Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 7, 2021	2021_857129_0006	005003-21, 008668-21, 011337-21	Critical Incident System

Licensee/Titulaire de permis

Liuna Local 837 Nursing Home (Hamilton) Corporation
44 Hughson Street South Hamilton ON L8N 2A7

Long-Term Care Home/Foyer de soins de longue durée

Queen's Garden
80 Queen Street North Hamilton ON L8R 3P6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PHYLLIS HILTZ-BONTJE (129), AILEEN GRABA (682)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 30, 31 and September 1, 2021.

The following intakes were inspected:
011337-21 related to an unexpected death
008668-21 and 005003-21 related to injuries for which residents was sent to hospital

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers, Housekeepers, scheduling clerk, resident service aide, Registered Practical Nurses, Registered Nurses, Program Manager, the Director of Care and the Administrator.

During the course of this inspection the inspectors observed residents and resident's environments, reviewed electronic and paper clinical records and reviewed licensee's policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Pain
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee failed to ensure that the home was a safe environment for the residents when they did not ensure identified items were stored in a safe manner.

i. An unsafe environment was created when staff did not provide care to a resident as

specified in the plan of care, specifically that an identified substance brought into the home by the resident was to be stored in the medication room refrigerator and random room checks for four identified items were to be completed.

Clinical notes made by registered staff indicated the resident took an identified item into their room on four identified dates.

Registered Practical nurse (RPN) #112 and RPN #113 acknowledged they were aware that the resident took the identified item into their room.

RPN #112 acknowledged that there was not a plan in place related to the room checks and there would not be clinical documentation that they were completed.

ii. An unsafe environment was created when staff did not comply with three identified licensee policies related to the safe storage of identified items and the management of responsive behaviours.

a) Staff did not comply with an identified licensee policy that provided specific directions and locations for the safe storage of three identified items.

Clinical notes made by registered staff indicated the resident was allowed to take two of the identified items into their room on two identified dates in 2021.

By allowing the resident to take these items into their room the licensee’s policy was not complied with and the items were not stored in a safe manner.

b) Staff did not comply with a second identified licensee policy that provided directions and location for the storage of one identified item.

Clinical notes made by registered staff indicated the resident was found to have this item in their room on four identified dates in 2021.

RPN #112 and RPN #113 acknowledged they were aware the resident took the identified item into their room.

By allowing the resident to take this item into their room, the licensee’s policy was not complied with and the item was not stored in a safe manner.

c) Staff did not comply with the licensee's policy identified as "Responsive Behaviours", when staff did not ensure that for residents who demonstrate responsive behaviours a program of prevention was developed, implemented, evaluated and an interdisciplinary assessment of each behavioural incident was carried out to prevent future incidents.

The clinical record and staff interviewed confirmed they did not implement a responsive behaviour program and did not complete an interdisciplinary assessment for each incident of responsive behaviour when the resident took four unsafe items into their room and these items were not stored in a safe manner.

RPN #113 indicated they expressed concern that they were unable to manage the responsive behaviours demonstrated by the resident, but nothing was done.

The failure of staff to provide care as specified in the resident's care plan, and to comply with three identified the licensees policies created an unsafe environment for the resident and all other residents who may have had access to the resident's room and unsafe items.

Sources: the resident's electronic clinical notes and care plan, three identified licensee policies as well as interviews with RPN #112 and RPN #113.

2. The licensee failed to ensure that the home was a safe environment for the residents when they did not ensure three identified items obtained by a resident were stored in a safe manner.

i. An unsafe environment was created when staff did not provide care to the resident as specified in the plan of care, specifically that three identified items were to be stored in a secure location and random room checks were to be completed by staff to ensure these items were not stored by the resident in their room.

A clinical note made by registered staff on an identified date in 2021, indicated the resident was allowed to take two of the identified items into their room and these items were not stored in a safe manner.

PSW #118 indicated the resident used to be compliant with the safe storage of these items, however, they no longer were. They also confirmed they do not do room checks because the resident becomes angry.

The Administrator acknowledged that they were aware the resident had been non-compliant with safe handing of the items and the resident could become angry with staff if they request these items.

ii. An unsafe environment was created when staff did not comply with three identified licensee policies related to the safe storage of identified items and the management of responsive behaviours.

a) Staff did not comply with an identified licensee policy that provided specific directions and locations for the safe storage of three identified items.

A clinical note made by registered staff on an identified date in 2021, indicated the resident took two of the identified items into their room.

By allowing the resident to take these items into their room, the licensee's policy was not complied with and the items were not stored in a safe manner.

PSW #118 indicated the resident used to be compliant with the safe storage of these items, however, they no longer were.

b) Staff did not comply with a second identified licensee policy that provided directions and location for the storage of one identified item.

Staff did not comply with a second licensee's policy, when staff did not ensure the identified item was stored in a safe manner.

The clinical record and PSW #118 confirmed staff had found the identified item in the resident's room.

c) Staff did not comply with the licensee's policy identified as "Responsive Behaviours", when staff did not ensure that for residents who demonstrate responsive behaviours a program of prevention was developed, implemented, evaluated and an interdisciplinary assessment of each behavioural incident was carried out to prevent future incidents.

The clinical record and staff interviewed confirmed that they did not implement a responsive behaviour program and did not complete an interdisciplinary assessment for each incident of responsive behaviour when the resident demonstrated behaviour related to the unsafe storage of identified items.

The failure of staff to provide care as specified in the resident's care plan, and to comply with three identified licensee policies created an unsafe environment for the resident and all other residents who may have had access to the resident's room.

Sources: the resident's electronic clinical notes and care plan, three identified licensee policies as well as interviews with PSW #118 and the Administrator.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

a) The licensee failed to ensure that care set out in a resident's plan of care was provided to the resident as specified in the plan, related to storage of an identified item and random room checks for two identified items.

The resident's plan of care directed the staff nurse would keep the identified item the resident had brought into the home in the refrigerator located in the medication room and random checks for two identified items would be completed.

Clinical notes made by registered staff indicated that on three identified dates in 2021, staff documented the resident took the identified item into their room and on another day in 2021, staff documented the identified item was found in the resident's room.

RPN #112 confirmed they did not ensure that the identified item brought into the home was secured in the medication room, verified the directions in the care plan were not followed and indicated there was not a plan in place related to random room checks and

there would be no documentation of the room checks.

RPN #113 and the Director of Care (DOC) confirmed interventions in the care plan to ensure the identified item was stored in the medication room and to complete random room checks for two identified items were not followed.

The failure of staff to ensure the identified item was not kept in the resident's room and random room checked for two identified items were completed, created a safety hazard for the resident and other residents who may enter the resident's room and have access to the two unsafe items.

Sources: the resident's electronic clinical notes and care plan as well as interviews with RPN #112, RPN #113 and the DOC.

b) The licensee failed to ensure that care set out in a resident's plan of care was provided to the resident as specified in the plan, related completing random room checks for an identified item and the safe storage of two identified items.

i. Staff did ensure care set out in the plan of care was provided to the resident, related to completing random room checks for an identified item.

The plan of care indicated the resident had been non-compliant with storage of an identified item they brought into the home and random checks for an identified item would be completed.

PSW #118 confirmed that staff had found the identified item in the resident's room and staff had not competed random room checks because the resident did not allow people in their room and staff were fearful of the resident.

RPN #112 confirmed there was not a plan in place for room checks to occur and there would be no documentation of random room checks being done.

The Administrator indicated that random room checks were not completed if the resident did not want them done and this resident did not want random room checks completed.

ii. Staff did not ensure care set out in the plan of care was provided to a resident, related to two identified items.

The plan of care indicated that the resident may refuse to provide registered staff with the identified items and staff were to remind the resident to return these items to the nursing station after they had used them.

A clinical note made by registered staff on an identified date in 2021, indicated when the resident returned to the home, they declined to give staff the two identified items and took them to their room.

There was no further documentation to indicate staff reminded the resident and the two identified items was provided to the registered staff for safe storage.

PSW #118 confirmed that the resident used to be compliant with the safe storage of these items, but they no longer were.

At the time of this inspection observations of the medication room confirmed these items had not been stored in the medication room.

Staffs failure to ensure care was provided to the resident as directed in the plan of care related to the completion of random room checks and the safe storage of the identified items created an unsafe environment for the resident and other residents who may enter the resident's room and access these items.

Sources: the resident’s electronic progress notes and care plan, observations in the medication room and interviews with PSW #118, RPN #112 and the Administrator.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

a) The licensee failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (4), the licensee is required to have an interdisciplinary pain management program.

In accordance with O. Reg. 79/10, s. 30 (1) 1, the licensee is to ensure that every organized program under section 48 of this Regulation has written policies.

Specifically, staff did not comply with the licensee's policy titled: "Pain", which directed registered staff to complete a new comprehensive pain assessment tool when a resident reports new pain that is not episodic in nature or easily addressed with medication adjustment.

i. According to the Critical Incident System (CIS) submission and progress notes, a resident sustained an injury. On an identified date in 2021, an ambulance arrived at the home because the resident had pain in their left leg and decreased mobility.

Personal Support Worker (PSW) #111 stated that earlier in their shift the resident reported burning in both legs and they had informed Registered Practical Nurse (RPN) #116.

Further review of the resident's clinical record did not include any completed comprehensive pain assessments at the time of the incident. The resident stated that they had experienced and reported significant pain in their left leg, and no one assisted

them.

RPN #108 and the Director of Care (DOC) confirmed that a comprehensive pain assessment should have been completed by registered staff when the resident reported pain in their legs.

ii. According to the CIS and progress notes a resident sustained an injury. Progress notes made on an identified date in 2021, indicated RPN #102 administered an identified medication to the resident when they reported pain. Post administration the resident stated "that medication doesn't work". RPN #102 contacted the nurse practitioner as a result and informed them of the resident's continued reports of pain.

A further review of the resident's clinical record did not include a comprehensive pain assessment. RPN #102 acknowledged that a comprehensive pain assessment should have been completed as the resident's pain was not relieved with medication administration.

Because the resident did not receive a comprehensive pain assessment when indicated, the resident was at risk for inadequate pain management.

Sources: CIS 2853-0000006-21, CIS 2853-0000009-21, the resident's electronic medical record, Licensee "Pain" policy last revised December 2017, Interview RPN #102, RPN #108, DOC and other staff. (682)

b) The licensee failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (4), the licensee is required to have an interdisciplinary pain management program.

In accordance with O. Reg. 79/10, s. 30 (1) 1, the licensee is to ensure that every organized program under section 48 of this Regulation has written policies.

Specifically, staff did not comply with the licensee's policy titled: "Pain", which directed registered staff to complete a new comprehensive pain assessment tool when a resident reports new pain that is not episodic in nature or easily addressed with medication adjustment.

According to the CIS and progress notes, a resident sustained an injury. On an identified date in 2021, RPN #102 documented they had identified the resident was experiencing pain in their right lower leg and had no mobility. A diagnostic procedure was performed and due to the findings, the resident was transferred to the hospital for further treatment.

Further review of the resident's clinical record did not include a completed comprehensive pain assessment of the new pain reported by the resident. RPN #102 confirmed that a comprehensive pain assessment would have been indicated and should have been completed.

Because the resident did not receive a comprehensive pain assessment when indicated, the resident was at risk for inadequate pain management.

Sources: CIS 2853-000010-21, the resident's electronic medical record, Licensee "Pain" policy last revised December 2017, interview RPN #102 and other staff. (682)

c) The licensee failed to ensure that policies and procedures included in the organized program of nursing services were complied with related to, the safe storage of identified items, substances and responsive behaviour policies.

In accordance with O. Reg. 79/10 s. 30 (1), every licensee shall ensure that for each of the organized programs required under section 8 to 16 of the Act there must be a written description of the program that includes goals and objectives and relevant policies, procedures and protocols and provide for methods to reduce risk and monitor outcomes.

In accordance with LTCHA, 2007 s. 8(1), every licensee of a long-term care home shall ensure there is an organized program of nursing services to meet the assessed needs of the residents.

The licensee's policies related to an identified activity, a specific substance and the management of responsive behaviours were not complied with for a resident.

1. An identified licensee policy last revised in September 2018, directed:
i. A resident's care/support plan must identify if the resident is safe to perform the identified activity without supervision.
ii. Residents who reside in LTC home may not maintain five identified items on their person. All items must be accounted for after use and are secured in the designated area

after each use.

Staff did not comply with the directions contained in this policy when the resident's care plan did not identify if the resident was safe to perform the identified activity without supervision.

Staff did not comply with the directions contained in this policy when clinical notes made by registered staff on three identified dates indicated resident #001 did not comply with the safe storage of two of the identified items and took these items into their room.

Registered Practical Nurse #113 and Director of Care (DOC) confirmed the resident was non-compliant with the safe storage of two of the identified items identified in the policy when they took these items into their room.

2. A second identified licensee policy related to an identified substance directed:
I. The identified substance is to be stored by the home in a locked room and residents are not permitted to store the substance in their room.

Staff did not comply with directions contained in this policy when clinical notes made by registered staff on four identified dates in 2021, indicated the resident stored the identified substance in their room.

RPN #112 confirmed that the resident was non-compliant with the safe storage of the substance, confirmed they were aware that the resident was not allowed to have the substance in their room and the policy had not been followed.

3. Licensee policy located in the Clinical and Resident Care section, identified as LTC-CA-WQ-200-07-13 "Responsive Behaviours", revised December 2017 directed:
i. It is the responsibility of the care team to develop and implement a program of prevention, treatment, management, and evaluation of those residents who demonstrate various forms of responsive behaviours.
ii. Strategies will be evaluated for resident response and effectiveness.
iii. An interdisciplinary analysis of each incident should be carried out to serve the purpose of prevention in the future.

Staff did not comply with the directions contained in the "Responsive Behaviour" policy when clinical notes indicated the resident demonstrated responsive behaviours related to the unsafe storage of identified items and substances.

The resident's plan of care did not contain a care focus, goals or interventions related to the behaviour demonstrated by the resident and there was no evidence in the clinical record that a program of behaviour prevention was developed when the resident demonstrated the behaviour of keeping unsafe items and substances in their room.

Registered staff were aware of the behaviour when they documented clinical notes that the resident demonstrated the behaviour on five identified dates in 2021.

The clinical record did not provide evidence that the effectiveness of actions taken to manage the behaviour were evaluated or an interdisciplinary analysis of each of these incidents was carried out for the purpose of preventing the behaviour in the future.

RPN #112 indicated that when the resident demonstrated responsive behaviour related to the unsafe storage of an identified substance, they could not force the resident to comply with the policy and did not know how to address the issue. They confirmed that there was not a plan in place about what they should do when the resident demonstrated this behaviour.

RPN #113 indicated they had communicated their concern that they were unable to effectively manage the behaviours demonstrated by the resident, ensure compliance with the directions in the resident’s care plan and comply with the policies but actions were not taken related to their concerns. The DOC confirmed the information RPN #113 communicated to the Inspector.

The failure of staff to ensure policies related to the safe storage of items and substances and management of responsive behaviours resulted in an unsafe environment for resident #001 and other residents who may have access to the resident’s room.

Sources: the resident’s electronic clinical notes and electronic care plan, Three identified licensee policies as well as interviews with RPN #112, RPN #113 and the DOC.

d) The licensee failed to ensure that a policy included in the organized program of nursing services was complied with for a resident related to an identified resident activity.

In accordance with O. Reg. 79/10 s. 30 (1), every licensee shall ensure that for each of the organized programs required under section 8 to 16 of the Act there must be a written description of the program that includes goals and objectives and relevant policies,

procedures and protocols and provide for methods to reduce risk and monitor outcomes.

In accordance with LTCHA, 2007 s. 8(1), every licensee of a long-term care home shall ensure there is an organized program of nursing services to meet the assessed needs of the residents.

The licensee's policy related to the identified resident activity was not complied with for the resident.

An identified licensee policy revised September 2018 directed: A resident's care/support plan must identify if the resident is safe to perform the activity without supervision.

Staff did not comply with the directions contained in the identified policy when the resident's care plan did not identify if the resident was safe to perform the activity without supervision.

Sources: the resident's care plan and the identified licensee's policy.

e) The licensee failed to ensure that policies and procedures included in the organized program of nursing services were complied with for a resident related to an identified activity, the storage of an identified substance and responsive behaviours.

In accordance with O. Reg. 79/10 s. 30 (1), every licensee shall ensure that for each of the organized programs required under section 8 to 16 of the Act there must be a written description of the program that includes goals and objectives and relevant policies, procedures and protocols and provide for methods to reduce risk and monitor outcomes.

In accordance with LTCHA, 2007 s. 8(1), every licensee of a long-term care home shall ensure there is an organized program of nursing services to meet the assessed needs of the residents.

The licensee's policies related to an identified resident activity, the use of a substance and the management of responsive behaviours were not complied with for the resident.

1. An identified licensee policy revised September 2018 directed: Residents who reside in LTC home may not maintain four identified items on their person. All items must be accounted for after use and are secured in the designated area after each use.

Staff did not comply with the directions contained in the identified policy when a clinical note made by registered staff on an identified date in 2021, confirmed staff had not ensured the resident did not take two of the identified items into their room.

The resident's plan of care indicated that the resident may refuse to comply with directions contained in the policy and staff were to remind the resident to return the items to the registered staff after their use.

PSW #118 confirmed the resident no longer gives the identified items to registered staff when they are finished using them.

RPN #119 acknowledged that they were not aware that residents could not keep the two identified items in their rooms.

The Administrator acknowledged that the resident had been non-compliant in the past with providing the identified items to registered staff and indicated this was a particular concern with this resident.

2. An identified licensee policy revised December 2017 directed: An identified substance is to be stored by the home in a locked room; residents are not permitted to store this substance in their room.

The resident's care plan acknowledged they had been non-compliant in the safe handing of this substance, as per the policy.

Staff did not ensure the resident did not take the identified substance into their room when PSW #118 confirmed staff had found this substance in the resident’s room.

3. The licensee policy located in the Clinical and Resident Care section, identified as LTC-CA-WQ-200-07-13 "Responsive Behaviours", revised December 2017 directed: It is the responsibility of the care team to develop and implement a program of prevention, treatment, management, and evaluation of those residents who demonstrate various forms of responsive behaviours, strategies will be evaluated for resident response and effectiveness and interdisciplinary analysis of each incident should be carried out to serve the purpose of prevention in the future.

Staff did not comply with the directions contained in the "Responsive Behaviour" policy when staff and a clinical note indicated the resident demonstrated responsive behaviours

when they did not comply with directions to provide a substance and two identified items to registered staff for safe keeping.

The resident’s plan of care did not contain a care focus, goals or interventions related to the behaviour demonstrated by the resident and there was no evidence in the clinical record that a program of behaviour prevention was developed when the resident demonstrated the unsafe behaviour of taking the identified items and the substance into their room.

The clinical record indicated staff were aware of the responsive behaviours when they documented on an identified date in 2021, that the resident declined to provide the two items for safe storage after they had finished using them and staff verified that an identified substance was found in the resident’s room.

The resident's plan of care contained a care focus related to the use of the substance which indicated the resident may refused to provide the identified substance to registered staff for safe storage.

The resident's plan of care contained a care focus related to the identified activity which indicated the resident may refuse to comply with the homes policy.

PSW #118 confirmed that the resident no longer provided the registered staff with the identified items and that staff had found the identified substance in the resident’s room.

The Administrator acknowledged the resident had been non-compliant in the past with providing the identified items and indicated this was a particular concern with this resident because they would become aggressive and threatening if staff requested they provide the items for safe storage.

The failure of staff to ensure policies related to identified items, an identified substance and management of responsive behaviours resulted in an unsafe environment for the resident, as well as other residents who may have access to the resident's room and the unsafe items and substances.

Sources: the resident’s electronic clinical notes and electronic care plan, three identified licensee policies as well as interviews with PSW #118 and the Administrator.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring where the Act and Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

a) The licensee failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to interventions were documented related behaviours that resulted in the unsafe storage of a substance and two identified items.

A resident demonstrated responsive behaviours when they stored two items and a substance in an unsafe manner in their room.

The care plan directed that the resident was to provide all of the identified items and substances to staff for storage in the medication room and that random room checks would be conducted to ensure these items were not stored in the resident's room.

The resident had been in the home for many years and was aware of the requirements for the storage of the identified items and the identified substance.

The resident began to demonstrate responsive behaviours when they failed to inform staff that they had brought the items into their room, refused to surrender the items to staff and refused to allow staff to enter their room to check for the items. Clinical notes made by registered staff indicated on five identified dates in 2021, the items and the substance were found in their room.

Registered Practical Nurse (RPN) #112 confirmed they did not ensure a substance brought into the home by the resident was secured in the medication room because the resident refused to surrender it and indicated they could not force the resident to provide the substance. RPN #112 confirmed interventions were not developed or implemented to respond to the resident's refusal to provide staff with items the resident was aware could not be kept in their room.

RPN #113 confirmed that the resident refused to provide two identified items and the resident took these items to their room. They indicated the inability to manage these behaviours had been raised but no actions had been taken or interventions identified to manage these behaviours.

The failure of staff to document the resident's responses to behavioral interventions and the failure of staff to reassess the resident when the interventions were not successful, resulted in the behaviours continuing to be demonstrated which created an unsafe environment for the resident and other residents who may access the resident's room and unsafe items and substances the resident stored in their room.

Sources: the resident's electronic clinical notes and care plan as well as interviews with RPN #112 and RPN #113.

b) The licensee failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to interventions were documented related behaviours that resulted in the unsafe storage of two identified items and one identified substance by a resident.

The resident demonstrated responsive behaviours when they brought the two identified

items and the substance into the home and kept these items in their room.

The resident's care plan related to the identified substance, confirmed the resident demonstrated responsive behaviours when the plan identified that the resident displays anger towards staff and they had been non-compliant with the handing and safe storage of the identified substance.

The resident’s care plan related to an identified activity, confirmed the resident demonstrated responsive behaviours when the plan identified the resident may refuse to provide registered staff with two identified items when they had finished with them.

PSW #118 indicated the resident used to give staff the two identified items after they were finished with them, but they no longer do, staff had found the identified substance in the resident's room and they do not do random room checks for the items or the substance because the resident does not allow people in their room and the resident gets angry if they ask the resident for the identified items or to check their room.

The Administrator indicated they were aware the resident had been non-compliant in the past with providing the two identified items to registered nurses to be secured in the medication room. They indicated that the resident was a particular concern.

The clinical record and staff indicated the resident was not reassessed, unsuccessful interventions were not reviewed or revised, the resident's responses to interventions were not consistently document and the behaviours continued to be demonstrated by the resident.

The failure of staff to document the resident's responses to behavioral interventions and the failure of staff to reassess the resident when the interventions were not successful, resulted in the behaviours continuing to be demonstrated which created an unsafe environment for the resident and other residents who may access the resident's room and unsafe items and substance the resident stored in their room.

Sources: the resident's electronic clinical notes and care plan as well as interviews with PSW #118 and the Administrator.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to interventions were documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (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. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee failed to ensure that actions taken with respect to pain management for a resident, including assessments, reassessments, intervention, and the resident's responses were documented.

In accordance with O. Reg. s. 48 (1) 4, the licensee is required to have a Pain Management program.

According to a Critical Incident submission (CIS) while at the home the resident informed ambulance attendants they were experiencing pain in their leg. The resident also reported to the ambulance attendants that the pain medication they had received at the home was ineffective.

Personal Support Worker (PSW) #111 stated that they were providing care to the resident when they reported to Registered Practical Nurse (RPN) #116 that the resident was experiencing pain in their leg. The PSW confirmed they observed RPN #116 respond to their report and attempted to assess the resident, but the resident was resistive and did not allow the registered staff to perform an assessment.

Further review of the resident's clinical record did not include any documentation of RPN's #116 attempts of assessments, reassessments of pain or resident responses to interventions to manage pain.

RPN # 108 confirmed the resident's clinical record did not include any documentation related to the incident or PSW reports that the resident had experienced any pain during care.

The licensee's pain policy directed registered staff to follow up on verbal reports from the personal support workers (PSW) by assessing the resident for new or an exacerbation of current pain. The evaluation of the effectiveness of interventions was to be documented in the resident's health record.

Sources: CIS 2853-0000006-21, the resident's electronic medical record, Pain policy last revised December 2017 Policy No. LTC- CA-WQ-200-05-04, interview PSW #111, RPN #108, and other staff.

Issued on this 8th day of October, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129), AILEEN GRABA (682)
Inspection No. / No de l’inspection :	2021_857129_0006
Log No. / No de registre :	005003-21, 008668-21, 011337-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 7, 2021
Licensee / Titulaire de permis :	Liuna Local 837 Nursing Home (Hamilton) Corporation 44 Hughson Street South, Hamilton, ON, L8N-2A7
LTC Home / Foyer de SLD :	Queen's Garden 80 Queen Street North, Hamilton, ON, L8R-3P6
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Candice Lanthier

To Liuna Local 837 Nursing Home (Hamilton) Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must comply with s. 5 of the LTCHA 2007.

Specifically, the licensee must:

1. Identify and maintain a list of all residents, including resident #006, who bring or have visitors bring two identified items and one identified substance into the home.

2. Provide training to registered staff and personal support workers related to the licensee's policy related to an identified resident activity and the use of an identified substance.

3. Develop and implement a written plan that will be initiated when it has been identified that the licensee's policies related to the safe storage of identified items and substances have not been complied with by staff or residents.

4. Develop, implement, and document responsive behaviour plans of care for any resident who demonstrates behaviours related to the safe storage of the identified items and substances.

5. Develop and implement an auditing tool for the review of the identified residents care plans to ensure the directions related to the storage of identified items and substances are clear and staff have complied with those directions.

6. Auditing is to continue until no further issues have been identified.

Grounds / Motifs :

1. The licensee failed to ensure that the home was a safe environment for the residents when they did not ensure identified items and substances obtained outside the home by a resident were stored in a safe manner.

i. An unsafe environment was created when staff did not provide care to the resident as specified in the plan of care, specifically that an identified substance brought into the home by the resident was stored in the medication room refrigerator and random room checks for identified items and substances were completed.

Clinical notes made by registered staff indicated the resident took an identified substance into their room on four identified dates in 2021.

Registered Practical nurse (RPN) #112 and RPN #113 acknowledged they were aware that the resident took the identified substance into their room.

RPN #112 acknowledged that there was not a plan in place related to the room checks and there would not be clinical documentation that they were completed.

ii. An unsafe environment was created when staff did not comply with the licensee's policies related to the safe storage of identified items, identified substances and responsive behaviours.

a) Staff did not comply with the licensee's policy identified as related to a resident activity, when staff did not ensure two identified items were not stored on the resident's person, all items were accounted for after use and were secured in the designated area after each use, as was required in the policy.

Clinical notes made by registered staff indicated a resident took two identified items into their room on two identified dates in 2021.

RPN #112 and RPN #113 acknowledged they were aware that resident #001 took the two identified items into their room.

b) Staff did not comply with the licensee's policy related to an identified substance, when staff did not ensure that the substance was stored in a locked room and residents did not have the substance in their room, as was required in

the policy.

Clinical notes made by registered staff indicated the resident took the identified substance into their room on four identified dates in 2021.

RPN #112 and RPN #113 acknowledged they were aware that resident #001 took the identified substance into their room.

c) Staff did not comply with the licensee's policy identified as "Responsive Behaviours", when staff did not ensure that for residents who demonstrate responsive behaviours a program of prevention was developed, implemented and evaluated and an interdisciplinary assessment of each incident was carried out to prevent future incidents.

The clinical record indicated that a resident demonstrated responsive behaviours related to the unsafe storage of two identified items and an identified substance on six identified dates in 2021.

The clinical record and staff interviewed confirmed that they did not implement a responsive behaviour program and did not complete an interdisciplinary assessment for each incident of responsive behaviour when the resident demonstrated the behaviour and took the identified items and substances into their room.

RPN #113 indicated they expressed a concern that they were unable to manage the responsive behaviours demonstrated by the resident, but nothing was done.

The failure of staff to provide care as specified in the resident's care plan, and to comply with three identified licensee's policies created an unsafe environment for the resident and all other residents who may have had access to the resident's room and the unsafe items and substances that were stored in their room.

Sources: the resident's electronic clinical notes and care plan, three identified licensee's polices as well as interviews with RPN #112 and RPN #113.
(129)

2. The licensee failed to ensure that the home was a safe environment for the residents when they did not ensure identified items and substances outside the home by a resident were stored in a safe manner.

i. An unsafe environment was created the staff did not provided care to the resident as specified in the plan of care, specifically that an identified substance and two identified items brought into the home by the resident were to be stored in a secure location and random room checks were to be completed by staff to ensure these products were not stored by the resident in their room.

A clinical note made by registered staff on an identified date in 2021, indicated the resident declined to provide two identified items when they had finished with them and took these items into their room.

Personal Support Worker (PSW) #118 indicated resident #006 used to provide the identified items to registered staff but they no longer did this, staff have found the identified substance in the resident's room and random room checks for the identified substance and the identified items were not completed because the resident gets angry.

The Administrator acknowledged that they were aware the resident had been non-complainant with the safe storage of the two identified and the resident can get angry with staff if they request these items.

ii. An unsafe environment was created when staff did not comply with the licensee's policies related to a resident activity and identified substance and responsive behaviours.

a) Staff did not comply with the licensee's policy related to a resident activity when staff did not ensure identified items were not store on the resident's person, all items were accounted for after use and were secured in the designated area after each use, as was required in the policy.

A clinical note made by registered staff on an identified date in 2021, indicated a resident declined to provide the identified items when they had finished using them and these items were taken into their room.

PSW #118 indicated the resident used to provide registered staff with the identified items, but they no longer did this.

The Administrator acknowledged that they were aware the resident was non-compliant with the safe storage of the identified and that the resident can become angry when the staff ask for these items.

The clinical record and staff interviewed confirmed the licensee's policy related to an identified resident activity was not complied with when the resident took the identified items into their room.

b) Staff did not comply with the licensee's policy related to the use of an identified substance, when staff did not ensure that the substance brought into the home by a resident was stored in a locked room and the resident did not have the substance in their room, as was required in the policy.

PSW #118 confirmed that staff had found the identified substance in the resident's room.

c) Staff did not comply with the licensee's policy identified as "Responsive Behaviours", when staff did not ensure that for residents who demonstrate responsive behaviours a program of prevention was developed, implemented, evaluated and an interdisciplinary assessment of each incident was carried out to prevent future incidents.

The clinical record, including a resident's care plan confirmed there was not a care focus or interventions to manage responsive behaviours when the resident demonstrated the unsafe storage of identified items and substances.

The failure of staff to provide care as specified in the resident's care plan and to comply with three of the licensee's policies created an unsafe environment for the resident and all other residents who may have had access to the resident's room and the unsafe items that were stored in their room.

Sources: the resident's electronic clinical notes and care plan, three identified licensee policies, as well as interviews with PSW #118 and the Administrator.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

An order was made by taking the following factors into consideration:

Severity: An unsafe environment was created when resident #001 and resident #006 stored unsafe identified items and substances in their room, leading to a risk of actual harm for those residents and any other resident who may have access to their rooms and the unsafe items stored there.

Scope: The scope of the non-compliance was noted to involve resident #001 and resident #006. Another resident who was identified as using the identified items and the identified substance was reviewed and no safety issues were identified.

Compliance History: A Voluntary Plan for Correction (VPC) was issued for s. 5 of the LTCHA 2007, on April 16, 2019 during inspection #2019_556168_007. In addition, five Written Notifications (WN), 22 VPCs and five Compliance Orders (CO) were issued to different sections of the legislation in the past 36 months. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 14, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax 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
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 7th day of October, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

Service Area Office /
Bureau régional de services : Hamilton Service Area Office