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 soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 2, 2017	2017_444602_0001	035426-16	Resident Quality Inspection

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

WENDY BROWN (602), CATHI KERR (641), DARLENE MURPHY (103)

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): January 9-13, 2017 and January 16 & 17, 2017

The following logs were included in the inspection:
Log# 031533-16 concerning alleged staff to resident abuse/neglect
Log# 032768-16 concerning a fall with injury and transfer to hospital
Log# 033664-16 concerning a complaint regarding alleged incompetent treatment
Log# 032601-16 follow up on an order specific to withholding admissions to the Home

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), as well as the Registered Dietician (RD), Clinical Nurse Coordinator (CNC), Restorative Care Lead (RCL), Family and Community Coordinator, Family Council Representative, Environmental Services Manager, Dietary Staff, residents and resident family members. Additionally, the inspector(s) conducted a tour of the home, completed resident care observations, observed medication administration and practices, reviewed resident health care records, observed and reviewed infection control practices, reviewed resident and family council minutes, applicable home policies & procedures, as well as the home's staffing plan.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 44. (7)	CO #001	2016_505103_0045	103

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. (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. The following non-compliance is related to Log #032768-16:

The licensee has failed to ensure #041's fall prevention measures were in place and in

working condition as outlined in the resident plan of care.

Resident #041 was admitted to the home on a specified date and had been assessed as high risk for falls. On a specified date resident #041 fell and sustained an injury requiring transfer to hospital. The fall was witnessed by a staff #111.

Staff #111 was interviewed and indicated at the time of this fall, she had been at the nursing desk when she observed resident #041 in the hallway. The staff indicated she attempted to intervene as the resident was known to be unsteady and at high risk for falls. She stated the resident fell onto the floor before she reached the resident.

At the time of this fall, the resident plan of care indicated the following under "Fall prevention":

High risk for falls characterized by history of falls/injury, multiple risk factors related to unsteady gait, SOBOE, incontinence, self-transferring behaviours and communication problems. A bed alarm was included in the fall prevention interventions and indicated: ensure bed alarm is applied and in working condition; bed alarm when in bed, monitor that alarms are on and working.

The staff indicated at the time of the fall, resident #041 used a wireless alarm as a fall prevention measure. She recalled hearing the alarm sounding when she was assessing the resident for injuries, but that the alarm had not been audible at the nursing desk. The staff stated the resident's room was located some distance from the desk. Staff #111 indicated the alarm should have also sounded to the staff pagers, but failed to do so.

The Clinical Nurse Coordinator #100 was interviewed and indicated she was the lead for the fall prevention program. She stated wireless alarms are used in the home for residents who are known to self-remove the alarm clip or disconnect the wires associated with a wired style of alarm. She indicated the wireless alarms are designed to ring at both the resident bedside and also designed to be audible through the staff pagers and serve to alert staff in a timely manner of residents who are at high risk of unsafe self-transfers.

#100 indicated resident #041 had a series of prior falls and had been a challenge in addressing ongoing falls. She indicated it was therefore decided a wireless alarm would be the most appropriate fall prevention measure for this resident. #100 indicated she had been made aware after #041's fall that the alarm had not gone to the staff pagers and requested the functionality of the bed alarm be checked by the Restorative care lead.

Restorative care lead #104 was interviewed and stated she assessed the functionality of the alarm post fall and found the alarm to be in working order. #104 stated the wireless alarm was fully functional and could not explain why it had not alarmed through the staff pagers at the time of resident #041's fall.

During a review of resident #041's health care record, the inspector noted an entry was made on a specified date by the physiotherapist which indicated the bed alarm was to be checked again to ensure it remained in good working order.

The DOC was interviewed in regards to resident #041's alarm not sounding to the staff pagers and speculated the call system can be overloaded at times and prevent the alarms from functioning as they are intended. The DOC did indicate she was unsure of the reason for the failure.

During the interview with #100, she stated she has noted issues with the call system whereby calls to her phone have not always come through, attributed this to the volume of calls at one time and also speculated this may have been the reason the alarm did not alert staff that day. Additionally, #100 indicated, regardless of the reason for the failure, all staff are responsible for ensuring all fall prevention measures are both in place in accordance with the resident plan of care and that they should be tested to ensure they are in good working order prior to each use.

On a specified date, the home failed to ensure resident #041's wireless alarm was in place and in working condition in accordance with the resident plan of care. [s. 6. (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 with fall prevention measures specifically the wireless alarm system, ensuring that the alarm will ring as designed at both the resident bedside and be audible through staff pagers, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The following non-compliance is related to Log #033664-16:

The licensee has failed to ensure that a written complaint concerning the care of resident #042 was immediately forwarded to the Director (MOHLTC).

On a specified date the Director of Care (DOC) received and read an email from a resident family/friend alleging the home had provided inept and inadequate care to the resident. The DOC was interviewed and indicated she immediately investigated the allegations, but did not forward the written complaint until another specified date to the Ministry of Health and Long Term Care. [s. 22. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a non-controlled substance was destroyed in accordance with the legislated requirements.

The Director of Care (DOC) was interviewed in regards to the procedure involving the destruction of non-controlled substances. She indicated the registered staff member removes all non-controlled substances that are no longer required and discards them into the Stericycle bin which is located in the locked medication room on each resident care unit. The DOC indicated the destruction is not done by a team acting together, rather the registered staff member discards the non-controlled substances independently.

This inspector interviewed RPN #101 who indicated the same process as outlined by the DOC for the destruction of non-controlled substances. [s. 136. (3) (b)]

Issued on this 7th day of February, 2017

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

Original report signed by the inspector.