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
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11ième étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Nov 7, 8, 10, 14, 15, Dec 30, 2011; Jan 6, 2012	2011_070141_0039	Complaint

Licensee/Titulaire de permis

488491 ONTARIO INC
689 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

SHARLEE MCNALLY (141)

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, Education Coordinator, Resident Assessment Instrument Minimum Data Set (RAI MDS) Coordinator, registered staff, Personal Support Workers

During the course of the inspection, the inspector(s) reviewed resident's records, homes medication incidents for 2011, investigation notes of incidents, policy and procedures for monitoring of residents, missing residents, medication administration and hypoglycemia.

Reference Log# H-001389-11

The following Inspection Protocols were used during this inspection:

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

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 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 saillants :

1. The licensee of the home did not ensure that their procedure related to responsive behaviour for wandering residents was complied with. An identified resident eloped from the home in 2011. The home's policy "Elopement - Resident" states that an immediate and thorough search should be completed if a resident is presumed to be missing. The police contacted the home at the time the resident was missing and stated that they had found a person walking near the home and questioned if the home had a missing resident. The staff did not initiate a search of the home to ensure all residents were accounted for. The staff who received the call from the police informed the registered staff at a later time and a search was completed at this time and it was confirmed that the resident was missing.
The home did not comply with their policy for "Monitoring of Residents". The policy states that all resident are to be checked every hour (at a minimum) for safety to ensure that all residents are present in the building and are safe in the environment. An identified resident left the building at a specified time. The nursing staff confirmed that they did not complete hourly checks of the resident for the subsequent 2 hours after they left the building. The homes "Failure Mode & Effects Analysis" related to resident's elopement confirmed that the resident left the building in an unsafe situation, that the resident needed close monitoring and it didn't always occur, and that phone call from police was not immediately followed up. 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 plans, policies, protocols, procedures and strategies or systems are complied with,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee did not ensure that drugs administered to residents is in accordance with the directions for used specified by the prebscriber. An identified resident received the wrong medication in 2011. As a result of this error the resident's status changed. The resident needed increased monitoring and treatment provided.
Review of the medication incidents for 2011 identified that were 12 other incidents in which residents received the wrong medication, the wrong dosage, or did not receive medication as prescribed. Six incidents involved medication for pain. s.131.(2)

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber,, to be implemented voluntarily.

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. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that an identified resident was reassessed and their plan of care reviewed and revised when their care needs changed. The resident eloped from the home in 2011. Staff confirmed that the family informed the home at the time of the elopement that the resident had exhibited similar behaviour in the past. There was no record that the resident had been reassessed for the risk to wander/elope. The written plan of care, at the time of this inspection, had not been revised to identify the risk of this responsive behaviour or the interventions developed to address the risk. s.6.(10)(b)

Issued on this 2nd day of February, 2012

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