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
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

Public Copy/Copie du public

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_0014	H-000191-13	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

MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 17, 22, 23, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care, Administrator, Resident Assessment Instrument Coordinator, nursing staff.

During the course of the inspection, the inspector(s) conducted a review of the health records for identified residents, reviewed relevant policies and procedures at the home.

The following Inspection Protocols were used during this inspection:

Pain

Skin and Wound Care

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 O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. A care conference of the interdisciplinary team providing the resident's care was not held for resident # 002 within six weeks of the resident's admission to discuss the plan of care and other matters of importance to the resident or their substitute decision-maker.

Resident # 001 was admitted to the home in 2012.
- The Ont. Multidisciplinary Care Conference assessment was initiated four months after admission in the home's electronic documentation system but this form was never completed and there was no documentation on the resident's health record to indicate that a care conference ever took place.
- During an interview with the Director of Care, it was confirmed that a care conference did not take place within six weeks of the resident's admission to the home. [s. 27. (1) (a)]

2. A record of the date, the participants and the results of the care conference held for resident # 003 was not kept.

Resident # 003 was admitted to the home in 2013.
- Staff at the home confirm that an admission care conference was held for the resident.
- A review of the care conference form initiated in the home's electronic documentation system revealed that the form was initiated but never completed and signed off after the conference was held.
- The resident's health file was not kept up to date related to the details of the care conference.
- An interview with the Director of Care confirmed that this documentation was not completed as required. [s. 27. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The written record for resident # 002 was not kept up to date at all times.

A) Resident # 002 was transferred to hospital in 2012.
- Four days after the resident's transfer to hospital, a progress note was made by the Registered Dietitian related to following up with the resident upon their return from hospital.
- Five days after the resident's transfer to hospital, a progress note was made indicating that the resident was being discharged from the home that day.
- There was no documentation on the resident's health record to indicate the reason for the resident's discharge or the condition of the resident at that time.
There was no follow up documentation by the home found on the resident's health file.
[s. 231. (b)]

Issued on this 3rd day of July, 2013

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

Marilyn Lone