

By pre-pouring medications in advance, the risk of medication errors was increased as the staff cannot conduct the appropriate medication check prior to the administration of the drugs.

Sources: Observations, interview with a registered staff and the DOC, and review of the home's policy on medication administration. [740860]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee has failed to ensure that the CQI committee was composed of at least one employee of the home's regular nursing staff.

Rationale and Summary
The Administrator acknowledged they did not include nor currently have one

regular nursing staff as part of their CQI committee.

Failure to include at least one employee of the home's regular nursing staff in the CQI committee posed a potential risk to the quality improvements for the home.

Sources: July 2023 CQI meeting minutes and interview with the Administrator. [740765]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that CQI committee was composed of at least one employee hired by the licensee as a personal support worker (PSW).

Rationale and Summary
The Administrator acknowledged they did not include nor currently have a PSW as part of their CQI committee.

Failure to include at least one employee hired by the licensee as a PSW in the CQI committee posed a potential risk to the quality improvements for the home.

Sources: CQI committee meeting minutes and interview with the Administrator.

[740765]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
10. One member of the home's Family Council, if any.

The licensee has failed to ensure that the CQI committee was composed of at least one member of the home's Family Council.

Rationale and Summary
The Administrator acknowledged they did not have a current member of the family council as part of their CQI committee.

Failure to include at least one member of the home's Family Council in the CQI committee posed a potential risk to the quality improvements for the home.

Sources: CQI committee meeting minutes and interview with the Administrator.
[740765]

COMPLIANCE ORDER CO #001 Infection Prevention and Control Program

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Provide education to all staff of the home's policy on personal protective equipment (PPE).
2. Provide education to all staff, including agency staff, students, and volunteers on the home's mandatory masking protocols.
3. Provide re-education to all registered staff on the four moments of hand hygiene.
4. Document the education, including the date and staff member(s) who were provided the education.
5. Conduct weekly audits on PPE use and hand hygiene practices for four weeks, or until no further concerns have been identified.
6. The home must keep a record of the education and audits including actions made based on audit results for Long-Term Care Home Inspector review.

Grounds

A) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) were implemented. Specifically, a staff member failed to use proper personal protective equipment (PPE) in accordance with the "IPAC Standard for Long Term Homes Revised September 2023," by not ensuring that they were wearing the appropriate eye protection when they entered a resident room that was on contact and droplet precautions.

Rationale and Summary

As per 9.1 d) of the IPAC Standard, the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program, and at minimum routine practices shall include proper use of PPE, including appropriate selection, application, removal, and disposal.

On a specified date, a staff member was observed preparing to enter a resident room that was on additional contact and droplet precautions. The staff had donned a gown, gloves, and an N95 respirator mask, reviewed the PPE signage and acknowledged that eye protection was required, searched the PPE drawer for goggles or eye shield and found none, and then proceeded to enter the room with only the staff's prescription eyeglasses on.

The Associate Director of Care (ADOC) acknowledged that this did not follow the home's IPAC procedure and that the expectation was that the staff donned either goggles or a face shield when entering a room on contact and droplet precautions. They also acknowledged that if the PPE was not available in the drawer, that there would have been supplies available at the nursing station, and that prescription eyeglasses was not considered appropriate PPE.

Additionally, the home's policy titled Personnel Protective Equipment, stated that PPE shall be used by all employees when entering a room where residents are on additional precautions, and that prescription eyeglasses were not acceptable by themselves as eye protection.

By not wearing the appropriate PPE when entering a resident room on additional precautions, the risk for transmission of infection was increased.

Sources: Observations, interview with the ADOC and IPAC Lead, and review of the home's policy. [740860]

B) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC were implemented.

Specifically, a staff member failed to perform hand hygiene in accordance with the "IPAC Standard for Long Term Homes Revised September 2023."

Rationale and Summary

As per 9.1 b) of the IPAC Standard, the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program, and at minimum routine practices shall include hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

On a specified date, a staff member was observed during a medication administration process. During this observation, the staff did not perform hand hygiene prior to preparing the residents' medication outside of the resident room, prior to entering and upon exiting the resident's room. The staff acknowledged that hand hygiene was performed prior to bringing the medication cart outside of the resident's room but not prior to entering or exiting.

The home's policy titled Hand Hygiene Program, stated that hand hygiene was to be performed when direct care was being provided including before initial contact with the resident or resident environment, and after resident or resident environment contact.

The DOC also indicated that as part of the medication administration process, IPAC practices should be done including hand hygiene.

Sources: Medication administration observations, interview with staff and the DOC, and review of the home's Hand Hygiene program. [740860]

C) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC were implemented.

Specifically, three staff failed to follow the mandatory masking protocol that was in place within the home in accordance with the "IPAC Standard for Long Term Homes Revised September 2023."

Rationale and Summary

As per 6.7 of the IPAC Standard, the licensee shall ensure that all staff, students, volunteers and support workers comply with applicable masking requirements at all times.

On a specified date, two staffs' masks were observed below their chin while interacting with a resident and visitor by inspector 740860. One staff was also observed on several occasions since the start of the inspection with their mask either below their nose or chin, and upon noticing inspector would then place their mask above their nose. One staff acknowledged that the expectation of the home was for staff to follow mandatory masking.

On the same day, inspector 740765 observed another staff on an identified unit without a mask. This staff member acknowledged that they should have been wearing a mask and applied a mask on when approached by the inspector.

The IPAC Lead acknowledged that the expectation of all staff, volunteers and student were to follow mandatory masking protocols that was communicated to them via a memo and through in-person discussion.

By not following mandatory masking protocols, the risk for the transmission of infection was increased.

Sources: Observations, interview with staff, and the IPAC Lead, and review of the home's memo regarding mandatory masking. [740860]

This order must be complied with by February 28, 2024

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

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.