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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: January 16, 2025
Original Report Issue Date: December 31, 2024
Inspection Number: 2024-1406-0002 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Liuna Local 837 Nursing Home (Ancaster) Corporation
Long Term Care Home and City: Regina Gardens, Hamilton

AMENDED INSPECTION SUMMARY

Compliance Order (CO) #001 was amended to revise the orders as additional information was provided by the home. The CO #001 is being newly issued in this Amended Inspection Report, with a served date of January 16, 2025. All other non-compliances (NC) are included in this report for reference; however, were not amended; therefore, the serve date remains December 31, 2024.

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INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 11, 13, 16-17, and 19, 2024

The following intakes were inspected:

- Intake: #00128169- Complaint related to falls prevention and management, continence care, bowel management, food and nutrition, and palliative care.

- Intake: #00124819- Critical Incident (CI) related to resident injury and resident care and support services.
- Intake: #00126322- CI related to neglect and resident care and support services.
- Intake: #00128113- CI related to resident injury of unknown etiology and resident care and support services.
- Intake: #00128401- CI related to resident injury of unknown etiology and resident care and support services.
- Intake: #00129094- CI related to neglect.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Palliative Care
Falls Prevention and Management

AMENDED 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) 20.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
20. Every resident has a right to ongoing and safe support from their caregivers to

support their physical, mental, social and emotional wellbeing and their quality of life and to assistance in contacting a caregiver or other person to support their needs.

The licensee has failed to ensure that a resident had ongoing support from their caregiver to support their mental, and emotional wellbeing.

Rationale and Summary
On a specified date, a resident's substitute decision maker (SDM) emailed the Assistant Director of Care (ADOC) that the resident had requested for a specific visitation. The ADOC forwarded the request to the Executive Director (ED). The ED responded that the resident did not meet a specific criteria, they were not able to accommodate the request at that time.

The home's Visitors Policy specified that the home was open to residents, their family members and significant others 24 hours a day, seven days a week.

Failure to allow a resident's SDM to visit as requested may have resulted in the resident not feeling emotionally supported.

Sources: A resident's clinical records, email correspondences, Visitor's Policy, and interviews with the ED and other staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of

care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident was reassessed and their specified plan of care was reviewed and revised when the care set out in their plan was not effective.

Rationale and Summary
On a specified date, a complaint was lodged regarding a resident not being provided specific care. A review of the home's investigation records indicated that direct care staff were not reporting to the registered staff when the resident would be resistive to the specified care. Their plan of care did not outline the resident's resistance to the specific care nor were interventions identified when the resident demonstrated resistance. As a result, the resident did not receive thorough care and acquired an altering health status.

The Director of Care (DOC) acknowledged that the residents' plan of care was not reviewed and revised accordingly, and the care set out was not effective at the time. The DOC explained if the registered staff were informed of the resident's resistance of care, a reassessment of the resident and their plan of care could have indicated further interventions required.

Failure to ensure that a resident was reassessed and their plan of care was reviewed and revised when the care set out in the plan was not effective, resulted in the resident having an altered health status.

Sources: A resident's clinical records, CI investigation notes, and interviews with staff and the DOC.

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) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to comply with section (s.) 28 (1) 1 of the Fixing Long-Term Care Act (FLTCA) in that a person, who has reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in harm, failed to report the suspicion and information it was based upon immediately to the Director in accordance with the FLTCA.

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

Rationale and Summary
On a specified date, a staff member informed registered staff about an injury sustained by a resident. The CI was not reported to the Ministry until two days later. The home's ED stated that registered staff should have identified the injury as suspected improper care and reported the incident to the Ministry immediately.

Sources: CI investigation package and an interview with the ED.

WRITTEN NOTIFICATION: General Requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under the pain management program, as required in Ontario Regulations (O.Reg.) 246/22, s. 53 (1), including the assessment, interventions, and their responses to interventions were documented.

Specifically, the home was to complete a new comprehensive pain assessment when a resident reported new pain that was not episodic in nature.

Rationale and Summary
On a specified date, a resident reported pain, swelling, and a skin alteration to a specified area to their body. On review of the resident's clinical records, there was no pain assessment completed when the injury was reported. The ADOC acknowledged there was no pain assessment conducted and should have been completed immediately as per the home's pain management program.

Failure to ensure a pain assessment was conducted for a resident posed a risk for not identifying any interventions and the effectiveness of the interventions.

Sources: A resident's clinical records, CI investigation notes, Pain Management Program, and an interview with the ADOC.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with monitoring of a resident after an unwitnessed fall.

In accordance with O.Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a fall prevention and management program that provided strategies to mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the policy "Resident Fall Prevention Program", which was included in the licensee's Fall Prevention and Management Program.

Rationale and Summary
The home's Resident Fall Prevention Program required registered staff to conduct an assessment of the resident's condition every shift for a minimum of 48 hours following all falls, which must be documented in progress notes. It also specified that a head injury routine (HIR)/neurological assessment would be initiated for 48 hours after an unwitnessed fall. The HIR form specified the monitoring schedule, after the initial assessment, as four times every 30 minutes, four times every hour, five times every four hours, and three times every eight hours.

A resident was found on the floor at a specified date and time.

a) A review of progress notes indicated that only one note was written specifically related to the resident's condition post fall and there should have been at least two progress notes documenting the resident's condition.

b) A review of an HIR, dated a specified date, showed that the schedule was followed until the monitoring shifted to every four hours. At that point, not all of the monitoring was completed as acknowledged by the ADOC.

Failure to complete the post fall monitoring as required may have resulted in staff not identifying complications if a resident had sustained a head injury.

Sources: A resident's clinical records, Resident Fall Prevention Program, and interviews with the ADOC and other staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a clinically appropriate skin assessment when they acquired a skin alteration.

Rationale and Summary
On a specified date, a resident reported a skin alteration to a registered staff member, the DOC, and the ED. On review of the resident's clinical records, there was no initial skin assessment completed when the injury was reported. A skin assessment was completed eight days later. The ADOC acknowledged there was no initial skin assessment conducted and should have been completed immediately as per the home's skin and wound care program.

Failure to complete an initial skin assessment posed a risk for not identifying potential worsening skin conditions.

Sources: A resident's clinical records, CI investigation notes, Skin and Wound Care Program, and an interview with the ADOC.

WRITTEN NOTIFICATION: Palliative Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (2)
Palliative care
s. 61 (2) The licensee shall ensure that the interdisciplinary assessment of the resident's palliative care needs for their plan of care considers the resident's physical, emotional, psychological, social, cultural, and spiritual needs.

The licensee has failed to ensure that an interdisciplinary assessment of a resident's palliative care needs for their plan of care considered the resident's emotional, psychological, social, cultural and spiritual needs.

Rationale and Summary
On a specified date, a resident was transferred to the hospital for a specified condition. At the hospital, the resident's SDM requested a palliative care consultation. A meeting was conducted between the home's management team and the hospital team, with the SDM present. During that meeting the home's team confirmed they were able to provide palliative/end-of-life care for the resident. The resident returned to the home on a specified date.

The ADOC explained that they would complete an interdisciplinary assessment of a resident's palliative care needs if they had the time. The documentation of that assessment would be found in progress notes, care plan and interdisciplinary care conference form in the home's electronic medical record keeping system. During review of the resident's clinical records between the time of the resident's re-admission and passing, on a specified date, no interdisciplinary assessment of the resident's palliative care needs for their plan of care considering their emotional, psychological, social, cultural and spiritual needs was identified.

Failure to complete an interdisciplinary assessment of the resident's palliative care needs may have resulted in their emotional, psychological, spiritual, cultural and social needs not being fully met.

Sources: A resident's clinical records, Palliative Care Philosophy, and an interview with the ADOC.

WRITTEN NOTIFICATION: Resident Records

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)

Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record be kept up to date at all times.

Rationale and Summary
On a specified date, a resident was found on the floor. A registered staff completed a post fall assessment and initiated a HIR. The home's fall policy specified that the resident's condition should be assessed every shift for a minimum of 48 hours post fall and be documented in progress notes.

A review of progress notes between specified dates, showed five late entries that were made 15 days later. The ADOC acknowledged the late entries.

Failure to document contemporaneously may have resulted in registered staff on subsequent shifts and allied health professionals not being fully up to date on the resident's condition.

Sources: A resident's clinical records, Resident Fall Prevention Program, and interviews with ADOC and other staff.

COMPLIANCE ORDER CO #001 Nursing and Personal Support Services

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 11 (1) (b)
Nursing and personal support services

s. 11 (1) Every licensee of a long-term care home shall ensure that there is,
(b) an organized program of personal support services for the home to meet the assessed needs of the residents.

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

Specifically, the licensee must:

1. Provide education to all direct care staff, registered nursing staff, and PSW students in placement within the home of the home's "Nursing Students and Internationally Educated Nurses" policy. Specifically, to ensure that PSW students are not assigned solely to care of residents and that they will work under the supervision of another PSW or assigned mentor.
2. Maintain written records of the education provided and the list of staff and students who received and completed the education. All written records must be available on request.
3. Maintain written records of PSW students' training on the areas listed in the policy's procedure statement under section #10. All written records must be available on request.

Grounds

A) The licensee has failed to ensure there was an organized program of personal support services for the home to meet the assessed needs of the residents.

In accordance with O.Reg. 246/22, s. 11(1)(b), the licensee was required to have their PSW student protocols under the personal support services program complied with. Specifically, to ensure that PSW students do not provide a two-person resident care

with another student without the supervision of the home's regular staff; and to ensure their duty to report changes in a resident's health status that included altered skin integrity, pain, or injury.

Rationale and Summary
On a specified date, a resident sustained a specified injury. On review of the home's investigation records and confirmed by a staff member, the resident was provided specified care by two PSW students without the supervision of the home's regular staff. Both PSW students acknowledged they had observed the resident's specified injury while providing care but did not report the injury to any regular staff.

The ADOC explained that PSW students were given instructions not to provide resident care without their preceptor's supervision specifically with two-person care. Additionally, the ADOC acknowledged that the resident's specified injury should have been reported immediately.

Failure to ensure that PSW students had regular staff supervision when providing care to a resident and reported changes in their status, posed a risk to resident safety and may have resulted in the resident sustaining further injury.

Sources: CI investigation notes, PSW student protocols and education records, a resident's clinical records, and interview with staff.

B) The licensee has failed to ensure there was an organized program of personal support services for the home to meet the assessed needs of the residents.

In accordance with O.Reg. 246/22, s.11(1)(b), the licensee was required to have their PSW student protocols under the personal support services program complied with. Specifically, to ensure that PSW students do not provide a two-person resident care with another student without the supervision of the home's regular staff.

Rationale and Summary

On a specified date, three PSW students provided care to a resident without a regular staff member present. Later that shift, two staff members noted that the resident had a specified area of skin alteration. An x-ray of that area determined that the resident had sustained a specified injury.

The home's investigation notes confirmed that three PSW students provided specified care to the resident without the supervision of a regular staff member. A staff member and the ED confirmed that this was against the home's PSW student protocols.

Failure to ensure that the PSW students had regular staff supervision when providing care to a resident posed a risk to their safety and may have resulted in the resident sustaining the specified injury.

Sources: CI investigation notes, PSW student protocols, a resident's clinical records, and interview with staff.

This order must be complied with by April 1, 2025

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.