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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 12, 2014	2014_188168_0025	H-001540-14	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

LISA VINK (168)

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): November 5, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Client Care, the Assistant Director of Resident Client Care, housekeeping staff, Personal Support Workers (PSW's), registered nursing staff and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured an identified home area and reviewed relevant records including but not limited to policies and procedures and clinical health records.

The following Inspection Protocols were used during this inspection:

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 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. The licensee failed to ensure that the resident was protected from abuse by anyone in the home.

In 2014, resident #04 was touched inappropriately by resident #03, which was abuse.

According to staff interviews and the records reviewed, both residents had some cognitive decline.
Resident #03 had a history of behaviours towards staff.
The two residents were found in a room when staff witnessed resident #03 touching resident #04, before they were able to separate the residents and provide interventions as required.
Staff identified that resident #04 was upset following the incident.
The resident was not protected from abuse. [s. 19. (1)]

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 resident is protected from abuse by anyone in the home, to be implemented voluntarily.

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 licensee failed to ensure that a written record was maintained for each resident of the home.

Interviews and records reviewed identified that resident #03 had a history of responsive behaviours. According to staff, the resident's behaviours became more difficult to manage during a specified period of time. A referral to Behavioural Supports Ontario was initiated to assist in the management of the behaviour. Nursing staff identified that the presence of the behaviours were monitored and documented consistently on the Resident Client Behaviour Record. A review of the clinical record did not include any Resident Client Behaviour Records since a specified date. Regular registered nursing and PSW staff confirmed that the records were being completed up to the end of a specified date. A search was conducted to locate the records in the home without success, as confirmed during an interview with registered staff.
The resident's record was not maintained. [s. 231. (a)]

Issued on this 12th day of November, 2014

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