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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Apr 17, 2015	2015_338147_0007	H-001953-15	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

LALEH NEWELL (147)

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): February 19, 20, 23, 24, 25, 26, 27, March 3, 4, 5, 9, 24 and 25, 2015

H-001953-15 - completed in conjunction with Resident Quality Inspection (RQI)- Inspection # - 2015_338147_0004

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Care Managers, Registered staff, Personal Support Worker(PSW), Physiotherapist and Family.

The Inspector also toured the home, observed the provision of care and services, and reviewed documents including but not limited to: clinical health records, policies and procedures and meeting minutes.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident

A. Review of resident #204's clinical records and interview with the physiotherapist and the nurse manager confirmed that since the resident's last fall, the resident was assessed for the use of a wheelchair for mobility around the unit. However, review of the resident's current plan of care, did not include the assessment of the resident's needs related to transfers, mobility and post fall interventions .

B. Review of the resident #204's clinical records and interview with the registered staff confirmed that the resident was assessed for bladder incontinence and chronic Urinary Tract Infection(UTI) and placed on a toileting schedule. As per the current plan of care, the toileting scheduled was to be posted in the resident's room on a pink sheet. Observation and tour of the resident's bathroom with the registered staff confirmed that the toileting schedule was not posted in the resident's bathroom to ensure that the care set out in the plan of care was based on as assessment of the resident's needs. [s. 6. (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 the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care.

Review of the resident #204's clinical chart and interview with the staff confirmed the resident had a physician's order for a physical restraining device as needed (PRN) when the resident becomes agitated or restless. Review of the resident's restraint flow sheets for February 2015 confirmed the staff had applied the restraint on four occasions within the month, even though the documentation indicated the resident was calm on three of those occasions. The resident's plan of care did not included the restraining of the resident by any physical device as described in paragraph 3 of subsection 30(1). [s. 31. (1)]

2. The licensee failed to ensure that The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: 2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1

Review of the resident #204's clinical chart and interview with the staff confirmed the resident had a physician's order for a physical restraining device as needed (PRN) when the resident becomes agitated or restless. However, review of the resident's clinical records and interview with the staff confirmed that alternatives to restraining the resident had not been considered and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1, prior to application of the physical restraining device. [s. 31. (2) 2.]

3. The licensee failed to ensure the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied with a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

Review of the resident #204's clinical chart and interview with the staff confirmed the resident had a physician's order for a physical restraining device as needed (PRN) when the resident becomes agitated or restless. Review of the resident's restraint flow sheets for February 2015 confirmed the staff had applied the restraint on four occasions during the month, however there are no documented evidence to substantiate that additional orders or approval of the application of the restraint were obtained by a physician, registered nurse in the extended class or other person provided for in the regulations. [s. 31. (2) 4.]

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 a resident may be restrained by a physical device as described in paragraph 3 of subsection 30, if the restraining of the resident is included in the resident's plan of care, that The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: 2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1 and the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied with a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, to be implemented voluntarily.

Issued on this 17th day of April, 2015

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

Original report signed by the inspector.