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: July 25, 2024
Inspection Number: 2024-1338-0004
Inspection Type: Complaint Critical Incident
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 2024.08.01 09:08:41 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 11-12, 15-18, 22, 2024.

The following intakes were inspected:

- Intake: #00114001 (complaint), related to resident care and personal support services; and,
- Intake: #00117220 (Critical Incident 2853-000016-24), related to falls prevention and management.

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

Falls Prevention and Management
Food, Nutrition and Hydration

Infection Prevention and Control
Reporting and Complaints
Resident Care and Support Services

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

In a post fall assessment, a registered practical nurse (RPN) identified that improper footwear may have contributed to a resident's fall A personal support worker (PSW) explained that the way the resident chose to wear their shoes, caused them to not fit as intended. After the fall, the resident's care plan was updated for staff to ensure that the resident was wearing "proper" shoes.

Observations identified that the resident only owned one pair of shoes. The PSW said that, the resident persisted in walking about the resident home area (RHA) despite non-weight bearing recommendations and being provided with a temporary

assistive mobility device.

The ADOC acknowledged that staff could not ensure the resident was wearing proper shoes when they only owned one pair and usually did not wear them as intended.

The ADOC clarified the resident's plan of care with details on the process of getting "proper" shoes, the resident's desire to wear their original shoes and their habit of how they wear those shoes.

Sources: resident's clinical records; observations; interviews with the ADOC and other staff.

Date Remedy Implemented: July 22, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
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.

A PSW was observed offering a resident a choice of beverages at nourishment pass. The resident was provided their preferred beverage.

A review of the resident's nutrition plan of care specified that were restrictions on the types and amounts of certain beverages. The PSW acknowledge that they were aware of the restrictions and said that the resident's meal trays often contained a variety of beverages, some the resident preferred over others..

The home's new Registered Dietitian (RD) stated that they had not yet assessed the resident; however, they expected staff to follow any resident's nutrition plan of care. The corporate RD assessed the resident's condition and had determined that the restrictions around providing certain beverages were no longer required, especially if that was the resident's prefer choice.

A review of the resident's care plan, kardex and dietary sheets determined that the restrictions involving beverages were removed.

Sources: resident's clinical records, dietary report; interviews with the corporate RD, home RD and other staff.

Date Remedy Implemented: July 22, 2024

NC #003 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

A RHA's bath/shower schedule showed that a resident was to be bathed on two specific days of the week. The resident's electronic treatment administration record (eTAR), kardex and care plan specified that the resident was to have nail care on their bathing days. The PSW confirmed that the resident's bathing day were moved and stated that it was not a recent change.

The RPN acknowledged that the information in the eTAR, care plan and kardex did not reflect the resident's current bathing schedule, and said the information would be updated accordingly.

A review of the resident's eTAR, kardex and care plan showed that all documents were updated to reflect that the resident would have nail care on a specific day of the week and on an as needed basis. All information regarding bathing days was removed.

Sources: resident's clinical records, Durand RHA bath/shower schedule; interviews with RPN and other staff.

Date Remedy Implemented: July 15, 2024

WRITTEN NOTIFICATION: Plan of Care

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

A. The licensee has failed to ensure that the provision of the care set out in the plan of care were documented related to bathing.

Rationale and Summary
A review of a resident's Point of Care (POC) documentation showed that for a period

of approximately six weeks, bathing was not documented following their admission.

The Resident Assessment Instrument (RAI) coordinator acknowledged that the bathing documentation was missing during that time frame.

Failure to document the provision of care may have resulted in staff not capturing information regarding the level of assistance and number of staff required to bathe the resident.

Sources: resident's clinical records; interviews with the RAI coordinator and other staff.

B. The licensee has failed to ensure that the provision of the care set out in the plan of care were documented related to behavioural observation.

Rationale and Summary
The home's Nurse Practitioner (NP) wrote an order for staff to complete observations and documentation for specific behaviours for seven days.

A review of the resident's chart identified a behavioural observation record that was completed for three days. The ADOC acknowledged that the behavioural observation record was not completed as intended and that they were unable to locate an additional record that contained the missing information.

Failure to complete the documentation as ordered by the NP may have resulted in missing information that may have identified the resident's behavioural pattern.

Sources: resident's clinical records; interview with the ADOC.

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that the outcomes of the care set out in the plan of care were documented related to bathing.

Rationale and Summary
A review of bathing documentation for eight weeks indicated that staff documented bathing a resident as "not applicable" (NA) at least once per week. The RAI coordinator determined that there was an error in how the task was originally scheduled and it would show up on the night shift when bathing did not occur.

The ADOC acknowledged that the purpose of the documentation was to capture information on the level of assistance and number of staff required and documenting NA did not provide any useful information.

Failure to properly document the outcomes of care related to bathing may have resulted in not capturing any changes to the required level of assistance and/or number of staff.

Sources: resident's clinical records; interviews with the ADOC and other staff.