Ontario

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 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 8, 2019	2018_739694_0019	005499-17, 021207-17, 025746-17, 029160-18, 030165-18	Critical Incident System

Licensee/Titulaire de permis

488491 Ontario Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Avalon Retirement Centre
355 Broadway Avenue ORANGEVILLE ON L9W 3Y3

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

AMANDA COULTER (694), KATHLEEN MILLAR (527)

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): December 4, 5, 6, 7, 10, 11, 12, 14 and 17, 2018.

During the course of the inspection, the following Critical Incidents (CIS) were inspected;
log #008346-18 and log #021207-17, related to fall prevention
log #0257456-17, log #005499-17, log #030165-18, log # 016591-17 and log #029160-18 related to Prevention of Abuse and Neglect
log #010950-18, related to responsive behaviours

PLEASE NOTE: A Written Notification (WN) and Compliance Order (CO) related to O. Reg. 79/10, s. 50 (2) (b) (i) and (iv) was identified in this inspection and has been issued in Complaint Inspection Report 2018_739694_0020, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family members and residents.

During the course of the inspection, the inspector toured the facility, reviewed residents clinical records, reviewed the facility's policies and education attendance, completed observations and interviewed residents and staff of the facility.

Inspector Kiyomi Kornetsky, #743 also attended this inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

4 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	Légende 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone.

For the purposes of the definition of 'abuse' in subsection 2 (1) of the Act, "verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or (b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

A) The home's investigation notes showed resident #001 reported they were upset that a staff member was cross with them.

The resident was no longer in the home and could not be interviewed. The progress notes did not indicate any negative effects related to the incident.

B) A review of a critical incident system (CIS) report, resident #005 reported to the staff that they felt their care was not completed as requested.

The resident was interviewed and stated the PSW was rude and did not respect them. The PSW told the resident they could care for themselves and declined to provide assistance to the resident.

The home's investigation notes were reviewed which included a check-off list and an interview with resident, the home's response was disciplinary action.

The licensee failed to protect resident #001 and #005 from abuse by anyone. [s. 19. (1)]

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 all residents are protected from abuse, 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 failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #022 was assessed as a potential to restore function and as a result the resident was placed on a plan. Staff were to assist the resident at specific times and whenever necessary, as outlined in the plan of care.

The clinical record was reviewed and the home's investigation notes were reviewed, resident #022 had used the call bell system for assistance on a specific date in October 2018. PSW #130 came into the resident's room and turned off the call bell. The resident rang the call bell a second time, approximately 30 minutes later, and PSW #147 attended and assisted the resident.

Resident #022 was interviewed and recalled the incident. The resident said that PSW #130 had turned off the call bell and did not come back to help and they waited 30 minutes before getting assistance.

Based on the interview notes, PSW #130 had admitted in the interview with their DOC, that they did not follow the plan of care and the resident did not receive assistance when they rang the call bell.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #022, as specified in the plan. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that, a written record was kept relating to each evaluation under that included the date of the evaluation, the names of the persons who participated in the evaluation, and the date that changes and improvements were implemented.

The 2017-2018 annual program evaluation for the Abuse program document was reviewed and the written record included the summary of changes made; however the date that those changes were implemented were not documented in the written record.

The DOC and Administrator were interviewed separately and acknowledged that an annual program evaluation was required and that the date(s) their plan to correct/celebrate were implemented for the Abuse program were not documented in the written record for their annual evaluation.

The licensee failed to ensure the Abuse annual program evaluation written record included the dates their plan to correct/celebrate were implemented. [s. 99. (e)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that where the licensee determined that an injury resulted in a significant change in the resident's health condition, the Director was informed of the incident no later than three business days after the occurrence of the incident, and followed with the report required under subsection (4).

Resident #010 had an injury of unknown cause on a specific date in July 2017. The resident had a significant change in their activities of daily living, increased pain, and had altered skin integrity.

The home's investigation notes and the clinical record was reviewed. The home submitted a Critical Incident (CI) report to the Director on a specific date in July 2017, which was eight days after the incident that resulted in a significant change in resident #010's health status.

The Administrator #100 was interviewed and acknowledged that the Director was not notified within three business days of when they were able to determine the injury resulted in a significant change in resident #010's health condition.

The licensee failed to inform the Director of the incident no later than three business days after the occurrence of the incident. [s. 107. (3.1)]

Issued on this 11th day of February, 2019

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

Original report signed by the inspector.