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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 15, 2018	2018_543561_0013	016921-18, 019225-18	Critical Incident System

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

DARIA TRZOS (561)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 27, 30, 31, 2018, and August 1, 2, 8, 2018

A Follow Up Inspection log number 004283-18 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Senior Nursing Manager, Manager of Resident Care, Registered Deititian (RD), Nutrition Services Supervisor, Behavioural Supports Ontario (BSO) nurse, Wound Care Nurse, registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

During the course of the inspection, the inspector observed the provision of care, reviewed investigation notes, clinical health records, polices and procedures, training records, staff employee files, and program evaluations and any other relevant documents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
- **0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The Long Term Care Homes Act, 2007, defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.
Emotional abuse is defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2018 alleging abuse by staff towards resident #008. Following the incident, resident #008 was noted to have an injury. The CI also indicated that a staff #114 also witnessed the alleged staff #115 calling resident #009 a derogatory name.

The licensee's investigation notes were reviewed by LTCH Inspector #561 during inspection in the home. Investigation notes confirmed the alleged two incidents.

A witness staff was interviewed by LTCH Inspector #561 and stated that on an identified date in 2018 the alleged staff abused resident #008. Following the incident they observed an injury on the resident. They also witnessed the same staff being abusive towards resident #009.

Staff #117 was interviewed by LTCH Inspector #561 and stated that on an identified date in 2018, they witnessed staff #115 being abusive towards resident #009.

During a review of records it was identified that there was previous history of allegation of abuse with the same staff member.

LTCH Inspector attempted to interview resident #009; however, was not able to due to

their cognitive status.
Resident #002 was interviewed by LTCH Inspector #561; however, could not recall this incident.

The Administrator was interviewed and indicated that the home had a zero tolerance for abuse and neglect and based on the investigation completed by the home action was taken.

The licensee failed to ensure that residents in the home were protected from abuse by anyone.

This area of non-compliance was identified during a CIS Inspection, log #016921-18.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A) The home's policy titled "Prevention, Reporting & Elimination of Abuse & Neglect", number 01-05-03, revised January 2017, stated that any person who has reasonable grounds to suspect abuse or neglect of a resident shall immediately report the suspicion and the information upon which is it based to the Director, Performance Improvement and Compliance Branch MOHLTC.

i) A CIS report was submitted to the Director on an identified date in 2018 alleging abuse from staff #115 towards resident #008. Following the incident, resident #008 was noted to have an injury. The CI also indicated that staff #114 also witnessed the alleged staff calling resident #009 a derogatory name.

Staff #114 that witnessed the incident reported it to registered staff #113; however, they failed to report this further or notify the Director immediately after this occurred. Investigation notes were reviewed and indicated that the registered staff #113 failed to report the incidents to the Manager and was not reported to the Director immediately. Staff #114 was interviewed by LTCH Inspector #561 and stated that they reported both incidents to registered staff #113.

ii) Staff #117 was interviewed by LTCH Inspector #561 and stated that on an identified date in 2018, they witnessed the alleged staff calling resident #009 a derogatory name. Staff #117 indicated that they had not reported this incident to the home.

iii) Staff #117 also stated that a long time ago; however, was not able to recall the date, staff #115 was rough with resident #010; the resident was yelling to stop. This incident was never reported to registered staff. The licensee was not aware of this incident.

iv) Staff #116 was interviewed by LTCH Inspector #561 and stated that a long time ago, but could not recall the date, staff #115 was rough with resident #011. This incident was never reported to the registered staff. The licensee was not aware of this incident.

The Administrator was interviewed and indicated that the home had a zero tolerance for abuse and neglect policy and acknowledged that the incidents were not reported immediately to Director. The Administrator acknowledged that staff failed to follow the requirement of immediate reporting. The Administrator was not able to speak to the incidents prior as they were not working at this home at the time.

The licensee failed to ensure that any alleged, suspected or witnessed abuse by anyone was reported to the Director immediately.

This area of non-compliance was identified during a Critical Incident System CIS Inspection, log #016921-18.

B) The home's policy titled "Prevention, Reporting & Elimination of Abuse & Neglect", number 01-05-03, revised January 2017, stated that the staff were to ensure the

following was completed:
-the resident's well-being and safety including the removal of the alleged abuser from the situation, and any continued resident care or contact.
-to immediately inform their manager/supervisor of the alleged abuse
-complete a head to toe assessment of the resident treat as required and contact the Attending Physician or Physician on call.
-registered staff to document the incident thoroughly in PCC progress notes and complete and Incident Report in PCC.

A CIS report was submitted to the Director on an identified date in 2018 alleging abuse by staff #115 towards resident #008 that caused an injury.

The clinical record review including investigation notes, indicated that the above actions as indicated in the policy were not completed after the staff #114 reported the abuse to registered staff #113 after the incident.

The licensee failed to ensure that the home's Prevention, Reporting & Elimination of Abuse & Neglect policy was complied with.

This area of non-compliance was identified during a CIS Inspection, log #016921-18.

C) The home's policy titled "Prevention, Reporting & Elimination of Abuse & Neglect", number 01-05-03, revised January 2017 indicated that one of the steps to follow upon becoming aware of abuse or neglect was for registered staff to document the incident thoroughly in Point Click Care (PCC) progress notes and complete an Incident Report in PCC.

A CIS report was submitted to the Director on an identified date in 2018, alleging abuse by staff #115 towards resident #008 that caused an injury. The CI also indicated that staff #115 was witnessed calling resident #009 a derogatory name.

Investigation notes and interviews with staff #114 and staff #117 indicated that staff #115 was abusive towards resident #009 on the identified date.

Staff #114 was interviewed by LTC Inspector #561 and stated that they witnessed staff #115 being abusive towards resident #009.
Staff #117 was interviewed by LTCH Inspector #561 and stated that on the date of the incident in 2018, they witnessed staff #115 being abusive towards resident #009.

The clinical records were reviewed by LTCH Inspector #561 and documentation of the incident that occurred towards resident #009 was not documented in PCC.

The Manager of Resident Care indicated that any incidents of abuse were expected to be documented under the risk management report in PCC.
The Senior Nursing Manager acknowledged that the incident of abuse towards resident #009 was not documented in the risk management report or the progress notes in PCC.

The licensee failed to ensure that their policy related to abuse and neglect was complied with.

This area of non-compliance was identified during a CIS Inspection, log #016921-18. [s. 20. (1)]

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 written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Clinical care records for resident #001 were reviewed and stated that the resident returned from the hospital on an identified date in 2018 with a change in condition. The physician had ordered an identified treatment for the condition.

Registered staff #104 was interviewed, and stated that the treatment was not added to Electronic Medication Administration Record (EMAR) or to Electronic Treatment Administration Record (ETAR).
PSW #110 was interviewed and stated that resident #001 refused to have the treatment applied at times.
Registered staff #112 was interviewed and stated that they recalled the resident having the equipment for the treatment; however, they did not see it being applied. They confirmed that the application and monitoring of treatment was not checked on their shift and did not recall that there was an order in place for that.

Progress notes were reviewed and indicated that the resident had a change in condition and they refused application of the treatment at times.
The written plan of care after return from the hospital did not include interventions for the

treatment or any alternative strategies in place for when the resident refused to have it applied.

The Senior Nursing Manager acknowledged that the written plan of care did not set out the planned care for the resident related to the treatment.

The licensee failed to ensure that there was a written plan of care for resident #001 that set out the planned care for the resident.

This area of non-compliance was identified during a CIS Inspection, log #019225-18. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Clinical records indicated that resident #001 was admitted to the hospital on an identified date in 2018 with an identified condition. The resident returned to the home with new orders. Progress notes indicated that after return from hospital the resident was prescribed a treatment for an identified condition. Physician's orders indicated that there was a new order after the resident returned which was later changed. The order did not specify whether to administer the treatment as per medical directive or as per the previous physician order. Progress notes were reviewed and there was no documentation found to indicate that registered staff were monitoring the resident's condition on every shift.

Registered staff #104 was interviewed and stated that resident's condition should have been monitored on every shift.
Registered staff #106 was interviewed and stated that the physician's order should have been clarified to identify the details of the application after the order was changed.

The Senior Nursing Manager acknowledged that the physician's order should have been clarified.

The licensee failed to ensure that the plan of care provided clear direction to staff related to administration of treatment.

This area of non-compliance was identified during a CIS Inspection, log #019225-18. [s. 6. (1) (c)]

3. The licensee failed to ensure that the resident was 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 changed or care set out in the plan was no longer necessary.

Clinical health records, specifically progress notes for resident #001 indicated that they were admitted to the hospital with a specified condition and returned to the home on an identified date in 2018 with new orders. After return from the hospital, the resident's ongoing altered skin integrity had deteriorated and they had other identified change in condition. The resident had interventions in place for the identified ongoing skin issue and the change in condition.

The written plan of care was reviewed prior to admission to the hospital and after return. The written plan of care was not revised when the resident's care needs changed post hospitalization.

PSW #110 that provided direct care to the resident was interviewed and confirmed the interventions in place.
Registered staff #112 was interviewed and stated that the resident had a change in condition after readmission.
Registered staff #104 was interviewed and indicated that the resident's condition changed after they returned from the hospital. Their altered skin integrity had deteriorated and required treatment. The registered staff stated that the written plan of care was not revised upon re-admission to include interventions in place for the skin integrity and other changes in their condition.

The Senior Nursing Manager acknowledged that the written plan of care was not revised when the care needs changed for resident #001.

The licensee failed to ensure that the written plan of care was revised when resident's care needs changed post readmission from hospital. [s. 6. (10) (b)]

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 plan of care sets out clear directions to staff and others who provide direct care to the resident and to 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 the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of resident's behaviours including responsive behaviours.

Clinical records for resident #001 were reviewed and stated that the resident returned from the hospital on an identified date in 2018 with a change in condition. The physician had ordered an identified treatment for the condition.
The progress notes on an identified date in 2018, indicated that the resident had experienced an identified behaviour and the home had completed a huddle and submitted a referral to Behavioural Supports Ontario (BSO). Registered staff assessed

the resident using a specified test. The resident scored high on the test.

The home’s policy titled "Responsive Behaviour Protocol" policy number 08-01-01, revised April 2018, indicated that upon a new or escalating responsive behaviour, the registered staff were to complete a CAM (Confusion Assessment Method) and if score was 3 or more, staff were to notify MD/NP, and complete a pain assessment.

Clinical records indicated that after the specified test the pain assessment was not completed and the physician was not notified.

Interview with RPN #112, indicated that the homes protocol was to call the physician and complete a pain assessment if the score on the identified test was high. The RPN acknowledged that this was not completed.
The BSO nurse was interviewed and confirmed that the policy was to call the physician and complete a pain assessment after a resident scored high on the CAM assessment. They acknowledged that this was not completed for resident #001.

The process was also not followed for resident #007 and resident #006 based on the record review and interview with staff.

In an interview, the Senior Nursing Manager they confirmed that the policy was not followed.

The licensee failed to ensure that the procedures and interventions to assist residents with responsive behaviours were implemented to minimize these behaviours.

This area of non-compliance was identified during a CIS Inspection, log #019225-18. [s. 55. (a)]

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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who were harmed as a result of resident's behaviours including responsive behaviours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident that resulted in harm or risk of harm and abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm that had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

The licensee's investigation notes related to a CIS report submitted to the Director on an identified date in 2018 with an allegation of abuse by staff #115 towards resident #008 were reviewed by LTCH Inspector #561.
During a review of records, it was identified that staff #115 had a history of an allegation against them. On an identified date in 2017, resident #002 reported to the home that staff #115 was abusive towards the resident and this had been an ongoing issue. The home completed and investigation; however this was not reported to the Director by the home.

The home's policy titled "Prevention, Reporting & Elimination of Abuse & Neglect", number 01-05-03, revised January 2017, stated that any person who has reasonable grounds to suspect abuse or neglect of a resident shall immediately report the suspicion and the information upon which is it based to the Director, Performance Improvement and Compliance Branch MOHLTC.

The licensee failed to ensure that any alleged, suspected or witnessed abuse by anyone was reported to the Director immediately.

This area of non-compliance was identified during a CIS Inspection, log #016921-18. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #001 had an ongoing issues with altered skin integrity in an identified year. The clinical records indicated that the resident was admitted to the hospital on an identified date in 2018 and when they returned to the home their alteration in the skin integrity had deteriorated. The RD and the referral to the Wound Care Nurse were completed; however, no documentation was found that the Wound Care Nurse had assessed the resident. Interview with registered staff indicated that resident refused the assessment from the Wound Care Nurse and that they forgot to document this.

The ETAR was reviewed for an identified period of time, and indicated that registered staff did not sign that the dressing had been changed for resident #001's skin alteration. Registered staff that worked on that shift were unable to be interviewed to confirm whether the dressing was changed. Registered staff #104 stated that once the dressing was done, the progress notes in PCC would show documentation of the dressing change. The progress notes were reviewed and the documentation was not found.

The Senior Nursing Manager acknowledged that the registered staff failed to document that the resident refused to be assessed by the Wound Care Nurse and failed to document that the dressing was changed.

The licensee failed to ensure that the assessments and responses to interventions were documented.

This area of non-compliance was identified during a CIS Inspection, log #019225-18. [s. 30. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home.

Resident #001 had an ongoing issues with altered skin integrity in an identified year. The clinical records indicated that resident's skin alteration had deteriorated on an identified date in 2018. There was no evidence that the referral to the Registered Dietitian (RD) was completed and no evidence that resident was assessed by the RD. The interview with registered staff #104 and the RD in the home indicated that the RD did not receive a referral to assess resident #001. The Senior Nursing Manager acknowledged that this was not done.

The licensee failed to ensure that a resident exhibiting an altered skin integrity including skin breakdown, pressure ulcers, skin tears, or wounds was assessed by the RD in the home.

This area of non-compliance was identified during a CIS Inspection, log #019225-18. [s. 50. (2) (b) (iii)]

Issued on this 26th day of November, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARIA TRZOS (561)
Inspection No. / No de l'inspection :	2018_543561_0013
Log No. / Registre no:	016921-18, 019225-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 15, 2018
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 :	Sean Weylie

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. 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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19(1) of the Long Term Care Homes Act, 2007.

Specifically the licensee must:
1. Ensure that residents #008, resident #009 and any other resident in the home are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The Long Term Care Homes Act, 2007, defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.
Emotional abuse is defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2018 alleging abuse by staff #115 towards resident #008. Following the incident, resident #008 was noted to have an injury. The CI also indicated that a staff #114 also witnessed the alleged staff calling resident #009 a derogatory name.

The licensee's investigation notes were reviewed by LTCH Inspector #561

during inspection in the home. Investigation notes confirmed the alleged two incidents.

A witness staff was interviewed by LTCH Inspector #561 and stated that on an identified date in 2018 the alleged staff abused resident #008. Following the incident they observed an injury on the resident. They also witnessed the same staff being abusive towards resident #009.

Staff #117 was interviewed by LTCH Inspector #561 and stated that on an identified date in 2018, they witnessed the alleged staff being abusive towards resident #009.

During a review of records it was identified that there was previous history of allegation of abuse with the same staff member.

LTCH Inspector attempted to interview resident #009; however, was not able to due to their cognitive status.
Resident #002 was interviewed by LTCH Inspector #561; however, could not recall this incident.

The Administrator was interviewed and indicated that the home had a zero tolerance for abuse and neglect and based on the investigation completed by the home action was taken.

The licensee failed to ensure that residents in the home were protected from abuse by anyone.

This area of non-compliance was identified during a CIS Inspection, log #016921-18.

The severity of this issue was determined to be a level 3 as there was actual harm to residents. The scope of the issue was a level 2 as it related to two residents. The home had a level 2 history as they had previous unrelated non-compliance with the legislation. (561)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 04, 2019

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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 du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 15th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

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