Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
April 12 & 13, 2011	2011_173_9536_12Apr101821 2011_129_9536_12Apr101518	Critical Incident – H-00292 Critical Incident – H-00273

Licensee/Titulaire
The Regional Municipality of Halton, 1151 Bronte Road, Oakville ON, L4R 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(s)
Lesa Wulff # 173
Phyllis Hiltz-Bontje #129

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct two Critical Incident inspections.

During the course of the inspection, the inspector(s) spoke with: Administrator, Director of Nursing, Consulting Pharmacist, Registered Nursing staff, personal support worker and Housekeeping staff.

During the course of the inspection, the inspector(s): Medication storage areas were examined, clinical records were reviewed, the homes policies, procedures and process were reviewed and interviews held.

The following Inspection Protocols were used in part or in whole during this inspection:
Medication Inspection Protocol
Prevention of Abuse and Neglect

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

[6] WN
[3] VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007, S.O. 2007 c.8, 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.

Findings:

- The home failed to protect an identified resident in relation to an incident of staff to resident abuse as a result of the resident demonstrating responsive behaviors.

Inspector ID #:	#173

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 related to developing a process to ensure that all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O. Reg. 79/10, s.26(3)5
A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
(5) Mood and behaviour patterns, including wandering, any identified responsive behaviors, any potential behavioral triggers and variations in resident functioning at different times of the day.

Findings:

- The plan of care for an identified resident did not include an interdisciplinary assessment of responsive behaviors being demonstrated or the care to be provided while the behaviours were being exhibited.

Inspector ID #:	#173

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 related to ensuring that a interdisciplinary assessment related to mood and behaviour patterns is included in the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O. Reg. 79/10, s.53(4)(a)
The licensee shall ensure that for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

Findings:

- A review of the clinical record indicated that staff did not identify the triggers of the responsive behaviours being demonstrated by the resident.

Inspector ID #:	#173

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 demonstrating responsive behaviors have triggers for those behaviours identified, where possible, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O. Reg 79/10, s.8(1)(b)
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, procedures, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is complied with

Findings:

- The homes policy # 03-08-07 "Disposal of Medications" in place at the time of an identified incident directs staff to "keep narcotics and controlled drugs separate. They are to remain under double lock and counts are to continue at shift change until the pharmacist performs drug destruction". In practice the home staff do not count surplus narcotics and controlled drugs every shift until the pharmacist performs destruction of these drugs. It is confirmed by the Director of Care that this has not been a practice in this home for many years.

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WN #5: The Licensee has failed to comply with O. Reg. 70/10, s.130(2)(i)
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
Access to these areas shall be restricted to,
(i) persons who may dispense, prescribe or administer drugs in the home

Findings:

The home failed to ensure that steps were taken to secure the drug supply:

- One of the two keys to access the Surplus Narcotic and Controlled drug storage bin was located in the Director of Care's (DOC's) office on a shelve in a binder labeled "Surplus Narcotics". Access to the DOC's office could be obtained through the use of a master key. Staff other than those individuals who may dispense, prescribe or administer drugs in the home have access to master keys including managers from non-nursing departments and environmental/housekeeping staff.

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WN #6: The Licensee has failed to comply with O. Reg. 79/10, s.136(4)(1–8)
Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:
(1) The date of removal of the drug from the drug storage area.
(2) The name of the resident for whom the drug was prescribed, where applicable.
(3) The prescription number of the drug, where applicable.
(4) The drug's name, strength and quantity.
(5) The reason for destruction.
(6) The date when the drug was destroyed.
(7) The names of the members of the team who destroyed the drug.
(8) The manner of destruction of the drug.

Findings:

- The home policy # 03-08-07 "Disposal of Medication" in effect at the time of this incident does not direct staff to document in the drug record:
  - -the date of removal of the drug from the drug storage area
  - -the name of the resident for whom the drug was prescribed
  - -the prescription number of the drug
  - -the drug's name, strength and quantity
  - -the reason for destruction
  - -the date the drug was destroyed
  - -the names of the members of the team who destroyed the drug.
  - -the manner of destruction of the drug

Inspector ID #:	#129

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: (if different from date(s) of inspection). Sept. 15/11