

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

Public Report

Report Issue Date: May 15, 2025

Inspection Number: 2025-1406-0003

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 dates: April 22-25, 28- 30, 2025 and May 1-2, 6-9, and 13-15, 2025

The following intakes were inspected:

- Intake: #00135890 - Follow-up #1- CO #001/2024-1406-0002- FLTCA, 2021 - s. 11 (1) (b) Nursing and Personal Support Services, CDD April 1, 2025.
- Intake: #00143217- Complaint related to prevention of abuse and neglect, skin and wound management, falls prevention and management, and nutrition and hydration.
- Intake: #00144049- Critical Incident (CI) related to prevention of abuse and neglect.
- Intake: #00139401- CI related to prevention of abuse and neglect.
- Intake: #00140598- CI related to an unexpected death of a resident.

Previously Issued Compliance Order(s)

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The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1406-0002 related to FLTCA, 2021, s. 11 (1) (b)

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

- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours
- 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. 6 (10) (b)

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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

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The licensee failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed. A resident's specified needs changed in February 2025, prompting an increase in care. The resident's written plan of care was updated to reflect the change on April 29, 2025.

Sources: A resident's care plan and interviews with staff.

Date Remedy Implemented: April 29, 2025

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

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:

16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure that a resident's rights for proper care and services consistent with their needs were upheld. A resident had a significant weight loss within a specified time. The resident was not assessed by the Registered Dietitian (RD) for an identified number of days when the dietary referral was initiated. The RD acknowledged they should have assessed the resident sooner due to their nutritional risk factors.

Sources: A resident's clinical records, Weights and Heights Policy, revised July 2024, Dietary Referral Policy, revised August 2024, and interviews with staff and RD.

WRITTEN NOTIFICATION: Plan of care

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NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in a resident's plan of care regarding specific staff monitoring was provided as specified in their plan. On a date in December 2024, the resident's specific staff monitoring was not in place.

Sources: A resident clinical records and interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 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 when a person who had reasonable grounds to suspect neglect to a resident, that this was immediately reported to the Director. The Executive Director (ED) acknowledged that a Critical Incident (CI) was not reported immediately to the Director.

Sources: CI and interview with ED.

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WRITTEN NOTIFICATION: Skin and wound care

NC #005 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 by a member of the registered nursing staff. A staff member acknowledged that a resident had a specified skin alteration on multiple days in a specified month but did not report them to registered staff for an assessment.

Sources: A resident's clinical records, Skin and Wound Care Program, revised March 2025, and an interview with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

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The licensee has failed to ensure that the ongoing monitoring and assessment of a resident's responsive behaviors using the Behavioural Support Ontario-Dementia Observation System Collection Sheet (DOS) between specified dates, was fully completed.

Sources: A resident's DOS and interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Responsive Behaviour Policy

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 60 (a)

Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee has failed to ensure that procedures and interventions were implemented to assist a resident and staff at risk for harm as a result of the resident's behaviours.

In accordance with Ontario Regulations (O.Reg.) 246/22, section (s.) 11 (1) (b), the licensee was required to ensure the home's Reactive Expressions policy was complied with. Specifically, when staff should seek help when a resident has an episode of violent or aggressive behavior. On a specified date, a resident had an episode of aggressive behavior and staff did not follow the policy's procedures and as a result the resident sustained an injury.

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Sources: Regina Gardens internal investigation notes, Reactive Expressions Policy, revised January 2025, progress notes, and interviews with staff.

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)

Medication management system

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 the home's Medication Administration Policy was implemented in accordance with evidence-based practices. Specifically, registered staff were responsible for signing a resident's Medication Administration Records (MAR) immediately when a medication was administered and to complete a follow-up assessment to determine the effectiveness of any pro re nata (PRN) medications given. A registered staff acknowledged that they had administered a specific PRN to a resident on several occasions on specified dates but had not documented on their MAR when they were administered and their effectiveness.

Sources: A resident's clinical records, Medication Administration Policy, revised June 2024, and interview with staff.