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
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Original Public Report

Report Issue Date: May 13, 2024

Inspection Number: 2024-1406-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Liuna Local 837 Nursing Home (Ancaster) Corporation

Long Term Care Home and City: Regina Gardens, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 30, May 1-2, 2024

The following intake(s) were inspected:

- Intake #00098191/CI #2922-000024-23 related to prevention of abuse and neglect
- Intake #00103454/ CI #2922-000027-23 related to prevention of abuse and neglect
- Intake #00105050/CI #2922-000032-23, intake #00105430/CI #2922-000003-24, and intake #00107468/CI #2922-000005-24 related to falls prevention and management .
- Intake #00107157/CI #2922-000004-24 and intake #00111417/CI #2922-000012-24 related to infection prevention and control
- Intake #00112341/complainant related to resident care and support services
- Intake #00104676/Follow-up #1- CO #001/2023-1406-0005, O.Reg. 246/22, s. 102(2)(b) IPAC, CDD February 28, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1406-0005 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Lesley Edwards (506)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) 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. 6 (1) (c)

Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
The care plan for a resident identified they required specific assistance for transfers depending on the resident's needs at the time.

The lift logo posted in the resident's room noted a different level of assistance.

Later, a second logo was added to the resident's room to provide clear direction for staff related to transfer status.

Sources: Plan of care and observations of room of resident and interviews with the Assistant Director of Care (ADOC) and other staff. [168]

Date Remedy Implemented: May 1, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
The home's policy Abuse Allegations and Follow Up identified that all facts related to a reported allegation were to be documented in the resident health chart.

On a specific date, a resident verbalized concerns to the Assistant Director of Care (ADOC) which the home determined were allegations of neglect.

The allegations were not documented in the resident's health chart as required in the policy until a late entry was completed on May 1, 2024, by the Administrator.

Sources: Review of the clinical record of a resident, review of investigative notes related to Critical Incident Report 2922-000027-23, review of Abuse Allegations and Follow Up, number LTC- CA-WQ-100-05-02, with a revised date of September 2023, and interviews with the Administrator and other staff. [168]

Date Remedy Implemented: May 1, 2024

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and

implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision maker (SDM) was notified when a new skin issue was identified.

Rationale and summary
A resident's clinical records showed a new skin impairment was documented and assessed. The initial skin and wound assessment had a designated area within the assessment to document SDM notification however the area was not completed. Progress notes were reviewed and it was found the registered staff did not indicate that the SDM was notified.

The Administrator verified that the resident's SDM should have been notified when a new skin impairment was identified.

Failing to notify the resident's SDM and allowing them to participate in the development and implementation of their care may have resulted in the resident's care not being individualized to their needs.

Sources: interviews with staff, resident's clinical records [740739].

WRITTEN NOTIFICATION: Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure a falls intervention was documented for a resident.

Rationale and summary
A resident's clinical records indicated they required a specific falls intervention. During a period of one month, the falls intervention was not documented as completed for 21 days.

Two staff members who provided care to the resident were aware of the falls intervention and verified that they would complete it.

The DOC and Administrator indicated they could not locate documentation that supported that the falls intervention was completed for the dates indicated.

As a result of not being documented, there was no confirmation that care was provided for the above dates as per the residents plan of care.

Sources: interviews with staff, resident's clinical records [740739].

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
Pursuant to FLTCA, 2021, s. 154 (3) the licensee was vicariously liable for staff members failing to comply with s. 28 (1).

On a date in September 2023, a personal support worker (PSW) observed a resident in a situation which the home determined was an incident of abuse or neglect of a resident. The Administrator acknowledged that the PSW did not report the incident immediately as required, which resulted in a delay in reporting the incident to the Director.

Sources: CI #2922-000024-23; home's investigation notes, interview with PSW and other staff. [683]

WRITTEN NOTIFICATION: Protection from certain restraining

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 1.
Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff.

The licensee has failed to ensure that a resident was not restrained for the convenience of staff.

Rationale and Summary
On a specified date, a resident was found with a restraint in place while in their wheelchair. The resident did not have orders for any restraints and was unable to remove the devices. A PSW reported that the resident was restrained for the convenience of the staff.

There was a risk to the resident when they were restrained for the convenience of staff.

Sources: CI #2922-000024-23; resident's clinical record; home's investigation notes; interview with the Administrator and other staff. [683]

WRITTEN NOTIFICATION: Prohibited devices that limit movement

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 38 (a)
Prohibited devices that limit movement
s. 38. Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident;

The licensee has failed to ensure that a prohibited device was not used to restrain a resident.

Rationale and Summary

In accordance with Ontario Regulation 246/22 s. 121 (7), sheets are a prohibited device to restrict the movement of a resident.

On a specified date, a resident was found in their room with a prohibited device around their waist and restrained to their wheelchair.

There was risk to the resident when staff used a prohibited device to restrict their movement.

Sources: CI #2922-000024-23; resident's clinical record; home's investigation notes; interview with the Administrator and other staff. [683]