



**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
prévus 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
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 24, 28, Nov 1, 2, 9, 28, 29, 2011; Jan 6, 24, 2012	2011_027192_0045	Complaint

Licensee/Titulaire de permis

THE THOMAS HEALTH CARE CORPORATION
490 Highway #8, STONEY CREEK, ON, L8G-1G6

Long-Term Care Home/Foyer de soins de longue durée

ARBOUR CREEK LONG-TERM CARE CENTRE
2717 KING STREET EAST, HAMILTON, ON, L8G-1J3

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

DEBORA SAVILLE (192)

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 the Administrator, Associate Directors of Resident Client Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Recreation Assistants, Residents and family members related to complaints H-001963-11, H-002013-11 and H-002134-11.

During the course of the inspection, the inspector(s) reviewed medical records, policy and procedure, incident investigation and observed the provision of care.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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. 218. Orientation

For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:

1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Findings/Faits saillants :

1. The licensee failed to ensure that training was provided in the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that are relevant to the staff member's responsibilities. [r.218.2.]

A specified resident receives treatment using specified equipment daily. Registered staff working on the resident's home area are responsible for starting, monitoring, stopping and troubleshooting the equipment during the administration of the treatment; including documentation of activities that may delay the treatment.

During interview with the Associate Director of Resident Client Care it was identified that not all agency staff working on the home area are trained on the use of the equipment used by the home. Agency staff are used on the designated home area frequently, based on interview with the Registered Practical Nurse and family member. Documentation provided indicates there were shifts during October 2011 that were covered by Registered agency staff.

During interview with a Registered Practical Nurse it was confirmed that sometimes agency and new staff don't know how to complete the documentation required for the treatment. It was noted that the documentation form used to monitor the treatment is not consistently completed by the evening registered staff (Oct 4, 5, 8, 9, 14, 15, 18, 19, 23, 2011). Training records provided indicated that only 2 staff who routinely work on the designated home area attended training on the equipment, offered by the home in March 2011. A review of the orientation checklist does include the specified equipment, interview with the Associate Director of Resident Client Care indicates that a comprehensive orientation is to be completed when the new staff member works on a home area where a resident is using the designated equipment. There is no documentation that confirms new staff received training on the equipment. Interview with the Associate Director of Resident Client Care indicates that agency staff use a checklist and are to assess their own skills related to use of the designated equipment. Routine orientation is not provided.

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 ensuring that training is provided in the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that are relevant to the staff member's responsibilities, to be implemented voluntarily.

WN #2: 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 subsections:

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
(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 instituted or otherwise put in place is complied with. [r.8(1)]

The policy (RC-09-02-01) Resident Client Falls identifies that when a resident has experienced a fall:

"5. Registered staff are to investigate the contributing factors associated with the fall and initiate interventions to prevent re-occurrence."

Interview with the Director of Care identified that a post fall conference is to be held to establish contributing factors related to the fall and establish appropriate interventions to minimize falls and mitigate injury related to falls. The plan of care for a specified resident was not updated to include new interventions related to fall prevention after falls in two months in 2011. No documentation of a post fall conference, as described by the Director of Care, was able to be provided by the home.

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 ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements Specifically failed to comply with the following subsections:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. [r.30(2)]

A specified resident receives treatment daily and based on the plan of care, the resident is to be monitored every three hours to ensure that the treatment is completed as ordered. A record is maintained by the home, but is not always complete. During a month in 2011, there were 8 occasions when no documentation was completed regarding the treatment.

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 ensuring that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

**WN #4: 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 subsections:**

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

- (a) the planned care for the resident;**
- (b) the goals the care is intended to achieve; and**
- (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

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;**
- (b) the resident's care needs change or care set out in the plan is no longer necessary; or**
- (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,

(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to 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 care set out in the plan has not been effective. [s.6(10)(c)]

A specified resident is identified to be at risk of falls, and demonstrates other specified behaviours. The plan of care indicates that the resident will have care provided by the home, but is contradictory. Documentation reviewed indicates that interventions are not always effective. Interview with resident's Power of Attorney indicates that staff are not always available as identified in the plan of care and do not continue with interventions as outlined in the plan of care. There are a minimum of 8 documented episodes where the specified resident was demonstrating behaviours, in spite of interventions.

2. The licensee failed to ensure that if a resident is being reassessed and the plan of care is being reviewed and revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care. [s.6(11)(b)]

A specified resident sustained falls in two months in 2011. One of the falls resulted in injury. A review of the plan of care indicates that interventions identified are generic. The plan of care has not been updated since the falls to include interventions to minimize the risk of falling or mitigate injury related to falls for the resident.

3. The licensee failed to ensure that the plan of care sets out clear direction to staff and others who provide direct care to the resident. [s.6(1)(c)]

a) A specified resident is identified under mobility as being dependent in wheelchair or Gerichair with seatbelt/lap table. The resident was observed on November 2, 2011 mobilizing on the home area in a wheelchair. Interview with the Director of Care confirmed that the resident uses a wheelchair, not a gerichair and does not use a seat belt or lap table.

b) A specified resident was admitted with an assistive device. The plan of care indicates that the resident has forgetfulness and confusion. The plan of care related to hygiene and grooming identifies that the resident is on a restorative program, that each step of grooming is to be explained to the resident and the resident is to be encouraged to perform tasks they are able to do. There is no direction to staff related to the use of the assistive devices used by the resident. It is noted that under "level of attendance in recreational programs" the use of assistive devices is mentioned but does not include direction to staff related to care of these items, or assistance required. The Director of Care was asked to point out where staff would find direction on the use of the assistive devices. She was unable to locate any information related to these devices within the plan of care.

c) A specified resident is identified in the plan of care to be able to walk within the unit safely. In October 2011 the resident was noted being transported in a wheelchair to the dining room. Staff interviewed indicated that the resident is able to walk in the room, to the bathroom, but usually mobilizes in the wheelchair. A documentation review identifies that the resident is noted to be wandering the home area in a wheelchair. The resident was observed walking without aid of a walker and with a PSW using a wheeled walker. The plan of care does not provide clear direction related to the use of mobility devices.

4. The licensee failed to ensure that care set out in the plan of care is provided to the resident as specified in the plan. [s.6(7)]

a) A specified resident has a specified diagnosis and is dependent on medication. Documentation in the progress notes indicates that the resident is to be monitored twice a day on Monday, Thursday and Saturday, if results of monitoring are abnormal, monitoring is to be increased to four times daily for five days. It is noted that the specified resident's monitoring was not completed four times daily in spite of abnormal monitoring results in September and October 2011.

b) For a specified resident it is identified under Restorative Care that the resident will receive a treatment each morning at a specified time, and that the resident will participate in an exercise program daily. The resident was observed on October 28, 2011. The resident was not involved in an exercise program and did not receive the designated treatment. The plan of care under toileting indicates that the resident is to be toileted at 1130. The resident was not observed being toileted between 1000 and 1200 hours before being taken for lunch.



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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 ensuring that if a resident is being reassessed and the plan of care is being reviewed and revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care; that the plan of care sets out clear direction to staff and others who provide direct care to the resident and that 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 2nd day of February, 2012

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

Deborah A. Smith