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
Dec 13, 2021	2021_868561_0012	008506-21, 008753-21, 012247-21, 013938-21, 017099-21	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

DARIA TRZOS (561), FARAH_ KHAN (695)

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): October 28, 29, 2021, November 1, 2, 3, 4, 5, 8, 9, 10, 12 (offsite), 16, 2021.

The following Critical Incident (CI) inspections with the following log numbers (#) were completed during this inspection:
log #013938-21 - related to a fall with injury,
log #012247-21 - related to a fall with injury,
log #008753-21 - related to a fall with injury,
log #008506-21 - related to a fall with injury,
log #017099-21 - related to a fall with injury.

A Complaint Inspections with number 2021_868561_0011 was conducted concurrently with this inspection.

A Follow Up inspection, log #005114-21, from inspection #2020_555506_0032, was also conducted with this inspection and was complied.

During the course of the inspection, the inspector(s) spoke with the Administrator, Senior Nursing Manager (SNM), Managers of Resident Care (MoRC), Clinical Resource Nurse and Infection Prevention and Control (IPAC) Lead, Infection Control Coordinator – Halton IPAC Hub, Infection Control Coordinator – Region of Halton Public Health, Physiotherapist (PT), registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Behavioural Supports Ontario (BSO) nurse, Personal Support Workers (PSWs), housekeeping staff, and residents.

During the course of the inspection, the inspector(s): toured the home, completed the IPAC checklist, observed provision of care, reviewed residents' clinical records, and any relevant policies and procedures.

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

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

- **2 WN(s)**
- **2 VPC(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to residents as specified in the plan related to falls.

A) The plan of care for resident #003 included an intervention for falls prevention. The resident sustained a fall with injury and the identified intervention was not in place. The Manager of Resident Care (MoRC) confirmed the intervention was not provided as per the plan of care.

Sources: CI report; resident #003's progress notes, written plan of care, risk management; interviews with staff.

B) Resident #003's progress notes indicated that the Physiotherapist (PT) recommended an intervention for falls. The intervention was not provided to the resident as recommended. The MoRC stated that the intervention should have been provided to the resident as recommended by the PT.

Not implementing the recommended interventions for falls placed the resident at a higher risk for injuries from falls.

Sources: Resident #003's progress notes; interviews with staff. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident a specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the infection prevention and control (IPAC) program was evaluated and updated annually in accordance with evidence-based practices (EBPs) related to staff access to Personal Protective Equipment (PPE).

During the tour of one of the units in the home, it was observe that three rooms had additional contact precautions signage on the doors. A yellow caddy was hanging on the doors with personal protective equipment (PPE) including gloves and gowns. There were no masks or face shields present.

Interviews with staff identified that masks and face shields were not kept with all PPE on

the caddies. Each PSW received two masks for the shift. If they needed more they would ask the registered staff to provide more. The registered staff also provided face shields at the beginning of the shift, which were disposable. Inspector #561 interviewed the IPAC Coordinator from the Region of Halton Public Health and they stated that all the PPE equipment should be readily available at the hanging caddies for staff to use.

The EBP document, “Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018” specified that long-term care homes must ensure that staff had sufficient supplies of, and quick, easy access to, the PPE required. The long-term care home’s IPAC program did not include this requirement and was not updated and evaluated in 2019 in accordance with the EBP document.

The failure to evaluate and update the IPAC program in accordance with the EBP presented potential risk to residents as the program did not require that the staff had quick and easy access to all PPE required.

Sources: the home’s IPAC procedures February 2020), the Ministry of Health and Long-Term Care EBP document “Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018” (November 2018), interviews with IPAC Coordinator from Region of Halton Public Health, IPAC Coordinator from Halton IPAC Hub, and other staff in the home. [s. 229. (2) (d)]

2. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

The home had protocols, IPC 03-03-01, last revised on February 2020, which identified that signs would be posted on the doors of resident rooms to alert staff that precautions were in place.

i) A tour of two home areas in the home, identified resident rooms with a caddy containing PPE, but no signage indicating what type of precautions were required. Interviews with PSW and registered staff confirmed residents were on additional precautions and the signage should have been placed on the doors.

ii) A tour of another home area identified that a room had a droplet precautions signage on the door; however, no PPE available at the door. An RPN stated that the resident in this room was no longer on droplet precautions, they had forgotten to remove the signage.

IPAC Lead and the SNM confirmed the staff failed to participate in the implementation of the IPAC program when the staff failed to place the signage on the door to rooms with additional precautions and failed to remove signage when a resident was no longer on additional precautions.

Not participating in the implementation of the IPAC program may have increased the risk of transmission of infections.

Sources: IPAC Protocols, observations of signage and PPE; interviews with staff. [s. 229. (4)]

3. The licensee failed to ensure that a hand hygiene program was in place in accordance with the Ontario evidence-based hand hygiene (HH) program, “Just Clean Your Hands” (JCYH) related to staff assisting residents with HH before and after meals.

The home’s HH program did not include a process for staff to assist residents to clean their hands before and after a meal.

On one of the units residents’ hands were not cleaned before lunch except for one resident. On another unit residents' hands were not washed or sanitized prior to lunch service.
On another home area it was observed that residents’ hands were not cleaned just prior to the snack service.

The IPAC lead and SNM indicated that it was an expectation that residents' hands were washed or sanitized prior to and after each meal.

According to JCYH program, staff are required to assist residents to clean their hands before and after meals.

The failure to have a hand hygiene program in place in accordance with EBPs may have increased the risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Observations of residents during lunch and snack; “Just Clean Your Hands” program resources; interviews with staff. [s. 229. (9)]

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 infection prevention and control (IPAC) program is evaluated and updated annually in accordance with evidence-based practices (EBPs); to ensure that all staff participate in the implementation of the infection prevention and control program; to ensure that a hand hygiene program is in place in accordance with the Ontario evidence-based hand hygiene (HH) program, "Just Clean Your Hands" (JCYH), to be implemented voluntarily.

Issued on this 14th day of December, 2021

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

Original report signed by the inspector.