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

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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
Apr 20, 2015	2015_389601_0004	O-001499-15, O-001552-15	Complaint

Licensee/Titulaire de permis

2109577 ONTARIO LIMITED
195 Forum Drive Unit 617 MISSISSAUGA ON L4Z 3M5

Long-Term Care Home/Foyer de soins de longue durée

2109577 ONTARIO LIMITED O/A ARBOUR HEIGHTS
564 Tanner Drive KINGSTON ON K7M 0C3

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

KARYN WOOD (601)

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 10-12, March 2, 2015

Log#O-001499-15/O-001552-15 were completed

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCP),RAI Coordinator, Physiotherapist, Physician, Residents, Family members of residents, and observation of residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. Related to Log# O-001499-15:

The licensee has failed to comply with O.Reg. 79/10, s.101(1) where by the home did not ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, commences the investigation immediately.

A review of Director of Care #1(DOC1)documentation regarding complaints brought forward by Resident #2's POA, identified concerns on two separate dates.

During an interview Resident #2's POA indicated that for the past year the home has

been made aware of the POA's dissatisfaction regarding Resident #2's personal care and nothing has been done. Resident #2's POA indicated that many complaints have been discussed with DOC1 and have not been resolved. Resident #2's POA states a response from the home regarding the concerns brought forward has not been received.

During an interview the Administrator and DOC1 acknowledge that when verbal complaints are received a formal response is not always provided within 10 business days. DOC1 did not respond to Resident #2's POA's verbal complaints concerning the care of Resident #2 within 10 business days of the receipt of the verbal complaint. [s. 101. (1) 1.]

2. Related to Resident #2: Log# O-001499-15

The licensee has failed to comply with O.Reg. 79/10, s.101 (2) where by the home did not ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

Resident #2's progress note on an identified date was reviewed and it indicated that Resident #2's POA was visibly upset when approaching RPN #121 regarding the offensive odour in Resident #2 room.

A review of Director of Care #1 (DOC1)documentation regarding complaints brought forward by Resident #2's POA, identified concerns on two separate identified dates.

The DOC1's documentation of verbal complaints received from Resident #2's POA and the documented record identified the concerns, but the nature of the complaint; the date the complaint was received; action taken to resolve the complaint; time frames for actions; follow up action required; final resolution was not clear. The DOC1 has no documentation indicating a response was provided to the POA, in regards to the verbal complaints brought forward. [s. 101. (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 that every verbal complaint made to the licensee or a staff member concerning the care Resident #1 is dealt with as follows: The verbal complaint shall be investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately and a documented record is kept in the home that includes: the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and; any response made by the complainant, to be implemented voluntarily.

WN #2: 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. (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).

Findings/Faits saillants :

1. Related to Log# O-001499-15:

The home has failed to comply with O.Reg. 79/10, s.6.(7) where by the home did not ensure that the care set out in Resident #2 plan of care was provided to the resident as specified in the plan for risk for falls.

A review of Resident #2's plan of care identified Resident #2 as a high risk for falls and the interventions included to check q1h to ensure safety and document in Point of Care; posey alarm on clothes; chair alarm on wheelchair; check working condition upon

application/use.

Inspector #601 observed and interviewed Resident #2 on an identified date and time. Resident was observed leaving the bathroom, and resident indicated sometimes staff assist with toilet use. Staff did not assist resident with toilet use at this time, and the chair alarm did not sound while Resident #2 was in the bathroom. RPN #101 was interviewed and indicated Resident #2's wheelchair and bed alarm were not in working order, and that Resident #2 requires the personal alarms for the wheelchair, and bed for safety reasons due to risk of falls.

During an interview Resident #2's POA indicated that when visiting Resident #2 the chair and bed alarm were not working properly; the personal alarm does not always go off when resident transfers in and out of the bed, or wheelchair. Resident #2 has had several falls because of this issue, a fall occurred on two occasions resulting in an injury.

The post fall assessment indicated Resident #2 was found sitting on buttocks in front of the Resident’s bed, beside wheelchair. Resident #2 was attempting to get ready for bed, and was trying to stand without assistance, using the bed side rails. Resident #2 lost balance and fell to the floor. Resident #2 reported mild pain following the identified fall.

Review of the progress notes and interview with RPN #116, who was working the day Resident #2 was found on the floor, next to wheelchair. RPN #116 confirmed that Resident #2's bed alarm did not have a functioning battery, and did not have the personal alarm on the wheelchair.

In an interview with PCP #117 who was working when Resident #2 was found on the floor in the bathroom. PCP #117 does not recall if the wheelchair alarm activated and doesn’t recall the last time the personal alarm for Resident #2's wheelchair or bed were activated. PCP #117 indicated that Resident #2 never rings the call bell, is very independent, and the personal alarm is the only way staff can be notified if Resident #2 is self-transferring.

Further interviews with PCP #103; RPN #101; RPN #104;RPN #116,RN #102 who regularly provide care for Resident #2, identified that in the past Resident #2's personal alarms for chair or bed would activate when the resident was attempting to self-transfer. The staff interviewed could not recall the last time they heard or responded to Resident #2's personal alarms for chair or bed.

Therefore, on an identified date it was identified the chair and bed alarm were not functioning properly for Resident #2 as identified in the plan of care. [s. 6. (7)]

2. Related to Log# O-001499-15:

The licensee has failed to comply with O. Reg. 79/10, s.6.(7) where by the home did not ensure that the care set out in Resident #2's plan of care related to the risk of developing pressure ulcers and impaired skin integrity is provided to the resident as specified in the plan.

A review of Resident #2's current plan of care for high risk for developing pressure ulcers and impaired skin integrity included the intervention to encourage compliance with use of specialized treatment. Resident #2's current care plan also included the intervention to encourage to wear proper footwear.

A review of the e-mar documentation for Resident #2 on a specified date and the order was to apply specialized treatment in AM and take off at HS. The e-mar documentation noted that Resident did not have specialized treatment applied therefore could not be removed.

On a specified date, Inspector #601 observed and interviewed Resident #2. Resident #2 did not have specialized treatment in place. Resident #2 was observed not wearing proper foot wear.

In an interview with RPN #101 indicated wasn’t sure if the specialized treatment was still ordered by the Physician for Resident #2. RPN #101 reviewed e-mar and confirmed that Resident #2 should have the specialized treatment in place and did not.

In an interview with Resident #2 POA it was indicated that Resident #2 requires specialized treatment and when visiting not always applied properly.

During an interview Physician identified that Resident #2's shoes were too tight. The Physician also identified that Resident #2's specialized treatment was not applied properly.

Therefore, the licensee did not ensure that Resident #2's specialized treatment was applied on a specified date and were not properly applied another specified date. [s. 6. (7)]

Issued on this 3rd day of July, 2015

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

Original report signed by the inspector.