Ontario

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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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
Facsimilie: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Quest, 11iém étage
Hamilton, ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
December 7 and 8 ,2010	2010_192_2853_07Dec093925	Critical Incident H - 00978 and H-01394

Licensee/Titulaire
Liuna Local 387 Nursing Home (Hamilton) Corporation, 44 Hughson Street South, Hamilton, Ontario, L8N 2A7

Long-Term Care Home/Foyer de soins de longue durée
Queen's Gardens, 80 Queen Street North, Hamilton, Ontario, L8R 3P6

Name of Inspector(s)/Nom de l'inspecteur(s)
Debora Saville Nursing Inspector # 192

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector: reviewed medical records, reviewed incident investigation notes, reviewed policy.

The following Inspection Protocols were used during this inspection: Personal Support Services Inspection Protocols.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activitiés

WN #1: The Licensee has failed to comply with [State the full section number/letters (including the full text) of the legislation/regulation here]	**WN #1:** The Licensee has failed to comply with [State the full section number/letters (including the full text) of the legislation/regulation here]

WN #1: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c. 8, 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.

Findings:

1. The plan of care for a specified resident under both toileting and transferring clearly indicates that two staff members are to be present for all transfers. Evidence indicates that care is not being provided to the specified resident according to the plan.

    i) On August 20, 2010 documentation indicates a specified resident was transferred independently by a specified PSW. No injury resulted.

    ii) On September 12, 2010 documentation indicates a specified resident was transferred independently by a specified PSW, resulting in a fall with injury.

    iii) During interview with the specified resident it was indicated that a staff member transferred the resident independently in the bathroom earlier in the day. No injury resulted.

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Additional Required Actions:

VPC - pursuant to the LTC 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 the interventions identified for each resident are clearly communicated to all staff and carried out as documented in the plan of care.

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.

Findings:
The plan of care provides clear direction to staff with regard to transferring a specified resident in a number of different scenarios. All transfers are to be completed by two staff members. Staff members continue to put the resident at risk by not following the identified safe transferring techniques.

i) On August 20, 2010, a critical incident submitted by the home indicates a specified resident was transferred independently by a PSW while in the shower room.

ii) On September 12, 2010, documentation indicates a specified resident was transferred independently by a PSW in the bathroom, resulting in a fall with injury.

iii) During interview with the specified resident it was indicated that a staff member transferred the resident independently in the bathroom earlier in the day. No injury resulted.

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Signature of Licensee of Designated Representative Signature du Titulaire du représentant désigné	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report (if different from date(s) of inspection).** January 28, 2011