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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 09, 2019	2019_560632_0011 (A1)	001780-18, 003541-18, 025729-18, 025759-18, 030655-18, 031263-18, 007236-19	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

Amended by YULIYA FEDOTOVA (632) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

PHI edits to public.

Issued on this 9 th day of July, 2019 (A1)

[redacted]

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

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

Amended by YULIYA FEDOTOVA (632) - (A1)

Amended 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 15, 16, 17, 18, 23, 24, 25, 26, 29, 2019.

The following Complaint inspections were completed:

log #025759-18, 025729-18, 007236-19, 003541-18 - related to abuse and neglect,

log #030655-18, 019950-18, 003541-18 - related to medication,

log #001780-18 - related to hospitalization and change in a condition.

A Critical Incident System (CIS) inspection was conducted concurrently with this inspection:

log #027747-17, 006193-19 - related to falls,

log #017314-18 - related to abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Senior Nursing Manager (SNM), Resident Assessment Instrument (RAI) Co-ordinator, Manager of Resident Care (MoRC), Nurse Manager, Dietary Aid (DA), Physiotherapist (PT), Resident Care Clerk, Administrative Assistant, Clinical Nurse Specialist, Social Worker, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), residents and their families.

During the course of the inspection, the inspector(s) reviewed clinical records, policies, procedures, and practices within the home, reviewed meeting minutes, observed the provision of care and medication administration.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of the original inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **2 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	Légende 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. 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 resident #013 was protected from abuse by anyone.

A complaint log #025759-18 (IL-60161-HA) and a Critical Incident System (CIS) report log #025729-18 (M536-000025-18) were submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in September 2018, alleging abuse of resident #013 by resident #012, which occurred on an identified date in September 2018. Also, CIS report M536-000013-19 was submitted to the MOHLTC on an identified date in April 2019, alleging abuse of resident #013 by resident #012, which occurred on an identified date in April 2019.

Based on clinical records review, resident #012 and #013 were cognitively impaired.

Progress notes review indicated that on an identified date in September 2018, resident #012 performed identified activity towards co-resident #013. Resident #013 was noted being under emotional distress. The Social Worker #140 confirmed that the Montreal Cognitive Assessment (MOCA) completed in 2018, suggested the resident #013 was cognitively impaired.

Progress notes review indicated that on an identified date in April 2019, resident #012 performed identified activity towards co-resident #013. No signs of injury or pain indicators were noted for resident #013. On an identified date in April 2019, the resident's Substitute Decision Maker (SDM) indicated that they did not want resident #012 to be performed identified activity towards resident #013.

Interview with RN #134 confirmed that the incident from April 2019, met the definition of abuse.

The RN #116 acknowledged that resident #013 was not protected from abuse by resident #012 in the home.

The home did not ensure that resident #013 was protected from abuse by resident #012 in the home. [s. 19. (1)]

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. 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 :

(A1)

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, the goals, the care was intended to achieve and clear directions to staff and others who provided direct care to the resident.

A. Clinical records were reviewed for resident #015, who was admitted to the home on an identified date in February 2019. As part of the admission medical directives, they had an order for monitoring their specified condition.

The current written plan of care was reviewed and did not set out the planned care for this resident related to the management of specified condition and did not identify the goals and clear direction to staff, or risks to the resident related to the specified condition.

Registered staff #122 stated that each resident, admitted with the specified diagnosis, should have this care planned and should have goals and interventions included in the written plan of care.

In an interview with MoRC #001, they stated that residents with the specified diagnosis were required to have in place a written plan of care with goals, interventions to manage the specified condition and the risks associated with the condition.

The licensee failed to ensure that resident #015 had a written plan of care that set out the planned care, the goals the care was intended to achieve and clear directions to staff and others, who provided direct care to the residents related to the management of the specified condition.

B. Clinical records were reviewed for resident #016. The resident was admitted to the home on an identified date in February 2019, and had an order for specified medication. Upon admission, the resident's reconciliation orders indicated specified interventions at an identified frequency.

The current written plan of care was reviewed and did not set out the planned care for this resident related to the management of the specified condition and did not identify the goals and clear direction to staff, or risk associated with the specified condition.

Registered staff #122 stated that each resident, admitted with specified diagnosis,

should have this care planned and should have goals and interventions included in the written plan of care.

In an interview with MoRC #001, they stated that residents with the specified diagnosis were required to have in place a written plan of care with goals, interventions to manage the specified condition and risks related to the condition.

The licensee failed to ensure that resident #016 had a written plan of care that set out the planned care, the goals the care was intended to achieve and clear directions to staff and others, who provided direct care to the residents related to the management of the specified condition. [s. 6. (1)]

2. The licensee failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

A review of CIS report number IL-57942-AH/M536-000017-18 with a log #017314-18 was submitted to the MOHLTC on an identified date in July 2018, identified an incident of alleged abuse occurred.

Review of resident #005's written plan of care identified they had a history of identified behaviours.

During an interview with PSW #138, they stated resident required assistance of staff with activities of daily living (ADLs).

RPN #127 acknowledged that resident #005 required a specific intervention, when care was provided related to their responsive behaviours. This intervention had been in place since July 2018, and should have been documented as an intervention under the responsive behaviour focus in the plan of care.

RPN #127 confirmed that a specific intervention was required, when providing care to resident #005, and this intervention was not identified in the written plan of care as planned care to manage the resident's responsive behaviours. (581) [s. 6. (1) (a)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care, so that the different aspects of care were

integrated and were consistent with and complemented each other.

Review of resident #022's admission note on an identified date in February 2018, indicated they required identified assistance with all ADLs and required identified number of staff for ADLs.

Review of the identified assessment completed on an identified date in February 2018, indicated the resident used a specified device for ADLs with assistance of identified number of staff.

Review of the clinical records upon admission, identified the physiotherapist had assessed the resident for ADLs using specified device with assistance of identified number of staff.

Review of the clinical health record indicated that on an identified date in February 2018, RN #104 revised the written care plan to indicate the resident would be using a specified device for an identified activity during identified period of time.

In an interview with RN #108, who was the registered staff that revised the written care plan on an identified date in February 2018, acknowledged that they updated the written care plan to identify that the resident was assisted with specified device during an identified time. They stated that the physiotherapist completed the assessment and the written plan of care should of reflected the assessment of the physiotherapist. They confirmed they did not collaborate with the physiotherapist assessment that was documented on an identified date in February 2018.

In an interview on an identified date in April 2019, with RPN #104 and review of the initial care plan, RN #104 stated that the physiotherapist was responsible to assess all residents in the home on admission, quarterly and when they received a referral from registered staff. They acknowledged there was no collaboration between the physiotherapist assessments and registered staff assessments.

RPN #104 confirmed that staff and others, involved in the different aspects of care related to resident #022's, did not collaborate with each other in the development and implementation of the plan of care, so the care was integrated and consistent with each other. (581) [s. 6. (4) (b)]

4. The licensee failed to ensure that the care set out in the plan of care was

provided to the resident as specified in the plan.

A complaint log #030655-18 was submitted to the Director on an identified date in November 2018, related to the home not completing specific monitoring of resident #011 and on an identified date in November 2018, the resident was sent to the hospital as a result of specified condition.

A. Clinical records were reviewed for resident #011 and identified that resident was admitted to the home on an identified date in June 2018, with a specified diagnosis and other medical conditions. Resident was not taking any medications to manage their specified condition. The admission and/or re-admission orders form, which included the medical directives, indicated that, when residents with the specified condition was admitted to the home, they were to be monitored at identified frequency. The admission and/or re-admission orders form and the medication directive were part of the plan of care. Resident #011's clinical records indicated that their specific monitoring was completed at identified frequency for specified period of time after admission to the home, however, was not completed at identified frequency after that, as indicated in the plan of care.

Progress notes indicated that on an identified date in November 2018, resident's SDM noticed that the resident had identified symptoms, alerted staff, the registered staff completed specific monitoring, which was not within normal limits. The physician was notified and had ordered to administer identified medication. On an identified date in November 2018, the resident was sent to the hospital as they continued to have identified symptoms. The resident was on identified interventions after re-admission from the hospital.

Resident #011's was not monitored as per the plan of care between identified dated in June 2018, and November 2018, except for an identified date in October 2018, when a progress note indicated that registered staff completed specific monitoring and they were not within normal limits.

Registered staff #122 was interviewed on an identified date in April 2019, and could not recall the admission of this resident; however, did confirm that each resident, admitted with specified condition, was required to have their specific monitoring completed as per the medical directive. The registered staff #122 referred to the admission and/or re-admission orders form and indicated that the orders for the specific monitoring were completed and then entered into the electronic Medication Administration Record (eMAR), as per the protocol, and

according to the resident's condition. The nurse, who completed the admission of a resident, was expected to add the medical directive for residents with specified diagnosis to the eMAR on admission.

The home's specified policy number 06-03-011, created in September 2011, stated standard monitoring of residents with specified diagnosis for identified residents, which included frequency and the time.

MoRC #001 confirmed that each resident admitted to the home with specified condition was required to have their specific monitoring completed as per the admission/re-admission orders, which were part of the medical directive and part of the plan of care. MoRC #001 also confirmed that resident #011 did not have their specific monitoring completed at identified frequency, as indicated in the plan of care.

B. Clinical records were reviewed for resident #015, who was admitted to the home on an identified date in February 2019, with specified diagnosis. As part of the admission medical directives, their specific monitoring were to be completed at specified frequency on admission and thereafter.

The eMAR was reviewed for the month of February 2019, and the resident's specific monitoring was only completed during specified period of time upon admission instead of specified period of time. Clinical records also identified that there was no monitoring afterwards, as indicated in the plan of care.

Registered staff #124 stated that the resident did not need to have their specific monitoring completed.

The interview with MoRC #001 confirmed that resident #015 was not monitored at specified frequency as per the plan of care.

C. Clinical records were reviewed for resident #016. The resident was admitted to the home on an identified date in February 2019, with specified diagnosis and had an order for administration of specified medication. Upon admission, the resident's reconciliation orders indicated to monitor the resident at specified time and frequency. On an identified date in February 2019, the physician had prescribed specified medication administration at specified time and frequency. Clinical records, including eMAR, indicated that the order was followed; however, the home did not continue to monitor the resident after this order was complete.

According to the medical directive, to monitor the resident at specified frequency.

In an interview with registered staff #124 they stated that the resident should have been monitored at specified frequency, as per the medical directive, after the physician's order was completed.

Interview with MoRC #001 confirmed that the plan of care was not followed for resident #011, #015 and #016 related to the monitoring of the residents.

D. A complaint log #030655-18, was submitted to the Director on an identified date in November 2018, from resident #011's SDM related to the home not managing the resident's specified condition. The complaint intake indicated that on an identified date in November 2018, the SDM notified registered staff on the unit that resident #011 had identified symptoms and had asked the nurse to completed the resident's specific monitoring and they did not.

The complaint log book was reviewed during this inspection and identified the written complaint, which stated that on an identified date in November 2018, registered staff was asked to complete specific monitoring of resident #011, as the resident had specified symptoms; however, the registered staff did not.

The investigation notes were reviewed and indicated that registered staff #139, who worked on the identified shift on an identified date in November 2018, was interviewed by MoRC #111, and confirmed it was reported to them that resident had specified symptoms. Registered staff #139 stated in the interview with the home, that they had not completed the resident's specific monitoring that day and they should have.

Registered staff #139 was interviewed on an identified date in May 2019, and stated that it was reported to them on an identified date in November 2018, that resident had specified symptoms. They stated that they were aware that resident had specified diagnosis; however, they were not taking any medications and for this reason they did not complete the resident's specific monitoring.

The clinical records were reviewed and indicated that resident #011 had specified diagnosis, was not on specified medications; their specified condition was diet controlled. As per the home's medical directive, the resident was to have their specific monitoring completed at specified frequency.

Resident #011's plan of care identified that the resident had a potential of specified condition related to specified diagnosis and one of the interventions on management of their specified condition was described.

The progress notes were reviewed and there was no documentation of the assessment of the monitoring of the resident on an identified date in November 2018. The resident was monitored on an identified date in November 2018, and they were not within normal range. The physician was notified and they had prescribed specified intervention for the resident. The resident was monitored and on an identified date in November 2018, resident #011 was sent to the hospital for further treatment as they continued to experience specified symptoms.

The interview with MoRC #111 on an identified date in May 2019, confirmed that registered staff #139 failed to monitor the resident #011 on an identified date in November 2018.

The licensee failed to ensure that the care was provided to resident #011 as specified in the plan related to specified condition management. (561)

E. A review of CIS report number M536-000012-19, with a log #006193-19 was submitted on an identified date in March 2019, identified resident #001 fell resulting in a specified injury.

Review of the plan of care identified the resident was to have specified device in place as a falls intervention. Review of the progress notes identified, when the resident fell on an identified date in March 2019, the specified device was not in place.

On an identified date in April 2019, RPN #102 was interviewed and stated that the specified device was to be in place as an intervention to manage falls. They confirmed that the specified device was not in place, when the resident fell on an identified date in March 2019, and sustained an injury.

RPN #102 confirmed that the care set out in the plan of care was not provided to resident #001 as specified in the plan related to the application of specified device. (632) [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any other time when the resident's care needs

changed.

A. A complaint log #003541-18 (IL-55586-HA) was submitted to the MOHLTC on an identified date in February 2018, for resident #017.

Review of written plan of care indicated that resident #017 required assistance from staff for ADLs.

Physiotherapy re-assessment was conducted on an identified date in February 2019, which indicated the resident's level of staff assistance required with ADLs.

Review of MDS and RAPS indicated that the resident required staff assistance with their ADLs. Review of written plan of care did not indicate the resident's requirements for assistance with ADLs based on the physiotherapist's re-assessment completed on an identified date in February 2019.

The home's Lift, Transfer and Repositioning Procedure Number 24-02-01 indicated that in the absence of the physiotherapist, the registered staff completed the resident's mobility assessment located in Point Click Care (PCC) within 24 hours of re-admission.

Interview with RAI Co-ordinator #104 indicated that the ADL level of assistance was not revised to include the change in assistance the resident required with ADLs.

The licensee failed to ensure that resident #017 was reassessed and the plan of care for resident #017 was reviewed and revised at any other time when the resident's care needs changed.

B. Review of written plan of care identified that resident #022 was to be assisted with ADLs from specified locations with a specified device.

On an identified date in April 2019, resident #022 was interviewed and stated they were assisted with ADLs at identified time only from one specified location with a specified device.

Review of the progress notes on an identified date in April 2019, identified that the PT reassessed the resident and documented that the resident was to be assisted at identified time only from one specified location with a specified device.

In an interview with RPN #122 they acknowledged, after reviewing the physiotherapist's progress notes, that the resident was to be assisted at identified time only from one specified location with a specified device.

RPN #122 confirmed that the plan of care was not reviewed and revised when the resident's care needs changed related to assistance with ADLs. (581) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

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).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A complaint log #030655-18 was submitted to the Director on an identified date in November 2018, related to a medication error involving resident #011.

The clinical records were reviewed and indicated that resident #011's specified medication was discontinued on an identified date in August 2018, during a quarterly review completed by the physician.

The investigation notes indicated that on an identified date in September 2018, RN #144 administered specified medication to resident #011. In an interview with the home's RN #144 stated that they did not check the electronic Medication Administration Record (eMAR) prior to administering the medication.

RN #144 was interviewed by LTCH Inspector #561 on an identified date in April 2019, and stated that prior to administering the medication they did not check the order on eMAR.

The SNM was interviewed and confirmed that the RN administered a medication to resident #011 without the physician order as it was discontinued on an identified date in August 2018.

The licensee failed to ensure that no drug was administered to resident #011 unless the drug had been prescribed for the resident. [s. 131. (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 and ensuring that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #4: 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 policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's Prevention, Reporting and Elimination of Abuse and Neglect Policy Number 01-05-03 indicated that any person, who had reasonable grounds to suspect abuse or neglect of a resident should immediately report the suspicion and the information upon which was based to the Director. This reporting could be done by any person by calling to the Long-Term Care toll free ACTION Line or by reporting the suspected abuse or neglect to the Home's Administrator or designate, who would immediately notify the MOHLTC.

A CIS report log #025729-18 (M536-000025-18) was submitted to the MOHLTC on an identified date in September 2018, alleging abuse of resident #013 by resident #012, which occurred on an identified date in September 2018.

Interview with MoRC #106 indicated that the incident of alleged abuse was to be reported right away through the MOHLTC ACTION Line. The RN was to call to the Manager-on-Call, who was to call to the MOHLTC.

Progress notes review indicated that on an identified date in September 2018, the registered staff #121 informed the Manager-on-Call about the incident involving residents #013 and #012. MoRC #106 indicated that they became aware of the incident on an identified date in September 2018, in the report posted in Point Click Care (PCC) on an identified date in September 2018, when at the same time the CIS report was submitted to the MOHLTC, which was not an immediate report to the Director.

The licensee failed to ensure that the home's Prevention, Reporting and Elimination of Abuse and Neglect Policy was complied with. [s. 20. (1)]

Issued on this 9 th day of July, 2019 (A1)

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

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by YULIYA FEDOTOVA (632) - (A1)
Inspection No. / No de l'inspection :	2019_560632_0011 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	001780-18, 003541-18, 025729-18, 025759-18, 030655-18, 031263-18, 007236-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 09, 2019(A1)
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

Ontario

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

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(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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2018_543561_0013, CO #001;

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 LTCHA, 2007 s. 19 (1).
Specifically the licensee shall ensure:
1. Resident #013 and all other residents are protected from abuse by anyone.
2. Resident #012 and all other residents, that are known to staff to demonstrate responsive behaviours, have interventions in place to monitor the resident(s) for their behaviours and interventions implemented to protect other residents from abuse.

Grounds / Motifs :

1. The licensee failed to ensure that resident #013 was protected from abuse by anyone.

A complaint log #025759-18 (IL-60161-HA) and a Critical Incident System (CIS) report log #025729-18 (M536-000025-18) were submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in September 2018, alleging abuse of resident #013 by resident #012, which occurred on an identified date in September 2018. Also, CIS report M536-000013-19 was submitted to the MOHLTC on an identified date in April 2019, alleging abuse of resident #013 by resident #012, which occurred on an identified date in April 2019.

Based on clinical records review, resident #012 and #013 were cognitively impaired.

Progress notes review indicated that on an identified date in September 2018, resident #012 performed identified activity towards co-resident #013. Resident #013 was noted being under emotional distress. The Social Worker #140 confirmed that the Montreal Cognitive Assessment (MOCA) completed in 2018, suggested the resident #013 was cognitively impaired.

Progress notes review indicated that on an identified date in April 2019, resident #012 performed identified activity towards co-resident #013. No signs of injury or pain indicators were noted for resident #013. On an identified date in April 2019, the resident's Substitute Decision Maker (SDM) indicated that they did not want resident #012 to be performed identified activity towards resident #013.

Interview with RN #134 confirmed that the incident from April 2019, met the definition of abuse.

The RN #116 acknowledged that resident #013 was not protected from abuse by resident #012 in the home.

The home did not ensure that resident #013 was protected from abuse by resident #012 in the home.

This order is made up on the application of the factors of severity (3), scope (1), and compliance history (3). This is in respect to the severity of actual harm or actual risk that the identified resident experienced, the scope of this being isolated incident. The home had a level 3 history as they had previous non-compliance to the same subsection of the LTCHA that included:
- Compliance Order (CO) issued November 15, 2018 (2018_543561_0013). (632)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 20, 2019

Ontario

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

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. (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 :

(A1)
The licensee must be compliant with s. 6(7) of the LTCHA, 2007.

The licensee shall prepare, submit and implement a plan to ensure that resident #011, #015, #016 and any other resident in the home with a specified diagnosis have ongoing monitoring as outlined in the plan of care.

The plan must include how the home will ensure the following:
1. Resident #011, #015, #016 and any other resident in the home will have ongoing monitoring as outlined in their plan of care.
2. An audit shall be completed of all residents with a specified diagnosis to ensure that the medical directive related to specific monitoring is being followed. The audit must be documented and identify who completed the audit.
3. Upon admission, the admission/re-admission orders form will clearly identify, which directive will be applied based on the condition of the resident.
4. The orders, based on the medical directive, will be added to the electronic Medication Administration Record (eMAR) for each resident. The home must demonstrate how they will ensure this is being completed.
5. Resident requiring additional monitoring will have their results clearly and accurately documented in the clinical record with the time, value, action taken and registered staff signatures.
6. All residents, admitted with a specified diagnosis, will have the written plan of care in place addressing the diagnosis, risks associated with the condition and any interventions in place to manage this condition.

Please submit the written plan for achieving compliance for inspection number 2019_560632_0011 to Daria Trzos, LTC Homes Inspector by email to HamiltonSAO.moh@ontario.ca by July 3, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

(A1)
1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint log #030655-18 was submitted to the Director on an identified date in November 2018, related to the home not completing specific monitoring of resident #011 and on an identified date in November 2018, the resident was sent to the hospital as a result of specified condition.

A. Clinical records were reviewed for resident #011 and identified that resident was admitted to the home on an identified date in June 2018, with a specified diagnosis and other medical conditions. Resident was not taking any medications to manage their specified condition. The admission and/or re-admission orders form, which included the medical directives, indicated that, when residents with the specified condition was admitted to the home, they were to be monitored at identified frequency. The admission and/or re-admission orders form and the medication directive were part of the plan of care. Resident #011's clinical records indicated that their specific monitoring was completed at identified frequency for specified period of time after admission to the home, however, was not completed at identified frequency after that, as indicated in the plan of care.

Progress notes indicated that on an identified date in November 2018, resident's SDM noticed that the resident had identified symptoms, alerted staff, the registered staff completed specific monitoring, which was not within normal limits. The physician was notified and had ordered to administer identified medication. On an identified date in November 2018, the resident was sent to the hospital as they continued to have identified symptoms. The resident was on identified interventions after re-admission from the hospital.

Resident #011's was not monitored as per the plan of care between identified dated in June 2018, and November 2018, except for an identified date in October 2018, when a progress note indicated that registered staff completed specific monitoring and they were not within normal limits.

Registered staff #122 was interviewed on an identified date in April 2019, and could not recall the admission of this resident; however, did confirm that each resident, admitted with specified condition, was required to have their specific monitoring completed as per the medical directive. The registered staff #122 referred to the admission and/or re-admission orders form and indicated that the orders for the specific monitoring were completed and then entered into the electronic Medication Administration Record (eMAR), as per the protocol, and according to the resident's

condition. The nurse, who completed the admission of a resident, was expected to add the medical directive for residents with specified diagnosis to the eMAR on admission.

The home's specified policy number 06-03-011, created in September 2011, stated standard monitoring of residents with specified diagnosis for identified residents, which included frequency and the time.

MoRC #001 confirmed that each resident admitted to the home with specified condition was required to have their specific monitoring completed as per the admission/re-admission orders, which were part of the medical directive and part of the plan of care. MoRC #001 also confirmed that resident #011 did not have their specific monitoring completed at identified frequency, as indicated in the plan of care.

B. Clinical records were reviewed for resident #015, who was admitted to the home on an identified date in February 2019, with specified diagnosis. As part of the admission medical directives, their specific monitoring were to be completed at specified frequency on admission and thereafter.

The eMAR was reviewed for the month of February 2019, and the resident's specific monitoring was only completed during specified period of time upon admission instead of specified period of time. Clinical records also identified that there was no monitoring afterwards, as indicated in the plan of care.

Registered staff #124 stated that the resident did not need to have their specific monitoring completed.

The interview with MoRC #001 confirmed that resident #015 was not monitored at specified frequency as per the plan of care.

C. Clinical records were reviewed for resident #016. The resident was admitted to the home on an identified date in February 2019, with specified diagnosis and had an order for administration of specified medication. Upon admission, the resident's reconciliation orders indicated to monitor the resident at specified time and frequency. On an identified date in February 2019, the physician had prescribed specified medication administration at specified time and frequency. Clinical records,

including eMAR, indicated that the order was followed; however, the home did not continue to monitor the resident after this order was complete. According to the medical directive, to monitor the resident at specified frequency.

In an interview with registered staff #124 they stated that the resident should have been monitored at specified frequency, as per the medical directive, after the physician's order was completed.

Interview with MoRC #001 confirmed that the plan of care was not followed for resident #011, #015 and #016 related to the monitoring of the residents.

D. A complaint log #030655-18, was submitted to the Director on an identified date in November 2018, from resident #011's SDM related to the home not managing the resident's specified condition. The complaint intake indicated that on an identified date in November 2018, the SDM notified registered staff on the unit that resident #011 had identified symptoms and had asked the nurse to completed the resident's specific monitoring and they did not.

The complaint log book was reviewed during this inspection and identified the written complaint, which stated that on an identified date in November 2018, registered staff was asked to complete specific monitoring of resident #011, as the resident had specified symptoms; however, the registered staff did not.

The investigation notes were reviewed and indicated that registered staff #139, who worked on the identified shift on an identified date in November 2018, was interviewed by MoRC #111, and confirmed it was reported to them that resident had specified symptoms. Registered staff #139 stated in the interview with the home, that they had not completed the resident's specific monitoring that day and they should have.

Registered staff #139 was interviewed on an identified date in May 2019, and stated that it was reported to them on an identified date in November 2018, that resident had specified symptoms. They stated that they were aware that resident had specified diagnosis; however, they were not taking any medications and for this reason they did not complete the resident's specific monitoring.

The clinical records were reviewed and indicated that resident #011 had specified

diagnosis, was not on specified medications; their specified condition was diet controlled. As per the home's medical directive, the resident was to have their specific monitoring completed at specified frequency.

Resident #011's plan of care identified that the resident had a potential of specified condition related to specified diagnosis and one of the interventions on management of their specified condition was described.

The progress notes were reviewed and there was no documentation of the assessment of the monitoring of the resident on an identified date in November 2018. The resident was monitored on an identified date in November 2018, and they were not within normal range. The physician was notified and they had prescribed specified intervention for the resident. The resident was monitored and on an identified date in November 2018, resident #011 was sent to the hospital for further treatment as they continued to experience specified symptoms.

The interview with MoRC #111 on an identified date in May 2019, confirmed that registered staff #139 failed to monitor the resident #011 on an identified date in November 2018.

The licensee failed to ensure that the care was provided to resident #011 as specified in the plan related to specified condition management.

This order is made up on the application of the factors of severity (3), scope (3), and compliance history (3). This is in respect to the severity of actual harm or actual risk that the identified resident experienced, the scope of this being widespread incidents. The home had a level 3
history as they had previous non-compliances to the same subsection of the LTCHA that included:
- voluntary plan of correction (VPC) issued November 15, 2018 (2018_543561_0013),
- VPC issued February 22, 2018 (2017_543561_0020),
- VPC issued July 15, 2016 (016_301561_0017). (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 20, 2019

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

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9 th day of July, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by YULIYA FEDOTOVA (632) - (A1)

Ontario

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

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