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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 27, 2014	2014_179103_0002	O-000151-14	Critical Incident System

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 24-27, 2014

During the course of the inspection, the inspector(s) spoke with Personal Care Providers (PCP), a Registered Practical Nurse (RPN), Associate Director of Care (ADOC) and the Administrator.

During the course of the inspection, the inspector(s) reviewed a resident health care record and the home's policy on Heat therapy.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 licensee has failed to comply with LTCHA, 2007 s. 6 (7) whereby care set out in the plan of care was not provided to the resident as specified in the plan.

On an identified date, Resident#1 asked S#102 to heat a magic bag for the treatment of identified pain.

S#102 advised S#100 of the resident request and was provided with instructions on the heating of the magic bag.

S#100 was interviewed and stated the magic bag belonged to the resident and staff had applied it on many occasions in the past when requested by the resident.

S#102 was interviewed and stated the bag was applied on two separate occasions during that evening.

The following day, during early morning care, Resident #1 was observed to have developed an injury to the skin as a result of the heat therapy.

The resident plan of care in effect at the time of the incident was reviewed. Under "Pain" it indicated, "Apply a warm blanket or towel to area of pain." The plan of care did not include directions for the use or application of a magic bag.

The Associate Director of Care was interviewed and stated the home has towel/blanket warmers on each unit for a variety of uses including resident comfort. The ADOC stated she was aware that magic bags can become very hot and retain heat for a much longer time than warm towels/blankets.

As a result of this incident, the home has developed and implemented a policy on heat therapy, "Use of Heat Therapy", RCSM-E-15 and this policy has been circulated to all staff for their acknowledgment/signature. [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 to ensure all staff comply with the policy, "Use of Heat Therapy", RCSM-E-15, to be implemented voluntarily.

Issued on this 28th day of March, 2014

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

Darlene Murphy