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 prévue le Loi de 2007 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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 05, 2018;	2017_543561_0020 (A1)	027435-17	Resident Quality Inspection

Licensee/Titulaire de permis

The Regional Municipality of Halton
1151 Bronte Road OAKVILLE ON L6M 3L1

Long-Term Care Home/Foyer de soins de longue durée

Allendale
185 Ontario Street South MILTON ON L9T 2M4

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

DARIA TRZOS (561) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Following the provision of additional information related to the designated lead for housekeeping, laundry and maintenance and after discussion with the Service Area Office Manager it has been decided that the WN related to O.Reg s. 92 will be rescinded.

Issued on this 5 day of April 2018 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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DARIA TRZOS (561) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): December 5, 6, 7, 8, 12, 2017.

During this inspection, other inspections were completed concurrently with the Resident Quality Inspection (RQI) with the following log numbers:

Critical Incident Inspections:

027088-16 - related to palliative care,

000725-17 - related to injury sustained after a fall,

003823-17 - related to injury sustained after a fall,

021675-17 - related to injury sustained after a fall,

023616-17 - related to alleged staff to resident abuse,

023822-17 - related to alleged staff to resident abuse,

Inquiries:

021824-16 - related to injury sustained after a fall,

023177-16 - related to injury sustained after a fall,

023210-16 - related to allegation of abuse,

007133-17 - related to injury sustained after a fall,

008882-17 - related to injury sustained after a fall,

005581-17 - related to injuries sustained after a fall,

005243-17 - related to injuries sustained after a fall,

022903-17 - related to a fall

During the course of the inspection, the inspector(s) spoke with the Administrator, Senior Nursing Manager, Managers of Resident Care, Social Worker, Housekeeping/Laundry Supervisor, Life Enrichment Supervisor, Nutrition Services Supervisor, Registered Dietitian, Administrative Assistant, Building Operations Supervisor, Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Council President, residents and families.

During the course of the inspection, the inspector(s): toured the home, observed the provision of care, reviewed resident health records, investigative notes, staff education records, program evaluations, reviewed the Family Council questionnaire completed by the Council, reviewed minutes from Resident Council meetings, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

Residents' Council

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

8 WN(s)
5 VPC(s)
1 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. 245. Non-allowable resident charges

The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:

1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,

i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and

ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.

2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.

3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.

4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.

5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.

6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.

7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.

8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not charged for goods and services that the licensee was required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network.

During the Resident Quality Inspection (RQI), a family member was interviewed and reported to the LTCH Inspector that resident #017 had an intervention, a falls prevention equipment to prevent them from sustaining an injury from falls.
The home informed them that they did not provide this falls prevention equipment for residents and that families were required to purchase them on their own. The family member stated that they purchased a number of the identified items since the intervention was implemented because every time they brought a new one, one had gone missing.

Progress notes were reviewed for resident #017 and confirmed that the family purchased a number of the identified falls prevention equipment items as they had gone missing in the home. The home was not able to find the missing ones and the family had purchased a new one each time.

Interviewed the Senior Nursing Manager on December 12, 2017 and they indicated that the home did not provide the identified falls prevention equipment for falls. Families were expected to purchase these items for residents. A list of residents with the identified equipment was provided to LTCH Inspector by the Senior Nursing Manager and indicated that currently, there were 17 residents using this intervention for falls. All these residents were expected to purchase this identified falls prevention equipment. The Senior Nursing Manager stated that this process has been in the home for few years now.

The home’s Falls Risk Assessment and Prevention Procedure, Policy number 19-01-02, revised August 2017 indicated that the identified falls prevention equipment was used for residents with an identified risk for falls.

The licensee failed to ensure that residents were not charged for goods and services that the licensee was required to provide to residents. [s. 245. 3.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care.

Resident #023 was at an identified risk of falls. They required interventions to

prevent falls after a fall on an identified date in 2016 which resulted in an injury.

On an identified date in 2017, resident #023 had a fall and sustained an injury. The plan of care had directions for staff related to the interventions for falls.

The post fall assessment completed after the fall on an identified date in 2017, identified that one of the interventions as specified in the plan of care was not provided. In an interview with the Manager of Resident Care #002, it was confirmed not all falls interventions were provided as directed in resident #023's plan of care.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #000725-17, conducted concurrently during the RQI. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Resident #023 was at an identified risk of falls. They required interventions to prevent falls after a fall on an identified date in 2016 which resulted in an injury.

On an identified date in 2017, resident #023 had a fall and sustained an injury. The post fall assessment completed, identified that staff were required to implement an intervention due to the fact that resident was at risk. The falls care plan was reviewed and it was noted that this intervention was not added to resident #023's fall care plan interventions. In an interview with the Manager of Resident Care #002, it was confirmed that resident #023's falls care plan was not revised when the resident's care needs changed.

This area of non-compliance was identified during a CIS Inspection, log #000725-17, conducted concurrently during the RQI. (583)

B) Resident #017 sustained an injury on an identified date in 2017. A critical incident report was submitted to the Director as resident's Substitute Decision Maker (SDM) alleged abuse from staff towards the resident. Investigation notes were reviewed and the alleged abuse could not be confirmed. The staff in the home were interviewed along with the Senior Nursing Manager and the alleged abuse of resident could not be confirmed; however, through these interviews and

health record review it was determined that the resident's transfer status should have been re-assessed due to change in condition.

During the investigation completed by the home, a number of staff were interviewed. The investigation concluded that the resident's transfer status should have been reassessed. In the investigation notes a statement made by the Manager of Resident Care indicated that resident's transfer status was not appropriate for resident.
The progress notes were reviewed and there was no documentation indicating that PSWs reported to registered staff that resident's change in condition and issues during transfers. There was no documentation showing when that change occurred.

Interview with the PSW #101 confirmed that resident had issues during transfers. The Physiotherapist was interviewed and stated that if a resident had issues such as this resident during transfers their transfer status should have been re-assessed.
The Senior Nursing Manager was interviewed and confirmed that resident should have been reassessed for transfers. The home could not confirm how the resident sustained the injury. The staff in the home stated that it might have happened during the transfer. Resident's transfer was changed after the incident.

The licensee failed to ensure that resident's transfer status was re-assessed when their care needs changed.

This area of non-compliance was identified during a CIS Inspection, log #023822-17, conducted concurrently during the RQI. [s. 6. (10) (b)]

3. The licensee has failed to ensure that when the resident was reassessed and the plan of care was reviewed and revised that different approaches were considered in the revision of the plan of care.

Resident #024 was at an identified risk of falls and their falls history was reviewed for a specific time period in 2017. During this time resident #024 had a number of interventions in place to prevent falls. Resident #024 had a health condition and an identified behaviour. During the identified period of time reviewed resident sustained a number of falls. After one of the falls resident sustained an injury and was sent to the hospital.

During this time period a review of the plan of care showed the falls care plan was reviewed and revised but no changes were made to the falls interventions and no new falls interventions were trialled. In an interview with the Manager of Resident Care #002, it was confirmed that different approaches were not considered when reviewing and revising resident #024’s fall care plan during the time resident sustained the number of falls in 2017.

This area of non-compliance was identified during a CIS Inspection, log #003823-17, conducted concurrently during the RQI. [s. 6. (11) (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 the care set out in the plan of care is provided to the resident as specified in the plan of care, and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, and to ensure that when a resident is reassessed and the plan of care is reviewed and revised that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: 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:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home complied with any policy, protocol, procedure, strategy or system that they had instituted or put in place.

Under s. 30(1)1. of Ontario Regulation 79/10 the licensee was to ensure that with respect to each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of the Regulation that a written description of the program include relevant policies and provided methods to reduce risk and monitor outcomes. Regulation s. 48(1)1. required the licensee to ensure a falls prevention and management program to reduce the incidences of falls and the risk of injury was implemented in the home.

Resident #024 was at an identified risk of falls and their falls history was reviewed for a specific time period in 2017. During this time resident #024 had a number of interventions in place to prevent falls. Resident #024 had a health condition and an identified behaviour. During the identified period of time reviewed resident sustained a number of falls. After one of the falls resident sustained an injury and was sent to the hospital.

A post fall assessment was completed after each fall using the “Nurse-Post Fall Assessment” tool.

The “Post Fall Follow up, Assessment and Management” procedure, #19-01-05, revised August 2017, directed staff to complete the following after a resident had a fall.
14. Complete a comprehensive Post-Fall Assessment as follows:
- gather the team on the unit, ensuring PSWs are involved

- review the circumstances surrounding the fall, including events leading up to the fall
- seek team input into strategies that may be helpful in reducing the risk or preventing future falls and document in the resident's plan of care
- review resident's environment as needed
- document in the post fall assessment, ensuring all fields are completed, note names of staff who were present for the review.

All of the post fall assessments had fields of the tool that had not been completed. Strategies that may have been helpful in reducing the risk of falls were not identified in any of the assessments. The only change to the plan of care was identified on the identified date in 2017, assessment at which time staff identified a new intervention. In an interview with the Manager of Resident Care #002, it was confirmed that the home's "Post Fall Follow up, Assessment and Management" procedure was not complied with. It was confirmed that resident #024's post falls assessments were not completed as directed in the home's procedure.

This area of non-compliance was identified during a CIS Inspection, log #003823-17, conducted concurrently during the RQI. [s. 8. (1) (a),s. 8. (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 the home complies with any policy, protocol, procedure, strategy or system that they had instituted or put in place, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment.

The quarterly Minimum Data Set (MDS) assessment on an identified date in 2017, indicated that resident was frequently incontinent of bladder.
The next quarterly MDS assessment, indicated that resident had deteriorated and was fully incontinent of bladder.

The clinical records were reviewed and revealed that the continence assessment was completed when there was a change; however, the resident did not have an individualized plan of care developed to promote and manage bladder continence. The current written plan of care did not identify any new interventions and no changes were made to it since the last quarterly review.

PSW #105 who provided direct care to the resident stated in an interview that resident did have a change in continence and had an intervention in place.
Registered staff #104 indicated that there was a change in resident’s continence. The process in the home was to complete an assessment when there is a change and develop interventions based on the assessment. The registered staff who completed the assessment was responsible to update the written plan of care. They also indicated that resident #021's interventions have changed due to the deterioration.
Registered staff #104 reviewed the care plan for this resident and confirmed that the care plan did not have specific interventions for this resident to address the change in continence.

The Senior Nursing Manager confirmed that this resident had a change in continence and did not have an individualized plan of care to promote and manage continence based on the assessment. [s. 51. (2) (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 the resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident that demonstrated responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible; (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

Critical incident report was submitted to the Director alleging a staff member had been rough with resident #026 during an incident. Prior to the incident, PSW #103 witnessed the resident had a change in behaviour. Investigation notes, clinical record review and interviews with staff were completed during inspection. The investigation notes indicated that the staff's actions were inappropriate.

PSW #103 that was involved in the incident was interviewed and denied the

allegation; however, did confirm that they should have approached the situation differently and used better techniques to prevent the situation. PSW also stated that they should have reported to registered staff that resident had a change in behaviour prior to the incident. Resident had a history of responsive behaviour; however, this was not the usual behaviour of the resident.

Resident's plan of care was reviewed and did not identify strategies or techniques to address resident's responsive behaviours and no triggers were identified.

Registered staff #113 indicated that when a new responsive behaviour was observed by PSWs they were to report it to registered staff. The care plans were to be individualized to meet the needs of residents and triggers were identified in the care plan. Interview with the registered staff confirmed that resident had responsive behaviours, what triggered these behaviours and described interventions that were used. None of these strategies or triggers were identified in the written plan of care

The Senior Nursing Manager was interviewed and confirmed that PSW should have reported to registered staff when resident demonstrated the unusual behaviour that day. The Senior Nursing Manager also confirmed that the care plan did not identified strategies and interventions for this resident.

The home failed to ensure that the triggers were identified, strategies were developed and actions were taken to respond to the needs of resident #026 who was demonstrating responsive behaviours.

This area of non-compliance was identified during a CIS Inspection, log #023616-17, conducted concurrently during the RQI. [s. 53. (4)]

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, for each resident that demonstrates responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that:
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review were implemented, and
(c) a written record was kept of everything provided for in clause (a) and (b).

A review of the home’s analysis of medication incidents from April 1, 2017 - until September 30, 2017, was completed. The documented review did not include a record of the changes and improvements that were implemented.
In an interview, the Senior Nursing Manager confirmed the home did not keep a record of any changes and improvements in the review to reduce and prevent medication incidents and adverse drug reactions. [s. 135. (3)]

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: (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b), to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) drugs were stored in an area or a medication cart, (i) that was used exclusively for drugs and drug-related supplies.

An observation of the mediation cart on an identified unit on an identified date in 2017, revealed non-drug related items were stored in the medication cart. Registered staff #100 confirmed that the items found in the medication cart were stored in the medication cart for safe-keeping.
A review of policy #IE01, titled “Storage of medication”, dated 2016, indicated that medication storage areas must be kept clean and free of clutter.

The home failed to ensure the medication cart was used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

(A1)
The following Non-Compliance has been Revoked: WN #7

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Issued on this 5 day of April 2018 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : DARIA TRZOS (561) - (A1)

Inspection No. / No de l'inspection : 2017_543561_0020 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 027435-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Apr 05, 2018;(A1)

Licensee / Titulaire de permis : The Regional Municipality of Halton
1151 Bronte Road, OAKVILLE, ON, L6M-3L1

LTC Home / Foyer de SLD : Allendale
185 Ontario Street South, MILTON, ON, L9T-2M4

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Allison Bricker

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To The Regional Municipality of Halton, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 245. The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act.
O. Reg. 79/10, s. 245.

Order / Ordre :

The licensee shall do the following:

1. Immediately stop requiring residents and/or families to purchase an identified falls prevention equipment.

2. For resident #017 and the 17 residents identified in the inspection that have paid for their own equipment the home shall reimburse total charges paid since the interventions were initiated

3. Complete an audit of all residents who were required to pay for their own falls prevention equipment from January 1, 2015 to current and arrange for reimbursement of each of those residents

4. Notify and explain the reason for the reimbursement of charges for the falls prevention equipment and include the name of the individual (resident/SDM) to whom this discussion was provided to in documentation in the health record

5. Obtain signature of receipt of total fees reimbursed to each resident

Grounds / Motifs :

1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Homes Act, Ontario Regulation 79/10.
The non-compliance was issued as a compliance order (CO) due to a severity level of 2 (minimum harm/risk or potential for actual harm/risk) a scope of 3 (widespread) and a compliance history of 2 (previous non-compliance unrelated).

The licensee has failed to ensure that residents were not charged for goods and services that the licensee was required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network.

During the Resident Quality Inspection (RQI), a family member was interviewed and reported to the LTCH Inspector that resident #017 had an intervention, a falls prevention equipment to prevent them from sustaining an injury from falls.
The home informed them that they did not provide this falls prevention equipment for

residents and that families were required to purchase them on their own. The family member stated that they purchased a number of the identified items since the intervention was implemented because every time they brought a new one, one had gone missing.

Progress notes were reviewed for resident #017 and confirmed that the family purchased a number of the identified falls prevention equipment as they had gone missing in the home. The home was not able to find the missing ones and the family had purchased a new one each time.

Interviewed the Senior Nursing Manager on December 12, 2017 and they indicated that the home did not provide the identified falls prevention equipment for falls. Families were expected to purchase these items for residents. A list of residents with the identified equipment was provided to LTCH Inspector by the Senior Nursing Manager and indicated that currently, there were 17 residents using this intervention for falls. All these residents were expected to purchase this identified falls prevention equipment. The Senior Nursing Manager stated that this process has been in the home for few years now.

The home's Falls Risk Assessment and Prevention Procedure, Policy number 19-01-02, revised August 2017 indicated that the identified falls prevention equipment was used for residents with an identified risk for falls.

The licensee failed to ensure that residents were not charged for goods and services that the licensee was required to provide to residents. (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

May 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l’ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l’ordre qui font l’objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l’adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5 day of April 2018 (A1)

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : DARIA TRZOS - (A1)

Service Area Office /
Bureau régional de services : Hamilton