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
Direction de l'amélioration de la performance et de la conformité

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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
Mar 7, 2014	2014_248214_0009	H-000205-14	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

CATHY FEDIASH (214)

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): February 26, 27, 2014

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, Interim Director of Care, Registered Nursing Staff, Personal Support Workers.

During the course of the inspection, the inspector(s) interviewed staff and residents, reviewed clinical records, relevant policies and procedures, meeting minutes and observed care.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours
Training and Orientation

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. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(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. (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 did not ensure that there was a written plan of care that set out the planned care for the resident.

A review of resident #003's Behavioural Symptom Resident Assessment Protocol, completed on a specified date in January 2014, indicated that registered staff would complete a weekly referral to the physician to evaluate their prescribed antidepressant, until stable. On a specified date in February 2014, a review of the physician's referral notes and interviews with the registered staff, confirmed that no weekly referral to the physician for assessment of the prescribed antidepressant, had occurred. [s. 6. (1) (a)]

2. The licensee did not ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A review of resident #001's written plan of care with a specified date of November 2012, indicated that the resident was very confused and disorientated to time, person and place. Interventions that were in place indicated that staff was to orientate the resident to person, place, time and activity as required. Staff interviewed stated that the interventions were not effective as this resident was no longer capable due to their level of confusion. The Interim Administrator and the Interim DOC confirmed that the written plan of care did not provide clear directions to staff regarding orientation for this resident. [s. 6. (1) (c)]

3. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) According to the written plan of care for resident #001, with a specified date of November 2012, indicated that staff were to document the resident's whereabouts hourly on a wanderers checklist.

b) According to the written plan of care for resident #003, with a specified date of January 2014, indicated that staff were to document the resident's whereabouts hourly on a wanderers checklist.

A review of the resident's clinical records identified that there were no records of hourly checks. Registered staff and the Interim Director of Care confirmed the documentation was never initiated, as specified. [s. 6. (7)]

4. The licensee did not ensure that staff and others who provided direct care to a resident were kept aware of the contents of the residents plan and had convenient and immediate access to it.

a) The printed copy of the plan of care for resident #001 located in the care plan binder and that was accessible to staff, had a specified print date of July 2013; however, the most current plan of care that was only in the electronic records had a specified date of December 2013.

b) The printed copy of the plan of care for resident #002 located in the care plan binder and that was accessible to staff, had a specified print date of December 2013; however, the most current plan of care that was only in the electronic records had a specified date of February 2014.

c) Resident #003 did not have a printed copy of their plan of care in the care plan binder that was accessible to staff and others who provided direct care. This resident's plan of care was only available in the electronic records.

Interviews with registered staff confirmed that front line staff did not have immediate access to these residents' current plan of care as they did not have access to the electronic records and relied on the printed copy. [s. 6. (8)]

5. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change.

a) Resident #001's written plan of care, with a specified date of January 2013, indicated that interventions were in place to assist and manage this resident's identified responsive behaviours. The residents plan of care indicated that the resident was frequently confused and disorientated and that they were unsteady when weight bearing. Staff interviewed confirmed that the resident was no longer capable of responding to the interventions and that the plan of care did not meet the resident's current care needs.

b) Resident #001's written plan of care, with a specified date of July 2013, indicated that staff was to monitor the resident closely when up in their wheelchair as their seat belt restraint was broken and not safe at the time. On a specified date in February 2014 the seat belt restraint was observed to be applied and interviews with staff confirmed that the restraint had been repaired and that the plan of care was not revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 written plan of care sets out the planned care for the resident; provides clear directions to staff and others who provide direct care; that care is provided to the resident as specified in the plan and that staff and others who provide direct care to a resident are kept aware of the contents and have convenient and immediate access to it, is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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 did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessment, interventions and the resident's responses to interventions were documented.

On a specified date in February 2014, registered staff documented in Point Click Care (PCC) that resident #001, with identified responsive behaviours was the recipient of physical aggression by resident #002, also with identified responsive behaviours. Documentation in PCC did not include a physical assessment of resident #001 and whether or not any injuries were present until approximately 23 hours later. This was confirmed by the Interim Administrator. [s. 30. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on an interdisciplinary assessment with respect to the residents sleep patterns and preferences.

A review of resident #001's clinical record and their Minimum Data Set (MDS) coding with identified dates of September 2013 and December 2013, indicated that the resident experienced insomnia/changes in their usual sleep pattern and that this indicator was exhibited up to 5 days a week, however, the residents written plan of care did not include their sleep patterns and preferences. This was confirmed by the Interim Administrator and the Interim DOC. s. 26(3) 21 [s. 26. (3) 21.]

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 plan of care is based on an interdisciplinary assessment with respect to the resident's sleep patterns and preferences, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations

Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee did not ensure that procedures and interventions were implemented to assist residents and staff who were at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

The home's policy and procedures direct staff to document residents demonstrating responsive behaviours each shift, by placing a check mark on the resident daily care flow sheets, next to the observed responsive behaviour. These responsive behaviours are to be documented on a form titled, Resident Client Behaviour Record which includes each resident behaviour, interventions used, effectiveness of the intervention(s) and the number of staff required. This form is then reviewed biweekly each shift and a summary is to be documented in the residents progress notes.

a) A review of daily care flow sheets from February 1 – February 26, 2014, for resident #001, with identified responsive behaviours of wandering, restlessness, hoarding, repetitive movements of pacing, verbal and physical aggression, indicated that 71 episodes of responsive behaviour occurred during this time, however, only 3 of these episodes were documented on the Resident Client Behaviour Record.

b) A review of daily care flow sheets from February 1 – February 26, 2014, for resident #002, with identified responsive behaviours of resistance to care, repetitive movements of pacing, verbal and physical aggression, indicated that 13 episodes of responsive behaviour occurred during this time; however, none of these episodes were documented on the Resident Client Behaviour Record.

c) A review of daily care flow sheets from February 1 – February 26, 2014, for resident #003, with identified responsive behaviours of wandering, restlessness, repetitive movements of pacing, hoarding, verbal aggression of screaming and physical aggression of hitting and kicking, indicated that 117 episodes of responsive behaviour occurred during this time, however, only 13 episodes were documented on the Resident Client Behaviour Record.

Registered staff confirmed that the Resident Client Behaviour Records were not completed, not reviewed biweekly, nor was a summary documented in the resident's progress notes in order to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 55. (a)]

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 procedures and interventions are implemented to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

Issued on this 7th day of March, 2014

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

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

Ministère 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

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 conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHY FEDIASH (214)
Inspection No. / No de l'inspection :	2014_248214_0009
Log No. / Registre no:	H-000205-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 7, 2014
Licensee / Titulaire de permis :	THE THOMAS HEALTH CARE CORPORATION 490 Highway #8, STONEY CREEK, ON, L8G-1G6
LTC Home / Foyer de SLD :	ARBOUR CREEK LONG-TERM CARE CENTRE 2717 KING STREET EAST, HAMILTON, ON, L8G-1J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~DORCAS HAIZEL~~ Lily Wang

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)

Linked to Existing Order / Lien vers ordre existant: 2013_214146_0027, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.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;
(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).

Order / Ordre :

The licensee shall ensure that every resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, including resident #001.

Grounds / Motifs :

1. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

1. Previously identified as non-compliant with a VPC on March 19, 2013 and a CO on May 3, 2013.

a) Resident #001's written plan of care, dated January 2013, indicated that interventions in place to assist and manage this resident's identified responsive behaviours. The residents plan of care indicated that the resident was frequently confused and disorientated and that they were unsteady when weight bearing. Staff interviewed confirmed that the resident was no longer capable of responding to the interventions due to confusion and safety risks of weight bearing and that the plan of care did not meet the resident's current care needs.

b) Resident #001's written plan of care, dated July 2013, indicated that staff was to monitor the resident closely when up in their wheelchair as their seat belt restraint was broken and not safe at the time. On a specified date in February 2014, the seat belt restraint was observed to be applied and interviews with staff confirmed that the restraint had been repaired and that the plan of care was not revised when the resident's care needs changed.

(214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 28, 2014

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2013_214146_0027, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

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 will be documented.

Grounds / Motifs :

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessment, interventions and the resident's responses to interventions were documented.

1. Previously identified as non-compliant with a CO on May 3, 2013.

a) On a specified date in February 2014, registered staff documented in Point Click Care (PCC) that resident #001, with identified responsive behaviours was slapped on their right side of their face by resident #002, also with identified responsive behaviours. Documentation in PCC did not include a physical assessment of resident #001 and whether or not any injuries were present until, approximately 23 hours later. This was confirmed by the Interim Administrator.

(214)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 28, 2014

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, 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 7th day of March, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : CATHY FEDIASH

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