Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 4, 2021	2021_704682_0008	021021-20, 005087-21, 005113-21, 006453-21	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

AILEEN GRABA (682)

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): May 12, 13, 14, 17, 18, 19 and 20, 2021.

The following intakes were completed during this Critical Incident System inspection:
006453-21 related to hospitalization and change in condition
005087-21 related to complaints and alleged neglect

The following compliance order follow-up intakes were completed concurrently:
005113-21 related to medication administration
021021-20 related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Senior Nursing Manager (SNM), Manager of Resident Care, Halton Region Public Health staff, Housekeeping, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) toured the home, reviewed investigative notes, critical incident submissions, resident health records, policies and procedures, complaint logs/ binder, medication incidents, observed infection prevention and control (IPAC) practices, medication administration, residents and provision of care.

Please note: Inspector Jobby James was present and job shadowing during this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #001	2020_555506_0032	682
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2020_560632_0012	682

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

Observations of the home identified that eye protection was not worn by staff in accordance with the most current and applicable direction to the long term care home.

A review of Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, directed all staff and essential visitors to wear appropriate eye protection when within two metres of a resident (s) as part of provision of direct care and/or when interacting with a resident in an indoor area.

A Registered Practical Nurse (RPN) was observed administering medication and providing a treatment to two residents without wearing any eye protection. Another RPN was observed in a resident's bedroom administering medication without wearing eye protection. Observations of a dining area and hallway within the home, identified three personal support workers that repositioned and assisted two residents without wearing any eye protection. All these staff were observed to be less than two metres while interacting with residents in an indoor space.

A RPN stated they were not aware of the requirement to wear eye protection when providing care within two metres of residents. The Clinical Resource Nurse (CRN) stated that wearing eye protection was always an option for staff and only a recommendation by the local public health unit not a requirement. Consultation with the Halton Region Public Health (HRPH) unit confirmed that all staff and essential visitors should be wearing eye protection at all times within two metres of residents while indoors. Failure to follow the additional precautions/practices of staff wearing eye protection put all residents residing in the home at increased risk of potential exposure to COVID-19.

The home was not a safe and secure environment for its residents when staff did not follow the infection prevention and control (IPAC) measures set out in Directive #3 implemented to protect residents in long term care homes from COVID-19.

Sources: Observations of home area, Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Interviews with HRPH public health and other staff. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for a resident that sets out clear directions to staff and others who provide direct care to the resident related to safe lifts and transfers.

The licensee's "Lift, Transfer & Repositioning" policy directed staff to follow transfer logos and sling logos placed in the resident's room to guide all transfers. A resident's plan of care identified that they required assistance with lifts and transfers. The physiotherapist's assessment also identified that the resident required assistance with lifts and transfers. Observations of a resident's bedside logo identified that the resident required a method of transfer not identified in the care plan.

Registered Practical Nurse (RPN) and a Personal Support Worker both confirmed that

the bedside logo is part of the residents' written plan of care. A PSW stated that the resident was transferred using a method of transfer that was not identified on the logo. A RPN confirmed that the logo posted did not provide clear direction. Because the written plan of care that included the bedside logo for the resident did not provide clear direction to staff, the resident was at risk for unsafe transfers.

Sources: The licensee's Lift, Transfer & Repositioning Policy, Observations, electronic medical records including their care plan, Interviews with RPN, PSW and other staff. [s. 6. (1) (c)]

2. The licensee failed to ensure that care set out in the plan of care related to transfers was based on an assessment of a resident and the needs and preferences of that resident.

According to a Critical Incident System report (CIS), a resident sustained an injury with an unknown source of origin.

The licensee's "Lift, Transfer & Repositioning" policy directed staff to ensure transfer techniques used were based on a mobility assessment completed by the physiotherapist or registered staff. A resident's plan of care identified that they required a certain method of transferring with the assistance of staff. No assessments or progress notes completed by either the physiotherapist or registered staff related to transfers were found within the resident's clinical record. The Senior Nursing Manager (SNM) confirmed that the resident was not assessed for the method of transfer at the time it was included in the plan of care. The resident was at risk for falls and potential injury when care set out in the plan of care was not based on an assessment of their needs related to safe transfers.

Sources: The licensee's Lift, Transfer & Repositioning Policy, CIS, electronic medical record and care plan, Interviews with SNM . [s. 6. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; to ensure care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant

According to a critical incident submission report (CIS) a resident's substitute decision maker (SDM) met with the Manager of Resident Care (MRC) and reported concerns related to care. The complaint binder/log did not include any documentation related to SDM's concerns or any follow- up action taken to resolve the concerns.

The licensee's "Reporting and Managing Complaints " policy directed the Manager/Supervisor to resolve any complaints and complete a Client Services Response Form. The policy also stated that "all complaints will be investigated and the follow-up resolution communicated with the individual who registered the complaint. This follow-up will occur within 10 business days and will include what the home has done to resolve the matter. "

The Senior Nursing Manager (SNM) confirmed the home's complaint log/binder did not include concerns reported by the resident's SDM. Any follow-up actions and responses by the complainant were also not documented on a Client Services Response Form in the complaint log/binder.

Sources: CIS, the home's Client Services Response Forms, Reporting and Managing Complaints Policy, Interview with SNM. [s. 101. (2)]

Issued on this 16th day of June, 2021

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

Original report signed by the inspector.