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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 21, 2016	2016_449619_0007	003183-15	Complaint

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

SAMANTHA DIPIERO (619)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 10, 2016, March 11, 2016

The following complaint inspection was completed: #003138-15 related to a fall, oral hygiene, and privacy.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) nurse, registered staff, unregistered staff, complainant, and the resident. The inspector also toured the facility, made observations on the resident and the bathroom area.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
2 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	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee failed to maintain confidentiality with respect to personal health information within the meaning of PHIPA

On an identified date in December 2015, a family member of resident #001 attended the home and requested staff members to write letters attesting to the family member’s participation in the resident's care. Three PSW’s, #103, #105, and #106, each wrote letters at the request of the family member; these letters, as observed by the LTC Inspector, included the personal health information of resident #001 including physical and mental health status. A review of the resident’s health records, legal documentation filed in relation to the resident's Power of Attorney document, and the homes internal investigation notes confirmed that the family member was not designated as a Substitute Decision Maker(SDM). In an interview, PSW #103, confirmed that they and two other staff members released personal health information to the resident’s family member without the consent of the residents SDM. An interview with the DOC confirmed that the homes policy titled “Confidentiality and Release of Information: Resident’s, Clients, and Families”, policy #08-01-02, stated that “Requests for personal health information relating to current residents by third parties require the resident’s or SDM’s consent to disclose the specific information being sought” and confirmed that consent was not obtained from the resident’s SDM prior to the release of the residents personal health information by PSW staff in the home. [s. 3. (1) 11. iv.]

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 with s. 3(1)(11)(iv) Every licensee shall ensure that the following rights of residents are fully respected and promoted: (11) Every resident has the right to, (iv) have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.

WN #2: 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) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and resulted in a significant change in the residents health condition.

On an identified date in September 2014, resident #001 fell in the bathroom and sustained an injury that required transfer to hospital for treatment. A review of the progress notes and assessment data indicated that staff assessed the resident prior to moving them, contacted the SDM, and contacted the physician who provided order for medication for pain and transfer to hospital for treatment to the injury. An interview with registered staff #102 indicated that after the resident returned from hospital they required medication to manage their pain, required cleaning of the affected area, and required a physician for treatment when the medical intervention was complete. A review of the critical incident system log indicated that a critical incident report was not submitted by the home to the Director. An interview with the DOC confirmed that a critical incident report was not submitted and confirmed that because of the significant change in the resident's status, a critical incident report should have been submitted to the Director. [s. 107. (3) 4.]

Issued on this 11th day of April, 2016

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

Original report signed by the inspector.