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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
December 7 and 8, 2010	2010_192_2853_07Dec093925	Critical Incident H-02894

Licensee/Titulaire
Liuna Local 387 Nursing Home (Hamilton) Corporation, 44 Hughson Street South, Hamilton, Ontario, L8N 2A7

Long-Term Care Home/Foyer de soins de longue durée
Queen's Gardens, 80 Queen Street North, Hamilton, Ontario, L8R 3P6

Name of Inspector(s)/Nom de l'inspecteur(s)
Debora Saville Nursing Inspector # 192

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident.

During the course of the inspection, the inspector spoke with: The Administrator, Environmental Supervisor, Director of Care, Registered Nurses (RN's), Registered Practical Nurses (RPN,s) and Personal Support Workers (PSW's).

During the course of the inspection, the inspector: observed a video of the events immediately preceding the fall of a resident, reviewed medical records, reviewed incident investigation notes, observed resident care.

The following Inspection Protocols were used during this inspection: Safe and Secure Home and Responsive Behaviour Inspection Protocols.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN

WN #1: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c. 8, 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.	
Findings: 1. The care plan indicates staff should redirect an identified resident when wandering, no action was taken to redirect the resident and a fall with injury resulted. 2. The plan of care indicates staff should redirect an identified resident as necessary related to responsive behaviours exhibited. Staff did not intervene to redirect the resident resulting in a fall with injury.	
Inspector ID #:	Nursing Inspector #192

Signature of Licensee of Designated Representative **Signature du Titulaire du représentant désigné**		**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Debora Saville
Title:	**Date:**	**Date of Report (if different from date(s) of inspection).** January 31, 2011