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
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 20, 2013	2013_205129_0012	H-000187-13	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

PHYLLIS HILTZ-BONTJE (129)

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): August 23, 26, 27 & 29, 2013

This inspection was initiated at a result of a complaint regarding the care being provided to residents related to management of infection and medication administration.
A Critical Incident inspection (#2013_205129_0013/H-001521-12) was conducted concurrently with is complaint inspection and an area of non-compliance identified during the inspection has been included in this inspection.

During the course of the inspection, the inspector(s) spoke with residents, registered and unregulated nursing staff, Minimum Data Set Coordinator, Registered Dietitian, Corporate Infection Control lead, Director of Care, Nurse Manager and the Administrator in relation to log # H-000187-13.

During the course of the inspection, the inspector(s) observed residents, reviewed clinical documents, infection control quarterly reports, staff training records, homes investigative notes including actions taken in relation to a medication error and the home's Incident/Adverse Event Management and Reporting policy.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

Personal Support Services

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(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 the care set out in the plan of care was provided to residents as specified in the plan, with respect to the following: [6(7)]
a) Resident #001 did not receive care as specified in the plan of care when this resident was not assisted to the toilet at designated times identified in the resident's plan of care. Following a toileting routine assessment, additions were made to this resident's plan of care that included specific times when staff were to assist the resident to the toilet and provide personal hygiene assistance. Personal Support Worker (PSW) #102 confirmed that on an identified date the resident was not assisted to the toilet at the designated time and also confirmed that she was unaware that there were specific times the resident was to be assisted to the toilet. At the time of this inspection the resident continued to experience a medical condition related to the urinary system.
b)Resident #002 did not receive care as specified in the plan of care when staff providing care did not apply bed rail pads to protect the resident from injury. Staff #104, clinical records and information documented on a critical incident form confirmed that this resident had a history of skin injuries caused by the bed side rails. Resident #002's plan of care specifically directed that staff providing care were to ensure that padded protection was applied to the resident's bedside rails whenever they were in use to prevent further skin injuries. On an identified date staff were monitoring the resident and noted the resident's left leg to be wedged between the bottom bed rail and the mattress and also noted the padded protection had not been applied to the bedside rail. The resident sustained an injury to the left shin when staff freed the resident's leg.
(PLEASE NOTE: This evidence of non-compliance was found during inspection #2013_205129_0013) [s. 6. (7)]

2. The licensee did not ensure that residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, in relation to the following: [6(10)(b)]
Resident #001 was not reassessed and the resident's plan of care was not revised when the resident's care needs changed in relation to the following:
Data collected and documented for resident #001 on the Minimum Data Set (MDS) completed in February 2013 indicated the resident's bowel and bladder continence had deteriorated. Staff #105 and clinical documentation confirmed that the resident was not reassessed when this decrease in function was identified.
Data collected and documented for resident #001 on the MDS completed in May 2013 indicated the resident's ability to perform activities of daily living related to personal

hygiene had deteriorated and the resident was now totally dependent of staff for all aspects of personal hygiene. The Resident Assessment Protocol (RAP) completed at this time indicated the resident's care plan would be altered with the goal to slow or minimize the decline and improve if possible. Staff #105 and clinical documentation confirmed that the resident's plan of care was not revised to reflect the deterioration or the goal to minimize the decline and improve the resident's ability to perform activities of daily living. [s. 6. (10) (b)]

3. The licensee did not ensure that resident #001's plan of care was reviewed and revised when the care set out in the plan of care was not effective in relation to the following: [6(10)(c)]
The goal for care for resident #001, established in September 2012, indicated that care would be provided with the goal of reducing the frequency and severity of medical events related to the urinary tract. Clinical documentation indicated that the resident experienced these medical events three times over a three month period in 2013. Although the resident received medical treatment for these conditions, staff #005 and the clinical record indicated that the plan of care was not reviewed or revised when care being provided to the resident was not successful in accomplishing the goals of care related thesed medical events. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 and ensuring that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan of care has not been effective, to be implemented voluntarily.

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

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Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 failed to ensure that no drug was administered to a resident in the home unless the drug has been prescribed for the resident, in relation to the following: [131(1)]
Resident #001 was given a drug not prescribed, when this resident received a narcotic analgesic on an identified date in 2013. Staff and clinical records confirmed that the resident received this medication, the resident's physician was notified of this incident and ordered that the resident be sent to hospital for monitoring and reversal of the medication. The resident was admitted to the hospital due to concerns related to the resident's vital signs and cognitive changes. The resident returned to the home two days following the incident. [s. 131. (1)]

2. The licensee did ensure that drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber, in relation to the following. [131 (2)]
Staff in the home did not administer medications to resident #001 as ordered by the resident's physician, when this resident did not receive a medication designed to manage fluid balance in the body. Staff and clinical documentation confirmed that on and identified date the physician assessed the resident and identified that the resident required an increased dose of a medication, ordered the resident to receive an increased amount of medication and also directed the previous order for this medication be discontinued. Staff and the Medication Administration Records (MAR) confirmed that the resident did not receive this medication for 39 days until a second assessment of the resident by the physician indicated that the resident again required an increased dose of this medication to manage the symptoms of fluid imbalance the resident was demonstrating. [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 and ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident and that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 16th day of October, 2013

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

Phyllis Hiltz-Bontje

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2013_205129_0012
Log No. / Registre no:	H-000187-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 20, 2013
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF HALTON 1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1
LTC Home / Foyer de SLD :	ALLENDALE 185 ONTARIO STREET SOUTH, MILTON, ON, L9T-2M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHERYL RAYCRAFT

To THE REGIONAL MUNICIPALITY OF HALTON, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that all residents, including resident #001 and resident #002 receive care as set out in the plan of care.

Grounds / Motifs :

1. Previously identified as non-compliant with a VPC on April 3, 2013
2. Two of two residents reviewed did not have care provided as specified in the plan of care.
3. Resident #002 did not receive care as specified in the plan of care when staff providing care did not apply bedside rail pads and the resident sustained an injury. Staff # 104, clinical records and information documented on a critical incident form confirmed that this resident had a history of skin injuries caused by the bed side rails. Resident #002's plan of care specifically directed that staff providing care were to ensure that padded protection was applied to the bedside rails whenever they were in use to prevent further skin injuries. On an identified date in 2012 staff were monitoring the resident and noted the resident's left leg to be wedged between the bottom rail and the mattress and also noted the padded protection had not been applied to the bedside rail. The resident sustained an injury to the left leg.
3. Resident #001 did not receive care as specified in the plan of care when this resident was not assisted to the washroom at designated times identified in the residents plan of care. Following a toileting routine assessment, additions were made to this resident's plan of care that included specific times when staff were to assist the resident to the washroom and provide personal hygiene assistance in an attempt to prevent recurring medical events related to the urinary system being experienced by this resident. Personal Support Worker (PSW) #102 confirmed that on and identified date in 2013 the resident was not assisted to the washroom at the designated time and also confirmed that she was unaware that there were specific times the resident was to be assisted to the washroom. At the time of this inspection clinical records indicated the resident was treated for medical events related to the urinary tract system three times over the previous three month period of time.
(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 18, 2013

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan of corrective action to ensure that all residents, including resident #001 are reassessed and the plan of care reviewed and revised whenever the resident's care needs change. The plan is to include, but is not limited to, training for all staff related to the identification and communication of changes in care needs, specific actions staff are directed to take when changes in care needs are identified as well a method and schedule for monitoring staffs performance. The plan is to be submitted on or before October 4, 2013 to Phyllis Hiltz-Bontje by mail at Ministry of Health and Long Term Care, 119 King Street, W, 11th Floor, Hamilton, Ontario L8P 4Y7 or by e-mail at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. Previously issued as non compliant with a VPC on March 3, 2011.
2. Resident #001 was not reassessed and the resident's plan of care was not revised when the resident's care needs changed in relation to the following:
-Data collected and documented for resident #001 on the Minimum Data Set (MDS) completed in February 2013 indicated the resident's bowel and bladder continence had deteriorated. Staff #105 and clinical documentation confirmed that the resident was not reassessed when this decrease in function was identified.
-Data collected and documented for resident #001 on the MDS completed in May 2013 indicated the resident's ability to perform activities of daily living related to personal hygiene had deteriorated and the resident was now totally dependent of staff for all aspects of personal hygiene. The Resident Assessment Protocol (RAP) completed at this time indicated the resident's care plan would be altered with the goal to slow or minimize the decline and improve function if possible. Staff #105 and clinical documentation confirmed that the resident's plan of care was not revised to reflect the deterioration or the goal to minimize the decline and improve the resident's ability to perform activities of daily living. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 02, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of September, 2013

Signature of Inspector / Signature de l'inspecteur : Phyllis Hiltz-Bontje

Name of Inspector / Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

Service Area Office / Bureau régional de services : Hamilton Service Area Office