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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Telephone: 613-569-5602
Facsimile: 613-569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
December 22-23, 2010	2010_103_9634_21Dec150459	Complaint Log #O-002977 Log #O-003002 Log #O-002988

Licensee/Titulaire
2109577 Ontario Limited o/a Arbour Heights 1050 Wenleigh Court, Mississauga, ON L5H 1M7 Fax# 905-278-6789

Long-Term Care Home/Foyer de soins de longue durée
Arbour Heights, 546 Tanner Drive, Kingston, ON Fax# 613-544-1101

Name of Inspector(s)/Nom de l'inspecteur(s)
Darlene Murphy (#103)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct three complaint inspections related to nursing staffing, bathing choices, clinical assessment and medication administration.

During the course of the inspection, the inspector spoke with the Assistant Director of Care, the Administrator, the President/CEO, two Registered Nurses, 2 Registered Practical Nurses, 3 Personal Care Providers, 4 family members and five residents.

During the course of the inspection, the inspector observed three medication passes, reviewed the health care records of four residents and observed resident care.

The following Inspection Protocols were used during this inspection:

Medication Inspection Protocol
Sufficient Staffing Inspection Protocol
Falls Prevention Inspection Protocol
Personal Support Services Inspection Protocol

☐ There are no findings of Non-Compliance as a result of this inspection.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8 s.6 (1)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. A resident had 4 falls between December 12, 2010 and December 19, 2010. The resident's plan of care does not identify any interventions to reduce the resident's risk of falls
2. Three Personal care providers (PCP's) were interviewed and provided conflicting information in regards to fall prevention interventions for this resident:
   - 2 of 3 PCP's reported the resident attempts to climb out of bed; bed is to be in the lowest position; bed was observed during inspection to be in lowest position
   - 1 of 3 PCP's reported the resident has a bed alarm in place at all times to alert staff; a bed alarm was not observed during the inspection to be in use or available in this resident's room
   - 1 PCP reported the need to monitor the resident every 20 minutes for safety
   - 1PCP reported the need to monitor the resident every 30 minutes for safety and
   - 1 PCP was unaware the resident was at risk for falls but reported the resident would be monitored hourly for safety
3. The resident was observed during the inspection to have wounds; the plan of care provides no interventions to reduce/relieve pressure or pain to wounds. The plan of care does not indicate the potential for skin breakdown
4. The resident was noted to be wearing briefs when observed during the inspection. The plan of care indicates the resident is continent of urine and stool.
   - 2 of 3 PCP's stated the resident is incontinent of urine and stool
   - 1 PCP was unsure of the resident's toileting needs

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WN #2: The Licensee has failed to comply with O.Reg 79/10 s.33 (1)
Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Findings:

1. A resident reports his/her method of bathing is not being respected. The resident's plan of care indicates he/she prefers a tub bath twice weekly.
2. This resident has received a tub bath on three occasions from Dec 1- time of inspection; and was washed in bed alternatively.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Jan 25/2011 Darlene Murphy
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).