Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 3, 4, 5, 11, 12, 15, 16, 2012	2012_184124_0002	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

LYNDA HAMILTON (124)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Residents, Administrator, Assistant Directors of Care, Registered Nurses, Registered Practical Nurses, Resident Support Services Manager and Personal Care Providers.

During the course of the inspection, the inspector(s) observed staff-resident interactions, reviewed resident health records and the Policy and Procedure regarding Responsive Behaviours.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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. (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
(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 failed to comply with LTCHA 2007, s. 6. (11) (b) in that the care set out in the plan of care has not been effective and different approaches have not been considered in the revision of the plan of care.

Resident #1 has a history of dementia and responsive behaviour. Resident #1 has had a medication prescribed on an as needed basis. As demonstrated by the findings below, Resident #1's medications were adjusted during the time period April 1, 2012-September 30, 2012 but other approaches were not considered in the revision of the plan of care.

During April 2012, Resident #1 had three progress note entries regarding responsive behaviour. Resident #1 received a number of doses of as needed medication and some of these doses were assessed as being ineffective.

During May 2012, the number of progress notes regarding responsive behaviour increased. Resident #1 received a greater number of doses of as needed medication with one third of these doses assessed as being ineffective. The Administrator reported to the inspector that Resident #1's plan of care review was completed on May 12, 2012. There were no changes to Resident #1's plan of care despite the increase in Resident #1's responsive behaviour.

During June 2012, Resident #1 had a greater number of documented entries in the progress notes related to responsive behaviour. Resident #1 received a number of doses of as needed medication with over half the doses being assessed as ineffective.

During July 2012, the progress notes regarding Resident #1's responsive behaviour were less than June 2012. Resident #1 received a smaller number of doses of as needed medication than in June 2012. One fifth of these doses were assessed as being ineffective. There is no clinical documentation to indicate that the factors contributing to the decrease in Resident #1's responsive behaviour were identified or included in the resident's plan of care. On July 31, 2012 Resident #1's as needed medication was increased.

During August 2012, Resident #1 had a greater number of entries in his progress notes related to responsive behaviour than in July 2012. Resident #1 received a higher number of doses of as needed medication with one quarter of the doses being assessed as ineffective. On a specific date there were changes to Resident #1's medication regime. The Administrator reported to the inspector that Resident #1's plan of care review was completed on August 13, 2012. There was no documented clinical evidence to indicate that there was a change in strategies or approaches to support Resident #1 with the behaviours.

During September 2012, there were an increased number of entries in Resident #1's progress notes related to responsive behaviour. Resident #1 received a higher number of doses of as needed medication and over half of these doses were assessed as being ineffective.

Throughout the time period of April 1, 2012-September 30, 2012, Resident #1's family expressed their concerns regarding the amount of medication Resident #1 was taking and the effect this medication was having on Resident #1.

S#100, S#101 and S#102 reported that redirection is used when Resident #1 has responsive behaviour. S#102 reported that when that doesn't work, the registered staff is notified and she knows what to do. One registered nurse, S#101 reported to the inspector that medication would be used if the resident had an as needed medication available. The interventions of redirection and as needed medication have been identified in Resident #1's plan of care since April 2011.

2. The licensee failed to comply with LTCHA 2007, c.8, s. 6. (7) in that the resident did not receive care as specified in the plan of care.

Resident #1's plan of care stated that if Resident #1 refuses care, staff are to leave and return in 5-10 minutes. S#102 reported that Resident #1 has responsive behaviour when care is delivered. S#102 recalled an instance when the resident was incontinent of bowel and three staff were required in order to provide care and staff would not leave the resident like that.

Resident #1's plan of care stated that if Resident #1 refuses care, staff are to allow for flexibility in Activity of Daily Living routine to accommodate the resident's mood. S#100 reported that Resident #1 was not usually awake when staff approached the resident to provide morning care and that Resident #1 was resistive to morning care 99% of the time. S#100 reported that staff could not leave Resident #1 in bed and deliver care later because Resident #1 has climbed out of bed in the past.

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 different approaches are considered when the resident's plan of care is being revised because interventions have been ineffective and that the residents receive care as specified in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 26. (3) 5. in that the resident's behaviour plan of care was not based on an interdisciplinary assessment of identified potential behavioural triggers and the variation in the resident's functioning at different times of the day.

S#100 and S#101 reported to the inspector that Resident #1 has responsive behaviours after the resident's visitors leave. Resident #1's plan of care did not identify the leaving of visitors as a potential trigger for behaviour and did not include strategies to address this trigger.

S#100, S#101 and S#102 reported that Resident #1's behaviours increase in the late afternoon-early evening. Resident #1's plan of care did not identify the variation in the resident's functioning at different times of the day and did not include interventions to address this.

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 a resident's behaviour plan of care is based on an interdisciplinary assessment of identified potential behavioural triggers and variation in the resident's functioning at different times of day, to be implemented voluntarily.

Issued on this 18th day of October, 2012

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