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_0005	006459-21, 008062-21	Complaint

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

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

The following intakes were inspected:
006459-21- related to hygiene, weight loss, dehydration, walking program, infection prevention and control, skin and wound and retaliation.
008062-21 - related to contact with police

During the course of the inspection, the inspector(s) spoke with resident family member, Personal Support Workers, Registered Practical Nurses, Registered Nurses, Physiotherapist, Occupational Therapist, Registered Dietitian, Physician, Director of Care and the Administrator.

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

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

The licensee failed to ensure a resident’s Substitute Decision Maker (SDM) was given the opportunity to fully participate in the development and implementation of the plan of care related to changes in two care areas.

a) The resident's ability to walk and participate in range of motion exercises declined and their SDM was not made aware of these changes or given the opportunity to participate in the development of plan of care related to the changes.

A clinical note by the Physiotherapist on an identified date in 2020, indicated the resident's ability to walk with the assistance of staff was in decline and the plan of care was to continue with the walking program and range of motion exercises.

A clinical note by the Physiotherapist five months later, indicated the resident had been unable to walk for several weeks, but continued, with increasing difficulty, to participate in range of motion exercises. The note indicated the plan was to discontinue the gait training/walking program, continue with the range of motion exercises and they would notify the resident's SDM of the discontinued walking/gait training program.

A clinical note by the Physiotherapist the following month, indicated that following an assessment it was determined that the resident was unable to continue to safely participate in a functional physiotherapy program and the SDM would be informed of the need to discharge the resident from the physiotherapy program.

The Physiotherapist acknowledged that there was no evidence in the resident's clinical record that their SDM was informed of the decline in the resident's ability to walk and participate in range of motion exercises or given an opportunity to participate in the development of the plan of care related to these changes.

b) The resident's care needs changed in relation to their diet and fluid consumption and their SDM was not made aware of these changes or given the opportunity to participate in the development of plans of care related to these changes.

A clinical note made by the Registered Dietitian (RD) on an identified date in 2020, indicated the resident was assessed for chewing problems. The note indicated staff were to discontinue the resident's current diet and provide an alternative diet related to the chewing problem.

A clinical note made by the RD four mouths later, indicated the resident was being

assessed related to a poor fluid intake. The note indicated staff were directed to encourage fluids at meals, snacks, when medications were administered, and they were to monitor the resident for signs of dehydration.

A clinical note made by the RD the following month, indicated the resident was assessed. The note indicated staff were directed to change the resident's diet following the assessment.

The RD confirmed they had not made contact with the resident's SDM to alert them to the changes being made to the resident's diet and fluid consistency or to provide them with an opportunity to participate in the development of the plan of care related to these changes.

The failure of staff to inform the resident's SDM when their care needs changed and to offer them an opportunity to participate in the development of potential care strategies related to those changes resulted in the SDM being unaware of the resident's changing condition and also prevented them from participating in decisions about the resident's care.

Sources: electronic clinical notes and interviews with the Physiotherapist and Registered Dietitian

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 the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that annual care conferences were held for a resident.

A review of the electronic clinical record confirmed that there was no evidence that annual care conferences were held for the resident for 2019 and 2020.

The Administrator confirmed annual care conferences were not held for the resident for 2019 and 2020.

Sources: electronic clinical record and the Administrator.

Issued on this 8th day of October, 2021

[redacted]

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

Original report signed by the inspector.