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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 15, 2013	2013_190159_0012	H-000170-13	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

ASHA SEHGAL (159)

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): April 3, 5, 10, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Nurse Manager, Registered Dietitian, Food Service Supervisor, nursing and dietary staff, physiotherapist, and the residents.

During the course of the inspection, the inspector(s) observed lunch meal service, reviewed health record and observed care being provided.

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

Nutrition and Hydration

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).

Findings/Faits saillants :

1. The care set out in the plan of care was not provided to the resident as specified in the plan of care s.6(7)
The plan of care related to nutritional care for resident #002 directs staff to provide 250 ml diet gingerale at lunch. The individualized menu posted in the servery also indicated resident to receive 250 ml fluids at lunch. On a specified date resident #002 was served 125 ml cranberry juice. Resident was not provided fluid requirement as specified in the plan of care.

The plan of care specified resident #002 be provided a modified therapeutic diet, finely cut up consistency with minced meat. The revised plan of care dated April 2012 identified resident reported to the registered dietitian that the resident was choking on salads. May 2012 the registered dietitian had documented in the plan of care that tossed, green , greek and ceasar salads were removed from individualized menu. On a specified date resident was served sliced bacon sandwich and arugula salad at lunch. Resident did not receive correct texture diet as specified in the plan of care. [s. 6. (7)]

2. The plan of care related to nutritional care for resident #001 directs staff to provide 250 ml milk, 250 ml water at lunch. During the lunch meal on a specified date it was observed dietary staff served resident 125 ml water instead of 250 ml. On a specified date April 2013 resident was served only 250 ml milk at lunch, water was not served or offered. [s.6.(7)]

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 provided to the resident as specified in the plan of care, to be implemented voluntarily.

WN #2: 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:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The resident's right to have his participation in decision making was not fully respected and promoted s. 3(1)9
A review of resident #001 health record identified that the resident had selected a specific advance care directive. On a specified date the resident was transferred to hospital, the transfer information included the incorrect advance care directive. Interview with the registered nurse and the record review confirm that the transfer information sent to hospital was incorrect and contrary to the resident's decision. [s. 3. (1) 9.]

Issued on this 25th day of April, 2013

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

Asha Sehgal