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
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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
Jul 23, 24, 26, 30, 31, 2012	2012_041103_0030	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

HALLOWELL HOUSE
13628 LOYALIST PARKWAY, PICTON, ON, K0K-2T0

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 Complaint inspection.

During the course of the inspection, the inspector(s) spoke with a Resident, a Registered Nurse, the Director of Care, and the Administrator.

During the course of the inspection, the inspector(s) reviewed resident health care records. This complaint inspection included the following log numbers: #O-001080-12 and O-001439-12.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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
(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 failed to comply with LTCH s. 6 (11) (b) whereby different approaches were not considered in the revision of the resident plan of care when the care set out in the plan was not effective.

Resident #1 had a cognitive impairment and had been assessed as high risk for falls. On an identified date, the resident was assessed as having a temperature of 37.9 Celsius (C) and was given two Tylenol plain. Resident #1 sustained a witnessed fall later that day and was assessed as having no injuries. The resident still had a temperature and received two tablets of Tylenol plain at two more identified times that same day. Resident #1 was now complaining of lower quadrant discomfort and had a poor appetite. A chest assessment was documented by nursing staff as being done which was negative for crackles or wheezes.

The following day, Resident #1 was assessed as having a temperature of 38.7 C and two Tylenol plain were given. The resident's temperature was rechecked later the same day, he/she remained febrile and was now exhibiting a hoarse cough.

The next day, the resident complained of feeling unwell and had a non productive cough. His/her temperature was 38.2 C and two Tylenol plain were given. A chest assessment was done by the nursing staff and documented as clear with a rattly cough. The fever continued and two Tylenol plain were administered later that same day. A Personal support worker documented the resident to be feeling unwell, shakey and complaining of a bad headache that evening.

The following day, the resident complained of whole body aches while up to the bathroom and was noted to be more confused. He/she was assessed as being afebrile (36.4 C) and was given two Tylenol plain for the complaints of discomfort. The Personal support worker documented the resident had a decreased appetite over the past few days, had a wet cough and was complaining of sharp pains in the back of his/her head/neck area. Two Tylenol plain tablets were given to the resident and the doctor was asked to assess the resident. The physician assessed the resident and prescribed an antibiotic as the fever has been ongoing for several days and the resident appeared flushed. Resident #1 sustained another witnessed fall and was assessed as having no injuries. The resident continued to have a temperature of 38.0 C at that time and was given two Tylenol plain.

The resident was assessed the following day as having back pain and was given two Tylenol plain with effectiveness for the pain. The resident sustained an unwitnessed fall and was assessed as being more confused but having no injuries. Head injury routine was initiated as the fall was unwitnessed and the resident was given two Tylenol plain for a temperature of 38.6 C.

During the night, the resident was awake, short of breath and complaining of pain in his/her rib cage area. Two Tylenol plain are given at this time. A chest assessment was documented as the resident having equal breath sounds at that time. The next morning, the Personal support worker advised the Registered Nurse that the resident had complaints of right side rib pain, was breathing heavily and was weepy because of the pain. The resident was given two Tylenol plain. There was no documented reassessment of the resident's temperature on this date.

The resident's family member visited in the early evening, was concerned by the resident's condition and took the resident to the local hospital. The family member later advised the resident had a hairline fracture of his/her hip, an infection and a perforated bowel. The resident was deceased five days later.

Resident #1 was febrile and demonstrated a deterioration in his/her condition for six days, despite the initiation of antibiotics. There was no documented evidence that additional causes were considered or explored in the continued presence of fever.

Issued on this 31st day of July, 2012

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