Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 27, 2013	2013_201167_0013	H-000274-13	Critical Incident System

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 System inspection.

This inspection was conducted on the following date(s): May 17, 22, 23, 2012

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

During the course of the inspection, the inspector(s) conducted a review of the health record for the identified resident, investigation notes completed by the home, relevant policies and procedures and relevant training records for staff.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Resident # 001 was not protected from abuse by a staff member at the home.

A) In 2013, resident # 001 told a staff member that another staff member had abused them the week prior.
B) The resident was taken to the administrator's office by the staff member to whom they reported the incident and the administrator initiated an investigation.
C) The police were contacted and conducted an investigation.
D) It was confirmed that the employee who allegedly committed the abuse had received prevention of abuse and neglect training twice in 2013. The home also had a current police check on file for the accused employee. There was no previous history of abuse by the employee.
E) During an interview with the resident involved, it was concluded that the incident did occur as reported. The resident also indicated that they were very upset by the incident.
F)The home's investigation concluded that the abuse did occur.

Resident # 001's right to be protected from abuse was not respected. [s. 3. (1) 2.]

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 every resident has the right to be protected from abuse., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Resident # 001 was not transferred using safe transferring technique.

A) In 2013, resident # 001 reported that a personal support worker staff transferred them by picking them up and carrying them from the wheelchair to the bed without the assistance of a mechanical lift or another staff member.
B) The resident's plan of care directed staff to: Provide two persons for constant physical assistance with mechanical lift. Two staff to transfer the resident using a "Hoyer" lift for all transfers. Two staff to apply sling, one staff operates the sling while the other staff guides the sling over to wheelchair.
C) It was confirmed during the home's investigation and their review of surveillance tapes of the hallway that a second staff did not enter the resident's room to assist with the transfer and that the resident had been transferred without the use of the lift or a second staff member.
d) Staff interviewed confirmed that two staff are required for transfers with a mechanical lift. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents., to be implemented voluntarily.

Issued on this 3rd day of July, 2013

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

Marilyn Jones