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
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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
May 31, Jun 6, 7, 2011	2011_035124_0008	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 Administrator, Director of Care, Assistant Director of Care, Registered Nurse, Two Registered Practical Nurses, Three Personal Care Providers, Physiotherapist and the resident.

During the course of the inspection, the inspector(s) reviewed the resident's health record, observed resident in dining room and in bed and reviewed the home's Falls Prevention Policy(RCSM-E-105) and Complaints Policy (ADM-VI -18).

The following Inspection Protocols were used in part or in whole during this inspection:

Falls Prevention

Quality Improvement

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
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. 22. Licensee to forward complaints

Specifically failed to comply with the following subsections:

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 sayants :

1. A family member called the Ministry of Health and Long-Term Care to report that she had sent two letters of complaint to the home.
2. Jenny Bedard, Assistant Director of Care(ADOC), stated that she had received an email from the family member on a specific date. Bedard reports that this email was forwarded to the administrator, David Clegg. Bedard was unable to advise the inspector the date she forwarded this email.
3. Christine Sellery, current Administrator, faxed the email letter of complaint to the Ministry of Health and Long-Term Care at a later date.
4. The home did not immediately forward the written complaint to the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 103. (2) The licensee shall comply with subsection (1) immediately upon completing the licensee's investigation into the complaint, or at an earlier date if required by the Director. O. Reg. 79/10, s. 103 (2).

Findings/Faits sayants :

1. The home received a complaint and began investigating the issue shortly after.
2. The complaint falls under s.24 (1) 1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to a resident.
3. The results of the investigation were shared with the complainant and the Administrator's notes indicate that the complainant was satisfied with these results.
4. At a later date, the response to the complainant was provided to the Ministry of Health and Long-Term Care.
5. The licensee did not submit a copy of the written report to the director immediately upon completing the investigation into the complaint.

WN #3: 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. (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).

Findings/Faits sayants :

1. These findings pertain to s.6(7)
-The resident's plan of care for falls states that the resident is to be checked to ensure safety.
-Three Personal Care Providers reported that the resident is checked to ensure safety.
-The staff were not checking the resident as frequently as specified in the resident's plan of care.
2. These findings pertain to s.6(8)
-A registered practical nurse reported that the Personal Care Providers (PCP) receive a team sheet each day that contains the specific details of each resident's care plan and that the team sheets are updated weekly.
-The team sheet for a specific week was reviewed and there is no direction to check the resident for safety.
-Three PCPs were interviewed and reported they were not checking the resident as frequently as specified in the resident's plan of care.
-One of the three PCP's reported not knowing that the resident had ever fallen.
-The staff that provide direct care to the resident were not aware of the contents of the resident's plan of care.

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 by ensuring that all staff who provide direct care [redacted] are aware of the contents of [redacted] plan of care and provide care [redacted] as specified in her plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits sayants :

1. This non-compliance refers to O.Reg. 79/10, s.48(1)1 whereby the licensee is required to develop and implement a falls prevention and management program.
Arbour Heights' Falls Prevention Policy (RCSM-E-105) was last updated September 30, 2010.
A resident sustained a number of falls.
The Falls Prevention Policy directs Personal Care Providers (PCPs) to follow the interventions as outlined in the care plan.
Three Personal Care Providers were interviewed and reported that they were not providing interventions as per the resident's plan of care.

The Falls Prevention Policy directs the Registered Nursing Staff to refer the resident to the interdisciplinary team based on their level of risk.
There is no evidence that the resident was referred to the physiotherapist after sustaining a number of falls.
The physiotherapist confirmed that she was not asked to assess the resident.

In the "Fall and Post Fall Assessment and Management" section of the policy, it directs the Registered Nursing staff to:
- complete a Fall/Near fall reporting form and an incident report including all contributing factors
The resident sustained a number of falls.
No Fall/Near Fall Reporting Forms could be located in relation to the resident's falls.
The Director of Care, Pam Devine reported that the home had implemented the Fall/Near Fall Reporting Form in May 2011.

In the "Fall and Post Fall Assessment and Management" section of the policy, it directs the Registered Nursing staff also to:
-review the fall prevention interventions and modify the plan of care in collaboration with the interdisciplinary team.
To reduce the resident's risk of injury from falls staff implemented some interventions.
Other than one intervention, there is no evidence that the resident's plan of care was modified to include fall prevention interventions.
Staff did not comply with the home's Falls Prevention Policy.

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 by ensuring that the staff understand their responsibilities with respect to the home's Falls Prevention Policy and staff fulfill those responsibilities, to be implemented voluntarily.

Issued on this 24th day of June, 2011

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

Lynn Duchesne for
Lynda Hamilton.