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
Jan 29, 2013	2013_201167_0003	H-000092-12, H-000561-12	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

MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 18, 23 and 24, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care, registered nursing staff, personal support worker staff, the Environmental Services Lead and identified residents and family.

During the course of the inspection, the inspector(s) conducted a review of the health files for identified residents, reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry

Continence Care and Bowel Management

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following:

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 2007, c. 8, s. 6 (11).
(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 did not ensure that resident # 002 was reassessed and their plan of care reviewed and revised when the care set out in their plan of care was not effective in preventing falls. The licensee did not ensure that different approaches were considered in the revision of the resident's plan of care.

a) Resident # 002 sustained five falls over a one year period. In each incident, the resident fell forward out of their wheelchair in a specific location of the home. All falls occurred during a specific time of day.
b) After a fall that occurred in October 2011, the resident's Power of Attorney (POA) requested that the resident use a restraint to prevent any further falls. The resident's POA was informed by staff that they would try monitoring and a chair alarm first before considering a restraint.
c) It was noted on the document that the home refers to as the care plan dated the November 2010 that the resident was already using a chair and bed alarm. Other interventions in place at that time included monitoring of the resident every hour and two side rails when up in bed for safety. No new interventions or different approaches were put in place after the October 2011 fall occurred.
d) In February 2012, the resident again sustained a fall from their wheelchair in the common area. No evaluation of the effectiveness of the current interventions was completed. No new approaches were considered to prevent further falls and no revisions were made to the care plan.
e) In March 2012, the resident sustained another fall and this fall resulted in serious injury to the resident.
f) After the March 2012 fall, the home finally put new interventions in place to assist in preventing falls. The care plan also included the need for staff to monitor the resident more closely at specific times of day. There have been no further falls sustained by the resident since these interventions have been put in place. [s. 6. (11) (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 when a resident is reassessed and the plan of care reviewed and revised, 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., 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:

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 the the home's policy related to reporting and locating of residents' missing clothing or personal items was complied with.

a) The home's policy related to lost Clothing and Personal Items (Policy # EVS-02-04 -03 dated May 2012) directs staff to ask for specific details; e.g. colour, style, and report to registered staff when a resident, client or family members report lost items.
- Registered staff are to fill out the Lost Personal Items form and take it to the laundry.
- When the missing item has been returned to the resident, registered staff will sign off on the form and give it to the Environmental Services Lead.
b) An interview with a registered staff member who regularly works at the home indicated that when a missing item of clothing is reported to them they would call the laundry staff to let them know. The registered staff member confirmed that they were not aware of any form that they have been directed to complete to serve this purpose.
c) During an interview with the Environmental Services Lead, it was confirmed that the staff at the home were not using any form to identify or track missing items of clothing when reported. [s. 8. (1) (b)]

Issued on this 14th day of February, 2013

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

Marilyn Tore