Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 20, 24, 2011	2011_027192_0021	Critical Incident

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, and Director of Care.

During the course of the inspection, the inspector(s) Reviewed medical records, and incident investigation notes.

The following Inspection Protocols were used in part or in whole during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits sayants :

1. A specified resident did not receive integrated and consistent assessment by staff and others involved in different aspects of care.
A specified resident sustained a fall. The Registered Practical Nurse (RPN) working on the home area reportedly assessed the resident and had the Personal Support Workers ambulate the resident back to his bed. Care was provided to open areas and monitoring was initiated.
The post fall assessment completed by the RPN indicated that the resident experienced no pain while documentation in the progress notes indicates that the resident sustained injuries and that analgesic was given for pain.
Statements taken from the Personal Support Workers (PSW) indicated the resident was crying in pain during attempts to stand the resident and that weight bearing was painful. It was also noted in all PSW statements that the registered staff member was notified of the residents pain and change in mobility.
Documentation in the progress notes indicates that the resident remained in the bedroom from the time of the fall related to generalized pain, lethargy, changes in mobility and at times periods of agitation. No further assessment was completed and the physician was not notified of the fall with change in condition for more than 48 hours. The specified resident was sent to hospital and diagnosed with an injury.
Assessments completed by the home were not integrated, consistent and complementary of each other.

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 ensuring that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other., to be implemented voluntarily.

Issued on this 3rd day of June, 2011

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

Debra Saville, Nursing Inspector