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
Jul 27, 2017	2017_552531_0016	005228-17, 007974-17	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

SUSAN DONNAN (531)

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): May 30, 31, June 1, 2, 5 and 6, 2017.

The following logs were included in this inspection.
Log #007974-17 related to personal care and services
Log # 005228-17 related to personal care and services

During the course of the inspection, the inspector(s) spoke with residents, residents Substitute Decision Maker, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Environmental Services Aides (ESA), the Environmental Services Manager (ESM), the Director of Care (DOC) and the Administrator. The inspector also toured the home, reviewed resident health care records, observed resident care and services, reviewed Environmental Services programs and practices, reviewed the reporting and complaint documentation log , reviewed Environmental Services laundry policies and procedures and reporting and complaints polices and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Personal Support Services
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)**

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. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a sufficient supply of clean linens, face clothes, hand towels and bath towels always available in the home for use by the

resident.

In reference to Log # 007974-17

During an interview with resident #001's SDM, the SDM indicated that he/she assists with resident #001's care and found that there were no face clothes or hand towels in the resident's bathroom on many occasions.

On May 30 and 31, 2017, in separate interviews, PSW # 101, 102, 103, 104, 112 and 115 indicated that there are not enough supplies on the 24 hour cart available on the cart or in laundry, especially for evenings and nights. PSW #101,103 and 112 indicated that staff on the evening and night shifts use up bath towels, disposable face clothes to wash and dry residents' and borrow from the next day supply cart when laundered; which leaves the staff short for the next day.
The PSWs indicated that the concern has been an ongoing issue for the past year and a half, the issue has been reported to the Environmental Services Manager, the DOC during PSW staff meetings and home area "coaches corner" however there continues to be a shortage of clean face clothes, hand towels, bath towels and bed linens available for each shift .
May 31, 2017 during an interview with RPN #107, and RPN #126 they indicated that on weekends the shortage encompasses, dining shirt savers, staff dining aprons and bed linens. Both indicated that the issue has been reported to management, however the supplies are not always available on a daily bases for the three shifts.

On May 30 and 31, 2017 the inspector observed the following:
May 30, 2017 at 0900 hours and 1410 hours there was no face cloth or hand towel in resident #001's shared bathroom.
May 31, 2017 at 1200 hours there was no face cloth or hand towel in resident #001's shared bathroom.

The written laundry policies and procedures (Policy ENV-VII-10) for the home, last revised on August 15, 2006 indicates the following:
Daily Linen Supplies per Home Area:
Policy:
Each resident home area will receive an adequate amount of linens for a 24 hour period,

Procedure:
1. Linens will be checked daily (when folding items) for any products that require

discarding. Items that are stained, damaged and thinning (worn) are to be discarded.
3. The Environmental Services Manager will monitor and review required linen orders.
5. Laundry staff will fold all items and stock the linen cart for each home area.
8. Carts will be stocked for 24- hour periods per resident as follows:
 -3 face clothes
 -3 hand towels
 -1 bath towel
 -3 Adult Bibs
 -1 bed pad
 -0.5 top sheet per resident on RHA
 -0.5 bottom sheet per resident on RHA
 -1 pillow case

On May 31, 2017, the full-time Environmental Services Aide (ESA), ESA # 117 was interviewed related to the linen supply services in the home. She indicated that there are two 24 hour supply carts for each home area; the cart with face clothes, hand towels and bath towels are delivered to each home area at 0700 hours, and the second cart with bed linens and bed pads are delivered to the floor in the afternoon at 1400 hours. ESA #117 indicated that the expectation is that the carts are stocked daily with enough linens for each resident for 24 hours.
The inspector was shown a large bin of washed face clothes, hand towels and bath towels from the night shift and morning care that had been washed and which will be dried on the afternoon shift, as resident personal clothes and afternoon bed linen are a priority for the 1400 hour delivery. ESA #117 indicated the face clothes, hand towels, and bath towels from the day shift will be laundered by the afternoon ESA. ESA #117 indicated that it takes one hour to wash the linens and 50 minutes to dry. She further indicated that the face clothes and hand towels are not counted therefore ESA #117 could not validate that there are enough face clothes or hand towels to cover the 24 hour period when they are delivered to the home area, as is the expectation. ESA #117 showed the inspector the white bins that extra supplies are to be stored in and indicated that there were no extra linen supplies available; that the supplies were either on the home areas or waiting to be laundered.

During an interview with the Environmental Services Manager he indicated that the expectation is that the linen carts are stocked with enough linen supplies for each resident for 24 hours. However, he did recognize that the shortage of face clothes and hand towels had been an ongoing issue, and acknowledged that the service will be reviewed and modified to ensure that the linen carts are always stocked with sufficient

linen supplies.

On the same day the Administrator and DOC during an interview indicated that the expectation is that the linen carts are to always be stocked with enough supplies for each resident for 24 hours. Both recognized that this had not been happening, that the service will be reviewed and revised to ensure that there is a sufficient supply of face clothes and hand towels available in the home for use by the resident. [s. 89. (1) (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 there are a sufficient supply of clean linens, face clothes, hand towels and bath towels always available in the home for use by the resident, 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. The licensee has failed to ensure that care set out in the plan of care was provided to resident #001 as specified in the plan with respect to grooming and hygiene needs.

In reference to log # 007974-17

On a specified date resident #001's Substitute Decision Maker (SDM) submitted a written letter of complaint to the home's management.

During an interview with resident #001's SDM, he/ she indicated that a conference had been arranged to discuss care concern which included the SDM's concerns related to grooming and hygiene needs and that the care plan was reviewed and revised that the

staff were to notify the SDM if unsuccessful providing care. The SDM's concern was that he/she had not received a call that assistance was required.

Resident #001's current Plan of Care indicated that the resident receive the necessary assistance with personal hygiene /oral care, requiring one person physical assist.

Resident #001's Plan of Care was revised to include " notify resident's SDM if unsuccessful providing care:"

Review of resident #001's progress notes and point of care documentation for a four week period indicated that staff were unsuccessful with resident #001's individualized grooming/hygiene care on several occasions however the SDM was not notified.

PSW #102 indicated in an interview on May 31, 2017 that resident #001 requires assistance with grooming and hygiene .
She indicated when staff meet with resistance after reapproaching the resident several times, and are unsuccessful in providing hygiene care it is reported to the nurse in charge.

On June 1, 2017 during interviews with RPN #107 and RN #118 and review of resident #001's documentation both indicated that the plan of care had been revised to notify resident #001's SDM for assistance. RPN #107 indicated that she had not notified the SDM as directed in the plan of care. RN #118 indicated that she had notified resident #001's SDM recently, reviewed and revised the plan to include a pictorial of the grooming/hygiene process to enhance communication and comprehension with the resident.

The Administrator and the Director of Care were interviewed and indicated that the care was not provided as specified in the plan as the SDM was not notified for assistance. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 receive individualized care with hygiene, grooming and dressing.

In reference to log # 005228-17.

Resident #002's current plan of care indicated that resident #002's required extensive assistance with activities of daily living including grooming and dressing. The care plan directed staff to ensure the resident is groomed and dressed appropriately.

On a specified date resident 002's substitute decision maker (SDM) during an interview with inspector #531 indicated that he/she observed resident #002 inappropriately dressed covered with a blanket . The SDM told inspector #531 that the resident is always cold; required extensive assistance dressing and preferred to be dressed appropriately for the time of day.

PSW #114 and RPN #121 indicated that resident #002 requires extensive assistance with activities of daily living including dressing. Both indicated that resident #002 preferred to be dressed appropriately and covered with a blanket.

PSW #114, indicated that on a specified date resident #002 attended the morning and noon meal dressed inappropriately.

RPN #121 indicated that she was not aware until the PSW staff informed her on the specified morning that the resident's preferred clothing, were sent to the laundry the evening prior.
RPN #121 told inspector #531 if the registered staff had been aware that resident #002 required more clothing, the SDM would have been notified and the resident would have been dressed in accordance to resident/family preference and suitability for the time of day.

On the same day the Administrator and Director of Care were interviewed, acknowledged the concern, provided communication to staff to ensure resident #002 was dressed appropriately and the SDM was to be kept informed when clothing required . [s. 32.] [s. 32.]

Issued on this 27th day of July, 2017

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

Original report signed by the inspector.