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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 16, 2014 | 2014_322156_0022 | H-001309-14 | 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

CAROL POLCZ (156)

### 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): December 9, 2014**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, registered staff, dietary staff, housekeeping staff and personal support workers (psw's)and residents.**

**The following Inspection Protocols were used during this inspection:**
**Nutrition and Hydration**

**During the course of this inspection, Non-Compliances were issued.**
- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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).**

**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. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.
The SDM for resident #1 was not provided the opportunity to participate fully in the implementation of the plan of care as the SDM was not informed when the resident was not provided the evening meal on September 16, 2014. [s. 6. (5)]

2. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan. The plan of care for resident #1 indicated the following: i) the resident was deemed to be at high nutritional risk. ii) The resident was to be provided with tray service when too agitated to eat in the dining room. iii) The resident required extensive to total physical assistance with eating and staff were to sit with the resident and feed the meal from beginning to end.
A critical incident report provided by the home indicated that on September 16, 2014 resident #1 was not provided with care as specified in the plan. The Administrator confirmed on December 9, 2014, that the resident was not provided with tray service and did not receive assistance with eating for the evening meal on September 16, 2014. [s. 6. (7)]

***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 care set out in the plan of care is provided to all residents including resident #1, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident was offered a minimum of three meals daily.
On December 9, 2014, the Administrator confirmed that resident #1 was not offered the evening meal on September 16, 2014. [s. 71. (3) (a)]

***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 all residents including resident #1 is offered a minimum of three meals daily, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.
The home policy LTC-CA-WQ-100-03-03 Health Records Documentation General Guidelines indicated that the documentation was to be an accurate account of what was heard, seen, or done.
The food and fluid intake flow-sheet for resident #1 indicated that on September 16, 2014 the resident consumed a full portion of the evening meal and received two glasses of fluid. The Administrator confirmed on December 9, 2014 that the resident was not provided with an evening meal and therefore the documentation completed by staff was not accurate. [s. 8. (1) (b)]

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that when a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.
On September 17, 2014 the Administrator was made aware of allegations that resident #1 was not provided with the evening meal on September 16, 2014; however, the Director was not informed until September 22, 2014. The DOC and Administrator confirmed on December 9, 2014 that the Director was not immediately informed of the allegations. [s. 24. (1) 1.]

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**Issued on this 18th day of December, 2014**

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

**Original report signed by the inspector.**