Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
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Original Public Report

Report Issue Date: August 10, 2023

Inspection Number: 2023-1338-0004

Inspection Type:
Complaint
Critical Incident System

Licensee: Liuna Local 837 Nursing Home (Hamilton) Corporation

Long Term Care Home and City: Queen's Garden, Hamilton

Lead Inspector	**Inspector Digital Signature**
Barbara Grohmann (720920)	Barbara Grohmann 2023.08.16 14:38:09 -04'00'

Additional Inspector(s)
Michelle Warrener (107)
Services of a translator were used during the inspection.
Inspector Yulia Fedotova (632) assisted during the inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 13-16, 19-21, 23, 26-30, July 4, and 6, 2023.

The following intake was completed in this complaint inspection:

- Intake #00086716 was related to resident rights.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake #00014736 (CI 2853-000021-22) was related to physical abuse.
- Intake #00022401 (CI 2853-000001-23) was related to falls prevention and management.
- Intake #00088328 (CI 2853-000004-23) was related to reporting a complaint; and
- Intake #00089798 (CI 2853-000005-23) was related to physical abuse.

The following intake was completed in this inspection: Intake #00087484, CI 2853-000003-23 was related to falls prevention and management.

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

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Residents' Rights and Choices
Responsive Behaviours

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) 19. i.

The licensee did not ensure that the rights of a resident were respected in relation to participating in the development, implementation, review, and revision of their plan of care.

Rationale and Summary
A resident contacted the Ministry of Long-Term Care with concerns about their placement in Long-Term Care and that they were not being included in care decisions.

a) The resident did not speak or understand most English communication. Staff at the Long-Term Care (LTC) home identified one family member as the resident's substitute decision maker (SDM). On admission, information about the resident's previous routines, preferences, and adjustment to the home was gathered from that family member or staff. The resident was not consistently included in the process; however, the resident signed their own consent forms on admission to the home.

Since that time, staff have contacted the family member for information and decisions about the resident's care needs. The home was unable to provide documentation of whether the resident was incapable of making health care decisions.

A registered practical nurse (RPN) stated the resident was capable of making decisions about their daily activities and care needs. Personal support workers (PSW) indicated that the resident was independent and did not require staff assistance for activities of daily living.

b) Prior to admission, a medical appointment was arranged for and consented by the resident. The appointment was cancelled by the staff at the request of the family member without the involvement or consent of the resident.

An RPN was provided a letter from the resident regarding that medical appointment and medical issues. The letter and an assessment were provided to the Director of Care (DOC) who acknowledged that they did not discuss the resident's medical concerns with the resident.

The resident was also not made aware of how to access their finances until almost a year after admission.

c) A four-page handwritten letter, signed with the resident's name, was located in the resident's physical chart. The letter voiced concerns with their medications, among other specific matters.

The resident stated that staff did not follow up with them regarding the contents of the letter. Front line and Management staff denied knowledge of the letter until the home was contacted by a Ministry of Long-Term Care Inspector.

The resident explained they had increased medical complications as a result of their placement in LTC, where they could not effectively communicate and were not always able to participate in decisions about their care.

Sources: resident's clinical records, Interviews with the resident, financial representative, Administrator, DOC and other staff; admission Behavioural Supports Ontario Who Am I form and progress notes, recreation admission assessment, records from administrative staff. [107]

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) 19. iii.

The licensee did not ensure that the rights of a resident were respected related to participating in any decision concerning their admission, discharge, or transfer to or from a long-term care home and the right to obtain an independent opinion with regard to any of those matters.

Rationale and Summary
A letter, signed with the resident's name, was located in their physical chart. The letter stated that they

had been at the home for four months and voiced concerns about their placement in LTC. The resident was requesting assistance to have a re-assessment of their ability to make certain decisions.

The resident stated that staff did not follow up with them as a result of the letter. Management and front-line staff denied knowledge of the letter until the home was contacted by a Ministry of Long-Term Care Inspector.

The resident was not provided an opportunity to have an independent opinion about their admission to the home until a Ministry of Long-Term Care Inspector spoke with them about their concerns and an appointment with the Psycho-Geriatrician was scheduled. The resident was also not informed of how the home was managing their request and expected timelines for a decision/outcome.

The resident stated they had increased medical complications as a result of the placement in LTC where they could not effectively communicate and were not always able to participate in decisions about their care.

Sources: resident's clinical records, Interviews with resident, Administrator, DOC and other staff. [107]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect two residents from abuse by anyone.

Section 2 (1) of the Ontario Regulation (O. Reg.) 246/22 defined physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
a) A resident was observed exhibiting a behaviour toward another resident by a volunteer which resulted in an injury.

b) The resident was observed exhibiting a behaviour toward a different resident by staff which resulted in an injury.

Behavioural Supports Ontario (BSO) consultant acknowledged that prior to the first incident, there were no interventions that directly addressed those behaviours exhibited towards other residents. New

interventions were implemented after that incident but were not utilized during the second incident.

The DOC acknowledged that both incidents met the definition of abuse.

Failure to protect the residents from abuse by anyone resulted in inquiries and had the potential for emotional trauma.

Sources: two residents clinical notes, interviews with DOC, BSO and other staff. [720920]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to immediately comply with section (s.) 28 (1) 2 of the Fixing Long-Term Care Act (FLTCA) in that a person, who has reasonable grounds to suspect abuse of a resident by anyone, failed to report the alleged abuse 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
A volunteer witnessed a resident exhibit a behaviour toward another resident which resulted in an injury.

Critical incident (CI) report 2853-000021-23, documented that the incident was reported to the Director three days after the witnessed abuse.

The registered staff, who assessed and treated the resident's injury, acknowledged that they did not call the Ministry's after-hours line to report the incident. The home's policy, Abuse Allegations and Follow Up, stated that abuse reporting was immediate and mandatory.

The DOC acknowledged that the timing of the reporting did not meet the requirements and that the registered staff received coaching on Ministry reporting timelines specifically regarding abuse.

Failure to immediately notify the Director of witnessed abuse had the potential for the Director to be unaware of the incident and to take actions as needed.

Sources: two residents' clinical records, home's CI investigation notes, Abuse Allegations and Follow Up policy (LTC-CA-WQ-100-05-02, July 2016), CI 2853-000021-23; interviews with the DOC and other staff. [720920]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident after a fall.

Rationale and Summary:
A resident had a fall which resulted in an injury. The resident was found sitting on the floor and in pain. A post fall pain assessment identified the resident's pain was severe and worsened with specific movements.

The resident refused to have certain assessments completed while they were on the ground due to their pain. Staff acknowledged that the resident was unable to get up independently. Two staff, who attended the fall, physically transferred the resident from the floor to a wheelchair and then to the bed without using a mechanical lift and prior to a full assessment.

The home's, "Resident Falls Prevention Program" policy directed staff to use a mechanical lift for lifting residents after a fall unless the resident was able to stand independently with minimal assistance from staff. The policy also directed staff to complete a head-to-toe assessment prior to moving a resident after a fall.

Failure of staff to follow the home's fall policy regarding post fall transfer may have caused increased pain and potential injury to the resident.

Sources: Policy LTC-CA-WQ-200-07-08 Resident Falls Prevention Program, Revised June 2022, Resident's clinical records, interviews with staff. [107]

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) (b)

The licensee has failed to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to their behaviours, specifically when a resident began demonstrating certain responsive behaviours.

Rationale and Summary
A resident was identified as having responsive behaviours and all interventions in their care plan were designed to address those behaviours.

The resident began exhibiting additional behaviours towards multiple resident during a short time frame. A referral was faxed to BSO and their intake form indicated worsening behaviours. BSO trialed a strategy that they believed addressed the possible triggers for their behaviours. BSO had documented in Point Click Care (PCC) that they were aware that the resident was exhibiting new behaviours towards other residents. The BSO consultant acknowledged that no interventions were in place or developed to specifically address those new behaviours.

The DOC acknowledged that they were aware of the change in the resident's behaviours at that time and that interventions to address those behaviours were put in place after the last incident.

The home's Responsive Behaviours policy stated that appropriate methods of interventions should be determined and care planned for.

Failure to develop and implement strategies to address the change in the resident's responsive behaviours resulted in altercations with co-residents and had the potential for those altercations to escalate.

Sources: multiple residents' clinical records, Responsive Behaviours policy (LTC-CA-WQ-200-07-13, December 2017); and interviews with the DOC, BSO consultant and other staff. [720920]

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)

The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including implementing interventions, specifically related to a resident's altercations with three other residents.

Rationale and Summary
A resident was discharged from BSO's case load. Their discharge summary noted an increase in responsive behaviours and risk to other residents.

The resident exhibited responsive behaviours towards another resident which resulted in an injury. Following that incident, interventions were added to the resident's care plan to address those specific behaviours and prevent further altercations.

Progress notes documented that the resident exhibited responsive behaviours towards a different resident that did not result in an injury. The interventions that were put in place after the first incident were not implemented, resulting in the altercation.

The resident had multiple altercations with a third resident. The RPN and PSW were in the same location during the incident. They stated that they were unaware that those interactions occurred and did not implement interventions that were in the resident’s care plan.

The resident exhibited responsive behaviours toward a forth resident which resulted in an injury. Interventions were not implemented to prevent the incident from occurring.

The home's Responsive Behaviour policy stated that staff were to monitor a resident for inappropriate behaviour and intervene before harmful, combative or frustrated behaviour was expressed.

The PSW acknowledged that they did not see the earlier incident between the two residents, despite being in the same location, but was aware of the interventions in the resident’s care plan designed to prevent such altercations.

The DOC acknowledged that the RPN and PSW were not following the resident’s care plan. They stated that staff should have enacted the preventative interventions prior to the incidents occurring.

Failure to implement interventions to minimize the risk of altercations between residents resulted in an injury to one resident and had the potential for the altercations to escalate.

Sources: multiple residents' clinical records, Responsive Behaviours policy (LTC-CA-WQ-200-07-13; December 2017), BSO discharge summary (October 25, 2022), Investigation notes; observations of video recording; interviews with DOC, BSO and other staff. [720920]