Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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119 King Street West 11th Floor
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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
Sep 24, 2019	2019_546750_0011	008820-19, 008821-19, 009837-19, 011101-19, 015034-19, 015420-19, 015662-19	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

STACEY GUTHRIE (750), LISA BOS (683)

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): September 4, 5, 6, 10, 11, 12, 13, 16, 17 and 18, 2019.

The following intakes were completed during this critical incident inspection:
Log #009837-19, related to the prevention of abuse and neglect,
Log #011101-19 - related to the prevention of abuse and neglect and responsive behaviours and the prevention and management of falls,
Log #015420-19- related to the prevention and management of falls,
Log# 015662-19- related to the prevention and management of falls,
Log #015034-19 related to the prevention of abuse, and concurrently two follow up intakes were completed within the CIS ;
Log #00821-19 follow up to Compliance Order (CO) #001 from inspection #2019_556168_0007 and
Log #00820-19 follow up to CO #002 from inspection #2019_556168_0007.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physio Therapy Assistants (PTA) and residents.

During the course of the inspection, the inspector(s) observed the provision of resident care and reviewed clinical health records, investigation notes, staffing schedules, meeting minutes, policies and procedures, Critical Incident System (CIS) submission and follow up compliance order.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 101. (1)	CO #001	2019_556168_0007	750
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2019_556168_0007	750

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. 19. Duty to protect

Specifically failed to comply with the following:

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. A. The licensee has failed to ensure that resident #003 was protected from abuse by

resident #002.

A Critical Incident (CI) report was submitted to the Director related to an unwitnessed fall for resident #003 at a specified location, that resulted in a transfer to hospital with injury. A CI report was submitted to the Director under the category resident to resident abuse, identified that the home reviewed video footage of resident #003's unwitnessed fall , which indicated that resident #003 demonstrated physical behaviours towards resident #002.

A review of the electronic records for resident #002 and resident #003 indicated that both residents had altered cognition. Resident #002's written plan of care indicated that they were a wandering risk as they wandered on the unit. There were interventions for resident #002's responsive behaviours in place. Resident #003's written plan of care indicated that they demonstrated responsive behaviours and interventions were also in place.

A review of progress notes for resident #002 and #003 indicated that there were other incidents between them, which all occurred near the same location.

In interviews with Registered Practical Nurse (RPN) #102 and Personal Support Worker (PSW) #103, they identified that resident #003 and resident #002 had responsive behaviours. RPN #102 indicated that they often used an intervention for both resident #002 and #003. PSW #103 identified that in relation to the incident on an identified date, they spoke to resident #002 who indicated to them that they felt threatened by #003 and retaliated.

In an interview with the Director of Care (DOC), they identified that they reviewed the video footage of the incident between resident #002 and #003 on an identified date, and the home concluded that resident #002 and #003 had contact. Inspector #683 read the DOC the definition of abuse and they acknowledged that the incident met the definition.

The home did not ensure that resident #003 was protected from abuse by resident #002 on a specified date. [s. 19. (1)]

2. The licensee has failed to ensure that resident #006 was protected from abuse by resident #007.

A Critical Incident (CI) report was submitted to the Director, under the category of

resident to resident abuse, which identified that on an identified date, resident #006 report to RPN #115 that an incident had occurred with resident #007. As per the CI report and the home's internal investigation notes, resident #006 and resident #007 had an encounter. Resident #006 indicated that they were uncomfortable at the time and left the area.

A review of the clinical record for resident #006 indicated that they had no cognition related concerns. A review of the written plan of care for resident #007 in placed at the time of the incident identified that they had altered cognition which was declining. Their written plan of care indicated that they had responsive behaviours and related interventions were in place.

In an interview with resident #006, they didn't like what happened with resident #007.

During a telephone interview with the DOC, Inspector #683 read the definition of abuse to the DOC and they acknowledged that resident #006 was not protected from abuse by resident #007 on a specified date. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #004 during an identified shift on a specified date, related to fall prevention interventions.

A Critical Incident (CI) report was submitted to the Director on a specified date related to an incident that caused injury to resident #004 for which they were taken to hospital and resulted in a significant change in their health status. As per the CI, on a specified date, resident #004 had noted changes and was sent to hospital where a diagnoses was provided.

A review of the written plan of care in place for resident #004 at the time of the incident indicated that they were at a risk for falls and interventions were in place.

The home's internal investigation notes were reviewed by Inspector #683. PSW #112 was interviewed by the Administrator on a specified date, where they indicated that they checked on resident #004 at a specified time, at another specified time care was provided and checked the other rooms and the next check was at a later specified time. The Administrator reviewed the video surveillance of the identified shift and as per their notes, there was discrepancies found between PSW #112 and the Administrator.

A review of the Administrator's documentation of their interview with PSW #112 on a specified date, indicated that when they reviewed the cameras, PSW #112 slept through a good portion of their shift, they did not implement the intervention as outlined in resident #004's plan of care. The PSW was encouraged to resign from their position at the home.

In an interview with the Director of Care (DOC), they indicated that staff should be following the interventions as outlined in a resident's plan of care. They acknowledged that staff did not follow the plan of care for resident #004 during the identified shift on the specified date, when they were intervention was not implemented as per their written plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the fall interventions outlined in resident #005's plan of care were provided to the resident as specified in the plan.

A Critical Incident (CI) that was submitted to the Director on a specified date , identified

resident #005 experienced a fall on an identified date, at which time resident was assessed and no concerns noted. Resident #005 was monitored post fall and on an identified date, resident #005 was reassessed by registered staff, was transferred to hospital and a fracture was identified.

A review of the resident's written plan of care identified resident #005 had risk of falls and associated interventions were identified.

An observation of resident #005, on a specified date, found resident sleeping. An intervention was in place in a location not identified in the plan of care and another intervention was not accessible.

On a specified date, Registered Practical Nurse (RPN) #109 accompanied inspector #750 to resident #005's room. Two identified interventions were not in place during the observation, which RPN #109 confirmed.

In an interview with the Director of Care (DOC) #100, they confirmed that the observations identified were not complaint and that interventions identified in a resident's care plan are to be implemented as documented.

The home failed to ensure that the fall interventions set out for resident #005 were provided as set out in the plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that resident #005 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

A Critical Incident (CI) that was submitted to the Director, identified resident #005 experienced a fall on a specified date, at which time resident was assessed and no concerns noted. Resident #005 was monitored post fall and on an identified date, resident #005 was reassessed by registered staff, transferred to hospital and a fracture was identified. The home reported to the Director on an additional date that a new intervention was added for resident #005.

A review of the resident's written plan of care identified resident #005 was at risk of falls, and associated interventions were outlined and no evidence of revisions following the noted incident reported to the Director on a specified date.

Interviews with Personal Support Worker (PSW)s #106 and #107 identified that both staff indicated that resident had the interventions in place that did not change after the incident. They also noted that the resident had a new intervention since the incident.

On a specified date, inspector #750 observed the new fall intervention as noted above.

In an interview with Registered Practical Nurse (RPN)#109 on a specified date, they acknowledged that resident #005's interventions related to falls, observed the noted intervention with Inspector #750 and confirmed it was an intervention for resident #005. RPN #109 acknowledged that the intervention should be documented in resident #005's plan of care.

The home failed to ensure that the resident was reassessed and the plan of care reviewed and revised to include a new fall strategy for resident #005. [s. 6. (10) (b)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 26th day of September, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STACEY GUTHRIE (750), LISA BOS (683)
Inspection No. / No de l'inspection :	2019_546750_0011
Log No. / No de registre :	008820-19, 008821-19, 009837-19, 011101-19, 015034-19, 015420-19, 015662-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 24, 2019
Licensee / Titulaire de permis :	Liuna Local 837 Nursing Home (Hamilton) Corporation 44 Hughson Street South, HAMILTON, ON, L8N-2A7
LTC Home / Foyer de SLD :	Queen's Garden 80 Queen Street North, HAMILTON, ON, L8R-3P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Deborah DiMauro

To Liuna Local 837 Nursing Home (Hamilton) Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA, 2007.

Specifically, the licensee must:
1. Protect resident #003 and all other residents from abuse by resident #002, or any other resident.
2. Protect resident #006 and all other residents from abuse by resident #007, or any other resident.
3. Provide training/education to all staff who provide direct care to resident #002, #003 and #007 on their responsive behaviours including the specific interventions in place to respond to their responsive behaviours, monitoring protocols and what to do in response to their behaviours.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #003 was protected from abuse by resident #002.

A Critical Incident (CI) report was submitted to the Director related to an unwitnessed fall for resident #003 at a specified location, that resulted in a transfer to hospital with injury. A CI report was submitted to the Director under the category resident to resident abuse, identified that the home reviewed video footage of resident #003's unwitnessed fall , which indicated that resident #003 demonstrated physical behaviours towards resident #002.

A review of the electronic records for resident #002 and resident #003 indicated that both residents had altered cognition. Resident #002's written plan of care indicated that they were a wandering risk as they wandered on the unit. There were interventions for resident #002's responsive behaviours in place. Resident

#003's written plan of care indicated that they demonstrated responsive behaviours and interventions were also in place.

A review of progress notes for resident #002 and #003 indicated that there were other incidents between them, which all occurred near the same location.

In interviews with Registered Practical Nurse (RPN) #102 and Personal Support Worker (PSW) #103, they identified that resident #003 and resident #002 had responsive behaviours. RPN #102 indicated that they often used an intervention for both resident #002 and #003. PSW #103 identified that in relation to the incident on an identified date, they spoke to resident #002 who indicated to them that they felt threatened by #003 and retaliated.

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The home did not ensure that resident #003 was protected from abuse by resident #002 on a specified date. [s. 19. (1)]
(683)

2. The licensee has failed to ensure that resident #006 was protected from abuse by resident #007.

A Critical Incident (CI) report was submitted to the Director, under the category of resident to resident abuse, which identified that on an identified date, resident #006 report to RPN #115 that an incident had occurred with resident #007. As per the CI report and the home's internal investigation notes, resident #006 and resident #007 had an encounter. Resident #006 indicated that they were uncomfortable at the time and left the area.

A review of the clinical record for resident #006 indicated that they had no cognition related concerns. A review of the written plan of care for resident #007 in placed at the time of the incident identified that they had altered cognition which was declining. Their written plan of care indicated that they had

responsive behaviours and related interventions were in place.

In an interview with resident #006, they didn't like what happened with resident #007.

During a telephone interview with the DOC, Inspector #683 read the definition of abuse to the DOC and they acknowledged that resident #006 was not protected from abuse by resident #007 on a specified date. [s. 19. (1)]

The severity of this issue was determine to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 2 as it was related to two of three residents reviewed. The home had a level 3 compliance history as they had one or more non-compliances, one of which was the same subsection that included:
• Compliance order (CO) #006 served on January 3, 2018 (2017_546585_0018) (683)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 24th day of September, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Stacey Guthrie

Service Area Office /
Bureau régional de services : Hamilton Service Area Office