**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**

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**Public Copy/Copie du public**

| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Jun 19, 20, 21, 22, Jul 16, 17, 27, 31, 2012 | 2012_061129_0006 | 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.**

**During the course of the inspection, the inspector(s) spoke with residents, unregulated and registered staff, Administrator, Director of Care, Nurse Managers, Physiotherapist and Physiotherapist Assistant related to log # H-001143-12.**

**During the course of the inspection, the inspector(s) reviewed resident's clinical records, observed resident activity, reviewed interview notes made by the home and reviewed home's policies and procedures.**

**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 | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | 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. 3. Residents' Bill of Rights**

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

**22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.**
**23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.**
**24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.**
**25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.**
**26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.**
**27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee did not ensure that resident #1's right to be treated with courtesy and respect and in a way that fully recognized the individuality and respected the resident's dignity was fully respected and promoted, in relation to the following: [3(1)(1)]
a) Resident #1 reported to registered staff in the home that they felt terrible and as though they were a burden to staff following an incident involving a Personal Support Worker (PSW) not meeting requests for care. This incident was documented in the clinical record and it is recorded that the resident was very upset and crying. The incident is described as a PSW who refuse to make environmental changes that the resident requested and was unable to make that would aid in sleep. The Administrator confirmed that no action was taken to address this issue with the staff person involved and that support was not provided to the resident to address the resident's feelings following this incident.
b) Resident #1 reported to the Administrator and Director of Care that she was fearful of being hurt by co-residents wandering into the room. These reports were made following each of three incidents that occurred where co-residents demonstrated responsive behaviours. The home was aware of the behaviours of the co-residents and although some measures were put in place to prevent the behaviours, these measures were not monitored for their effectiveness and were not consistently in place or operational. This resulted in the resident continuing to experience fear.

***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 every licensee shall ensure that every resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity shall be respected and promoted, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

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

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The Licensee did not ensure that the home's policy to promote zero tolerance of abuse was complied with, related to the following:
Policy # LTCE-RAC-E-002 [Abuse] last revised on March 2012 includes information that any behaviour including hitting and twisting exhibited towards a resident that the resident may or may not perceive as physical force, or that may or does cause injury, or inflicts pain or discomfort for the resident is considered physical abuse and that emotional abuse is defined as any verbal or non-verbal behaviour which demonstrates disrespect for the resident and which is perceived by the resident to diminish the resident's sence of identity , dignity, respect and self worth.
a. This policy directs that Staff are required to report any abuse or allegations of abuse and neglect immediately to the Administrator/Director of Care (DOC)/designate.
A registered staff member who became aware that a Personal Support Worker (PSW) providing care to resident #1 had refused to provide care to meet the resident's comfort/sleep needs did not report this to the Administrator/DOC/designate. A PSW reported this incident to the registered staff person including that this PSW found the resident very upset and crying. At the time the PSW involved in this incident was aware that the resident was unable to meet these needs themself. The Administrator and the Director of Care confirmed they were unaware of this incident and it was not reported to them.
b. The policy directs that, the person receiving the report is to report the allegations to the Ministry of Health and Long Term Care by phoning the duty inspector on the day of the report and following up with a Critical Incident Summary report.
-Administrative staff who received a report that a resident complained of pain after a co-resident demonstrated responsive behaviours, did not contact the Ministry either by phone or through the critical incident system in accordance with the policy.
-Administrative staff receiving a second report of an incident that involved a co-resident demonstrating responsive behaviours, did not contact the Ministry by phone or through the critical incident system in accordance with the policy.
3. The policy directs that written statements are obtained from all persons involved in or witnessed to the incident.
- The Administrator and the Director of Care confirmed that written statements by people involved in the above mentioned two incidents were not obtained.

***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 every licensee shall ensure that there is in place a written policy to promote zero tolerance for abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.***

**WN #3: 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. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible;**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee did not ensure that behavioural triggers, where possible, were identified for residents demonstrating responsive behaviours, with respect to the following: [53(4)(a)]

a)Staff in the home confirmed and documentation in the clinical record indicates that they did not attempt to identify behavioural triggers in order to manage the responsive behaviours being demonstrated by resident #2. As a result the resident continued to demonstrate these responsive behaviour.
b)Staff in the home confirmed and documentation in the clinical record indicates that staff did not attempt to identify behavioural triggers in order to manage the responsive behaviours being demonstrated by resident #3.

***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 behavioural triggers, where possible, are identified for residents demonstrating responsive behaviours, to be implemented voluntarily.***

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**WN #4: 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.**

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**Findings/Faits saillants :**

1. The Licensee did not ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents by identifying factors, based on an interdisciplinary assessment and observations made by staff that could potentially trigger such altercations as well as identifying and implementing interventions, with respect to the following. [54(a)(b)]
a) A harmful interaction occurred in 2012 when resident #2 demonstrated responsive behaviours targeted at a co-resident. Resident #2's responsive behaviours were known to staff in the home and the behaviours are documented in the resident's clinical record. Staff did not conduct an interdisciplinary assessment in order to identify factors that could potentially trigger such altercations nor did they implement interventions to manage the behaviour and prevent further altercations with co-residents. At the time of this inspection resident #2 continued to demonstrate these behaviours.
b) Two potentially harmful interactions occurred in 2012 when resident #3 demonstrated responsive behaviours targeted at a co-resident. These responsive behaviours were known to staff and the behaviours were documented in Resident #3's clinical records. Staff in the home did not conduct an interdisciplinary assessment in order to identify factors that could potentially triggers these behaviours nor did they implement interventions to manage the behaviours and prevent further altercations with co-residents. At the time of this inspection resident #3 continued to demonstrate these 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 and ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observations, that could potentially trigger such altercations; and identifying and implementing interventions, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes**
**Every licensee of a long-term care home shall ensure that,**
**(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;**
**(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and**
**(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.**

**Findings/Faits saillants :**

1. The licensee did not ensure that when a resident is taking any drug or combination of drugs there is monitoring and documentation of the resident's response and the effectiveness of the drugs, in relation to the following: [134(a)]
Resident #1's physician ordered Tylenol 650mg as needed to relieve pain. The resident received this medication on 10 occasions in a month in 2012. Staff did not document the effectiveness of this medication in managing the resident's pain for 5 of those 10 occasions. The Director of Care confirmed that staff are expected to document the effectiveness of all medications given on an as needed basis on the back of the Medication Administration Record (MAR) and this was not done for 5 the 10 occasions in 2012 when this resident received this medication.

**Issued on this 8th day of August, 2012**

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