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
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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
Jul 29, 2014	2014_323130_0011	H-000815-14	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

GILLIAN TRACEY (130), ASHA SEHGAL (159)

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): July 7, 8, 16, 17 and 18, 2014

Please note: Inspector Alex McWilliam was present with Inspector #130 in the home on July 17, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), registered staff, personal care attendants (PCA), Food Service Manager, dietary staff and residents.

During the course of the inspection, the inspector(s) Interviewed staff, reviewed clinical records, critical incident reports, incident reports, relevant policies and procedures and observed meal service.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

a) The home's policy and procedure, Unit Resident Client Summary, RC-04-11-03, Revised Date: March 1, 2007, indicated: The Unit Resident Client Incident Summary form was used in the individual nursing home areas and it was intended that it would facilitate a chronological record of all resident client incidents occurring in that home area. The RN/RNA (Registered Nurse/Registered Nursing Assistant) documented all incidents occurring in their home area during each month. The charge nurse should review the form daily to ensure all data was recorded using information from the resident client's record, change of shift report and 24-hour report.

1. On an identified date in 2012, resident #001 sustained an injury of unknown origin and on a second date in 2012 sustained another injury requiring treatment, resulting from an improper transfer. The DOC confirmed a Unit Resident Client Summary Report was not completed for these incidents. [s. 8. (1) (a),s. 8. (1) (b)]

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee did not ensure residents were provided with food and fluids that were safe, adequate in quantity, nutritious and varied.

a) Resident #3 had a physician's order on an identified date in 2014, for nectar consistency thickened fluids. On July 7, 2014, during the lunch meal on an identified home area dining room the inspector observed the resident had received coffee that was not at nectar consistency. The inspector observed the resident was drinking coffee and was coughing. The coffee was found to be of regular (thin) consistency and was not thickened. The inspector prevented the resident drinking the coffee. When brought to the attention of Personal Care Attendant (PCA), it was replaced with thickened coffee. The resident had a physician's order for Regular - Minced textured diet with extra gravy/sauce/butter as needed. The accessible plan of care and the dietary server identified the resident was on minced diet and staff were to moisten solid foods with gravy/butter as needed. On July 7, 2014, the resident was served minced waffles, the texture of the minced waffles was dry and crumbly. The resident was observed experiencing difficulty chewing and swallowing the food. The PCA confirmed the entrée served was not moistened with gravy/butter. The resident was identified at risk of choking. On July 7, 2014, the pureed food served to residents was not visually appealing. The texture of the pureed strawberries was thin and runny, and created a risk for choking for resident #4 and other residents requiring thickened fluids. The consistency of the pureed cucumber was sticky, slimy and glossy due to excessive use of thickening product, which not only had reduced nutritional value but also altered the taste and flavour. The Food Service Manager confirmed the recipe was not followed. [s. 11. (2)]

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 residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

a) Resident #001 sustained an injury on an identified date in 2012. The resident was sent to the hospital and returned on a specific date in 2012. The DOC confirmed that registered staff did not complete a head to toe skin assessment upon return from hospital. [s. 50. (2) (a) (ii)]

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 exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return from hospital, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrences of the incidents, followed by the report required under subsection (4):

(a) The progress notes in resident # 001's record indicated the resident sustained an injury on an identified date in 2012, that resulted in a transfer to hospital. On July 8, 2014, during the interview with the Director of Care, it was confirmed that the Director was not notified of the injury and transfer to hospital, nor was a Critical Incident Report submitted within 10 days of becoming aware of the incident.

(b) A review of progress notes in resident # 005's record indicated the resident sustained an injury on an identified date in 2012. The resident was transferred to hospital for assessment that same day. The critical incident had not been reported to the Director as per review of the home's incident investigation report. On July 8, 2014, interviews with the Administrator and the Director of Care confirmed that the incident was not reported within one business day nor was a Critical Incident Report submitted within 10 days of becoming aware of the incident. [s. 107. (3) 4.]

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 Director is informed of the following incidents in the home no later than one business day after the occurrences of the incidents, followed by the report required under subsection (4) An injury in respect of which a resident is taken to hospital, to be implemented voluntarily.

Issued on this 29th day of July, 2014

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