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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de sions de longue durée**

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 11, 2017 | 2016_570528_0025 | 033628-16 | Resident Quality Inspection |

## 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

CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): December 2, 6, 7, 8, 13, 2016.**

**This inspection was done concurrently with the following:**
**-complaint inspection log #015391-15, infoline #39258-HA, #39378-HA, CIS 2930-000004-15, CIS 2930-000005-15, related to responsive behaviours**
**-complaint inspection log #032788-16, infoline #48002-HA, related to transferring and positioning**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Chief Operating Officer, the interim Director of Resident Client Care (Interim DOC), Food Services Supervisor (FSS), Director of Recreation and Leisure, Nurse Managers, the Physiotherapist, the Cook, registered nurses (RN), registered practical nurses (RPNs), personal support workers (PSWs), dietary aides, residents and families.**

**During the course of the inspection, the inspectors also toured the home, observed provision of care and services, reviewed records including, clinical health records, electronic health records, meeting minutes, staff schedules, and policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Dignity, Choice and Privacy**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**

**13 WN(s)**
**8 VPC(s)**
**1 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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**WN #1: 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. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

In November 2016, resident #040 was transferred with a mechanical lift and sustained superficial injuries. Review of the investigation notes identified that PSW #120 transferred the resident by themselves. Registered staff #121 responded to the call bell and they observed the resident was no longer in the proper position on the lift. Interview with registered staff #121 confirmed the PSW did not transfer the resident with two person assistance and did not apply the lift's safety device. Interview with Interim DOC stated that all residents that were transferred with this particular lift were to be transferred with two staff assistance and that the safety device was to be applied. Registered staff #100 stated that PSW #120 did not use safe transferring techniques when they transferred resident #040. [s. 36.]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices**

**Specifically failed to comply with the following:**

**s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:**
**2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).**

**s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:**
**4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).**

**s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:**
**5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure the restraint plan of care included alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk.

In October 2016, resident #010 was observed to require a physical device as a restraint for safety. Review of the plan of care did not include documented alternatives to restraining that were considered and tried until two months later, on the Quarterly Physical Restraint Assessment. Interview with registered staff #113 confirmed that an initial restraint assessment which would of included alternatives to restraining that were considered and tried was not completed when the resident was initially restrained. (581) [s. 31. (2) 2.]

2. The licensee failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class.

In October 2016, the physician identified that resident #010 required a restraint device when up in a wheelchair for safety and review of the Motion Specialties service log sheets indicated that restraint device was installed at that time. Interview with registered staff #100 stated that after restraint device was installed, the resident was restrained as they were unable to undo the restraint device independently and confirmed the order by the physician for a restraint was not signed in the plan of care until seven day later. (581) [s. 31. (2) 4.]

3. The licensee failed to ensure that the restraint plan of care included the consent by the resident or if the resident was incapable, by the SDM.

Review of the plan of care for resident #010 identified they required a restraint device when up in their wheelchair for safety. Review of the Consent to Restraint documentation revealed that the resident's SDM did not sign for the restraint device until seven days later. Interview with registered staff #113 stated the restraint was put in place in October 2016, and confirmed the resident's SDM did not sign the consent form until seven days after the restraint was applied. (581) [s. 31. (2) 5.]

***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:***
***i. the restraint plan of care includes alternatives to restraining that are considered, and tried, but have not been effective in addressing the risk***
***ii. the restraint plan of care includes an order by the physician or the registered nurse in the extended class,***
***iii. the restraint plan of care includes the consent by thehe restraint plan of care included an order by the physician or the registered nurse in the extended class. resident or if the resident was incapable, by the SDM, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

**s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).**

**Findings/Faits saillants :**

1. The licensee failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

In October 2016, the satisfaction survey was distributed to residents and families. Review of the 2016 Resident Council (RC) minutes did not include any information that the home sought out the advice of the RC in the development of the survey. Interview with the Residents' Council assistant, staff #111 confirmed that the home did not seek out the advice of the RC in developing and carrying out the 2016 satisfaction survey, as required. (528) [s. 85. (3)]

***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 they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident, the SDM, was provided the opportunity to participate fully in the development and implementation of the plan of care.

In November 2016, resident #040 was transferred with a mechanical lift resulting in a superficial injury. Review of the progress notes identified that the substitute decision maker (SDM) was not notified of the injuries and the treatment until two days later when they arrived in the home to visit the resident. Interview with registered staff #100

confirmed they did not notify the SDM when the incident occurred nor were they informed the following day. Interview with registered staff #100 stated that the SDM should have been notified when the incident occurred. (581) [s. 6. (5)]

2. The licensee failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the plan of care and had convenient and immediate access to it.

Review of the current plan of care identified that resident #010 transfer status was reassessed by the Physiotherapist in November 2016 and staff were to provide two persons for constant supervision using mechanical lift with a full sling for all transfers. Interview with PSW #114 stated the resident was transferred with two person and if required due to resident's behaviours or weakness they would use the sit to stand lift. Review of the Kardex that the PSW's follow to provide care revealed that the transfer status stated the resident can weight bear and the sit to stand lift as needed. Interview with registered staff #113 confirmed that the PSW kardex was not updated to reflect the resident's current transfer with the mechanical lift and full sling, and therefore PSW staff did not have access to the resident's updated transfer status. [s. 6. (8)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

Review of the written plan of care for resident #040 identified they were transferred with the sit to stand lift for toileting. In November 2016, they were assessed by the Physiotherapist and their transfer status was changed from the sit to stand lift to a full mechanical lift for all transfers. Interview with PSW #118 confirmed the resident was not transferred using a full sling for toileting. Review of the written plan of care with registered staff #117 confirmed that the written plan of care was not reviewed and revised when the resident's transfer status changed related to toileting. (581)

B. Review of the written plan of care for resident #010 identified that they were a mechanical lift with full sling for all transfers with two person assistance. Review of the toileting focus and interventions revealed that the resident was a two person transfer to toilet only and if the resident refused, the sit to stand lift would be used. Interview with the Interm DOC stated that the resident was reassessed by the Physiotherapist and their transfer status was changed to a hoyer lift for all transfers and confirmed that the plan of care was not reviewed and revised when their transfers were changed. (581) [s. 6. (10) (b)]

4. The licensee failed to ensure that the resident was 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 had not been effective.

In September 2016, resident #017's was receiving a nutritional supplement with meals. That same month the resident was transferred to hospital and readmitted back to the home with an infection, resulting in a significant change. Two days after the resident was readmitted back to the home, an assessment was completed by the RD and revealed that the resident had decreased intake, was dehydrated, and fluid administration four times a day was initiated. The resident's weight had significantly decreased in October 2016. The RD noted that the resident's intake had increased and fluid was being given and therefore, required no change in the care plan and continued to monitor weight. The following month, the resident had a further weight loss. Review of the plan of care did not include a reassessment related to weight loss, instead there was note to discontinue the double portion of snack, due to reports from direct care staff that the resident was not eating the double portion. In December 2016, the resident had further weight loss.

Interview with RPN #116 confirmed that the resident had behaviours of refusing to eat and drink and therefore, was getting fluids and had a supplement at meals. Interview with the RD confirmed that there had been no reassessment completed after the resident had weight loss after the new intervention of additional fluids was initiated. The RD reported that they verbally spoke with staff on the floor in November 2016, but wanted to wait one more month to evaluate effectiveness of intervention. (528) [s. 6. (10) (c)]

***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:***
***i. the resident, the SDM, is provided the opportunity to participate fully in the development and implementation of the plan of care,***
***ii. the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change***
***iii. the resident is reassessed and the plan of care is reviewed and revised when the care set out in the plan has not been effective, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that medications were stored in an area or a medication cart that was secured and locked.

On November 5, 2016, at 0850 hours, a medication cart was noted to be sitting outside the dining area unlocked. RPN #101 was in dining room administering medication to a resident. The RPN's back was to the medication cart and was unaware the LTC Homes Inspector was able to open and close medication cart drawers. When RPN #101 returned to the cart, they confirmed that the cart was not locked and secured when unattended. (528) [s. 129. (1) (a)]

2. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On December 5, 2016, at approximately 0855 hours, RPN #101 was observed dispensing medications for a resident, including an opioid analgesic for the resident. When the RPN unlocked the medication cart, they were able to retrieve the opioid from the controlled substance bin without unlocking the second lock on the bin. Interview with RPN #101 confirmed that the bin lid was not closed all the way after the last narcotic was dispensed and therefore the controlled substances were not double-locked while in the medication cart, as required. (528) [s. 129. (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***
***i. that medications were stored in an area or a medication cart that is secured and locked***
***ii. controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home's dining and snack service included, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who required assistance.

A. In December 2016, PSW staff #104 was observed feeding resident #082 a thickened beverage, while standing. The resident was seated in a wheelchair that was tilted greater than 45 degrees. Review of the resident's plan of care identified that the resident had difficulty swallowing and required total assistance with feeding. Interview with PSW #104 confirmed that standing while feeding a resident who was tilted in their wheelchair was not safe and, therefore, the resident was not provided with proper techniques to assist the resident with eating. (528) [s. 73. (1) 10.]

***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 home's dinings and snack service includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

**Specifically failed to comply with the following:**

**s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:**
**4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).**

**s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:**
**6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).**

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).**

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that where a resident was being restrained by a physical device under section 31 of the Act that the resident was released from the physical device and repositioned at least once every two hours.

Resident #012's plan of care identified they required a restraint device when up in their wheelchair for safety. On multiple days during the course of the inspection, they were observed positioned in a tilted wheelchair with restraint device and were unable to undo the device independently.

i. On an identified day in December 2016, two hours and 35 minutes, the resident was observed seated in their tilt wheelchair, their restraint device was not released and reapplied and they were not repositioned during that period. Interview with PSW #124 stated the resident was restrained and was monitored every hour; however, confirmed that the restraint device was not released and the resident was not repositioned. Interview with registered staff #113 and PSW #124 both stated they were unaware residents with the specific restraint device needed to be released at least once every two hours when they were repositioned. Review of the Restraint Flow sheet in November and December 2016, and interview with registered staff #113 confirmed that the resident was not consistently released from the physical device at least every two hours. (581) [s. 110. (2) 4.]

2. The licensee failed to ensure that where a resident was being restrained by a physical device under section 31 of the Act that the resident's condition had been reassessed and the effectiveness of the restraining evaluated by a physician or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstance.

A. Review of the plan of care identified that resident #010 required a restraint device for safety; however, there was no documentation that the resident was reassessed and the effectiveness of the restraint evaluated by the registered nursing staff, at least every eight hours. Interview with registered staff #113 stated the Restraint Flow Sheet was not initiated when the resident was restrained and therefore confirmed the restraint reassessment and evaluation was not completed every eight hours.

B. Resident # 012's plan of care identified they required a restraint device when up in their wheelchair for safety. Review of the resident's Restraint Flow Sheet from November to December 2016, indicated that the restraint assessment was not completed on every shift for nine days in November 2016 and three days in December 2016. Interview with registered staff # 113 confirmed that resident #012 was not reassessed and the effectiveness of the restraining evaluated at least every eight hours on the above dates. (581) [s. 110. (2) 6.]

3. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented, including, all assessment, reassessment and monitoring, including the resident's response.

In October 2016, resident #010 was restrained with physical device when up in their wheelchair for safety. Review of the plan of care identified the Physical Restraint Assessment was not completed when the restraint was applied nor was there documentation the resident was monitored. Interview with registered staff #113 confirmed that an initial restraint assessment was not completed when the restraint was initially applied and monitoring of the resident and the resident's response to the restraint was not documented. (581) [s. 110. (7) 6.]

4. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented, including, every release of the device and all repositioning.

Review of the written plan of care identified that resident #010 required a restraint device for safety. Review of the PSW flow sheet binder revealed that a Restraint Flow Sheet was not initiated when the resident was restrained . Interview with PSW #114 stated the resident was restrained with physical device; however, they were not documenting the application, removal and release of the device, nor the monitoring and repositioning of the resident when there were positioned in their wheelchair with the device applied. Interview with registered staff #113 confirmed that the PSW staff were not documenting on the resident Restraint Flow Sheets every release of the device, monitoring and all repositioning of resident #010 since they were initially restrained. (581) [s. 110. (7) 7.]

***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 where a resident is being restrained by a physical device under section 31 of the Act that:***
***i. the resident was released from the physical device and repositioned at least once every two hours***
***ii. the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstance***
***iii. that every use of a physical device to restrain a resident is documented, including, all assessment, reassessment and monitoring, including the resident's response***
***iv. every use of a physical device to restrain a resident is documented, including, every release of the device and all repositioning, to be implemented voluntarily.***

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**WN #8: 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,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Review of the home's Complete Skin Assessment, policy No: RC-05-07-20.2, revised date: January 1, 2011, directed registered staff to complete the skin assessment form when documenting the actual impairment and this would include the assessment of the skin from head to toe, nails, feet and mouth. This assessment would be completed whenever there was a change in the residents' health condition that may affect skin integrity.

In November 2016, resident #040 sustained a superficial injury as a result of a transfer using a mechanical lift. Review of the plan of care identified that the skin assessment in Point Click Care was not completed at the time of the injury but was completed one week later. Interview with the Interim DOC stated that registered staff # 121 was to complete this assessment at the time of the injury and confirmed that registered staff did not complete the skin assessment as directed in the home's policy. (581) [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

In May 2016, resident #016 was noted to have a new area of altered skin integrity. The progress notes indicated that the wound was assessed and measured. Review of the plan of care did not include any weekly wound assessments for the area thereafter. Interview with RPN #119 and the Interim DOC confirmed that weekly wound assessments were not completed after the initial wound assessment for resident #016, as clinically indicated. (528) [s. 50. (2) (b) (iv)]

***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, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

In November 2016, resident #040 was transferred with a mechanical lift and sustained superficial injuries. Interview with registered staff #100 stated that all staff were trained to use the mechanical lift and apply the safety device. They confirmed that PSW #120 did not apply the safety device according to the manufacturers' instructions prior to transferring resident #040. [s. 23.]

***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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.***

**WN #10: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The homes policy "Resident Client Weight Change, #NS-03-20", effective December 2009, directed staff to "weigh resident monthly and record in each resident client chart. If Resident client as had a weight gain or loss of 5% or more over one month, 7.5% or more in three months, or 10% or more over 6 months then the resident client will be reweighed immediately and the second weight obtained will be recorded in the reweigh column of the weight record.

In December 2016, resident #17's weight was documented as a significant weight change from the November 2016, weight. Nursing staff requested a re-weigh to be completed on December 2016. However, review of the monthly weight report four days after the request was completed, did not include a re-weigh. Interview with PSW #111 and RPN #116 confirmed that the resident had not been re-weighed on, as requested, and staff were going to re-weigh the resident on their next scheduled bath day. The resident was not re-weighed immediately after a significant weight change, as requested by registered staff and directed in the home's policy. (528) [s. 8. (1) (b)]

**WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement**

**Specifically failed to comply with the following:**

**s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the PASD described in subsection (1) that was used to assist a resident with a routine activity of living included in the residents' plan of care.

Throughout the course of the inspection, resident #012 was observed in a tilted position in their wheelchair. The document the home referred to as the written care plan identified that staff were to tilt the wheelchair to relieve pressure. Section 33, subsection (4) of The Act identified that a PASD may be allowed in the plan of care only if the PASD was consented to by the resident, or substitute decision maker. Review of the plan of care did not include a consent for the tilt wheelchair by the resident's SDM, as confirmed by registered staff # 101; therefore, should not have been in the plan of care. (528) [s. 33. (3)]

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids**

**Specifically failed to comply with the following:**

**s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,**
**(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).**
**(b) cleaned as required. O. Reg. 79/10, s. 37 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items.

The home's policy "Labeling Resident Client Items - NA-08-14-04", dated December 2003, identified that clients belongings were individually labeled to ensure that staff and resident were aware of whom it belongs to and the Admission Pathway directed staff to make sure that resident's personal effects were labeled.

During the initial tour of the home, the following personal items were observed:

i. in the Hawthorn House home area tub room, infazinc, petroleum jelly, one deodorant, one electric razor appeared to be used and unlabeled
ii. in the Hawthorn House home area shower room two combs one deodorant and one nail clipper appeared to be used and unlabeled.
iii. in the Queenston House home area in the shower room, one clipper, one comb, one deoderant appeared to be used and unlabeled.

Interview with the DOC revealed that the expectation for staff is to use resident care baskets to store resident's personal care items, which were to be labeled and kept with the resident. Furthermore, unlabeled items found should be discarded. The home's policy "Labeling Resident Client items" was not complied with. [s. 37. (1) (a)]

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**WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 59. Family Council**

**Specifically failed to comply with the following:**

**s. 59. (7) If there is no Family Council, the licensee shall,**
**(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).**
**(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that if there was no Family Council, the licensee convened semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council.

During the course of the inspection, it was identified that the home no longer had a Family Council (FC). Interview with the Director of Recreation and Leisure, revealed that information updates were sent via email to previous FC members, but in 2016, the home had not convened semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council.  (528) [s. 59. (7) (b)]

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**Issued on this 2nd day of February, 2017**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

**Ministére de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de sions de longue durée**

## Public Copy/Copie du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581) |
| **Inspection No. / No de l'inspection :** | 2016_570528_0025 |
| **Log No. / Registre no:** | 033628-16 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Jan 11, 2017 |
| **Licensee / Titulaire de permis :** | THE THOMAS HEALTH CARE CORPORATION<br>490 Highway #8, STONEY CREEK, ON, L8G-1G6 |
| **LTC Home / Foyer de SLD :** | ARBOUR CREEK LONG-TERM CARE CENTRE<br>2717 KING STREET EAST, HAMILTON, ON, L8G-1J3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Lisa Paladino |

To THE THOMAS HEALTH CARE CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

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. O. Reg. 79/10, s. 36.

**Order / Ordre :**

The licensee shall ensure that staff use safe transferring and positioning techniques with all residents as identified in their written plan of care prior to transporting the resident including:
i. Provide education to all direct care staff on safe transferring and positioning techniques for all residents related to using sit to stand lifts and application of leg staps.
ii. Ensure that all staff are following the plan of care in relation to transferring the resident with the sit to stand lift using to staff members at all times.
iii. Ensure that all staff are following the manufacturers instructions for the sit to stand lift when using the device, specifically applying leg straps before transferring the resident.

**Grounds / Motifs :**

1. A. This non-compliance had a severity of "actual harm/risk", with a scope "isolated" and an ongoing history of noncompliance unrelated.

B. In November 2016, resident #040 was transferred with a mechanical lift and sustained superficial injuries. Review of the investigation notes identified that PSW #120 transferred the resident by themselves. Registered staff #121 responded to the call bell and they observed the resident was no longer in the proper position on the lift. Interview with registered staff #121 confirmed the PSW did not transfer the resident with two person assistance and did not apply the lift's safety device. Interview with Interim DOC stated that all residents that were transferred with this particular lift were to be transferred with two staff assistance and that the safety device was to be applied. Registered staff #100 stated that PSW #120 did not use safe transferring techniques when they transferred resident #040.

C. Interview with the Interim DOC stated that all staff were trained to apply the safety device prior to transferring any resident with lift. They confirmed that PSW #120 did not apply safety device according to the manufacturers' instructions prior to transferring resident #040. (581)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 28, 2017

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 11th day of January, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Cynthia DiTomasso

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office