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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Jul 16, 17, 19, 24, 31, Aug 13, 2012	2012_064167_0022	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

MARILYN TONE (167)

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 Director of Care, the Administrator, registered staff and personal support worker staff, the home's Resident Assessment Instrument Coordinator and residents identified related to Log # H-001342-12.

During the course of the inspection, the inspector(s) observed care and resident interaction on the unit where the identified residents reside, reviewed the health records for the identified residents, reviewed investigation notes provided by the home and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee did not ensure that resident # 002 was protected from abuse by a co-resident.
- Resident # 002 was abused by resident # 001.
- The progress notes for resident # 001 indicated that they had demonstrated responsive behaviours towards other residents seven times during an identified time frame.
- The plan of care for resident # 001 did not include strategies or interventions to minimize the risk of altercations between resident # 001 and other residents.

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 to ensure that residents at the home are protected from abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. s.53(1) The licensee did not ensure that the plan of care for resident # 002 included (i) written approaches to care and behavioural triggers that may result in responsive behaviours or written strategies, (ii) including techniques and interventions to prevent, minimize or respond to the responsive behaviours.

- The progress notes for resident # 002 indicated that they display identified behaviours.
- The staff interviewed confirmed that the resident displays these behaviours.
- The document that the home refers to as the care plan does not identify these behaviours or include written interventions or strategies to prevent, minimize or respond to this behaviour.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. 54(a) The licensee did not ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents, including identifying factors, based on information provided to the licensee or staff or through observation, that could potentially trigger such altercations.

- The progress notes for resident # 001 indicate that their behaviours began to escalate during an identified time period. It was noted that resident # 001 displayed responsive behaviours towards other residents seven times over an identified timeframe.
- The document that the home refers to as the care plan does not identify that the resident displays these responsive behaviours, nor does it identify any potential triggers that may precipitate these behaviours.
- Staff interviewed confirmed that the resident's responsive behaviours have increased over the past few months.
- Staff interviewed indicated that the resident needs to be watched carefully but were not able to provide any specific interventions related to monitoring activities.

2. 54(b) The licensee did not ensure that there were steps taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

- The document that the home refers to as the care plan did not include any nursing interventions to manage the resident's responsive behaviours towards other residents or contain strategies to protect other residents from resident # 001.
- Staff interviewed indicated that the resident needs to be watched carefully but were not able to provide any specific interventions related to the frequency of monitoring activities and there were no monitoring activities identified in the resident's care plan related to responsive behaviours towards other residents or prevention of potential behavioural triggers that may precipitate behaviours.

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 to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents, to be implemented voluntarily.

Issued on this 15th day of August, 2012

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