Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137
hamiltondistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: December 20, 2022	
Inspection Number: 2022-1556-0002	
Inspection Type: Follow up	
Licensee: The Regional Municipality of Halton	
Long Term Care Home and City: Allendale, Milton	
Lead Inspector Barbara Grohmann (720920)	**Inspector Digital Signature** Barbara Grohmann 2022.12.21 10:33:52 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 8, 12-14, 16, and 19, 2022.

The following intake(s) were inspected:

- Intake: #00001314 - Follow-up to CO #001 from inspection 2022-1556-0001, regarding O. Reg. 246/22 s. 102 (2)(b) + IPAC Standard 10.4 h and i, resident hand hygiene prior to meals.

- Intake: #00003170 - Follow-up to CO#001 from inspection #2021-868561-0011 regarding O. Reg 79/10 s. 51. (2), continence care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2022-1556-0002 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Barbara Grohmann (720920).

Order #001 from Inspection #2022-868561-0011 related to O. Reg. 79/10, s. 51 (2) inspected by Barbara Grohmann (720920).

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The following **Inspection Protocols** were used during this inspection:

Continence Care
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that they carried out every operational or policy directive that applied to the home, which included Minister's Directives.

In accordance with the Minister's Directive, COVID-19 Guidance Document for Long-Term Care Homes in Ontario, the licensee was required to ensure that all staff, students and volunteers wore a medical mask for the entire duration of their shift indoors regardless of their immunization status or whether the home was in an outbreak or not.

Rationale and Summary
The home's infection prevention and control (IPAC) lead stated that universal masking was a requirement for all staff. They also confirmed that the staff have designated areas where they can remove their mask to eat and/or drink.

During the inspection several staff members were observed either without a surgical mask or with their mask lowered, exposing their nose and mouth, in undesignated areas.

i) A maintenance staff member was observed in the administrative office hallway not wearing a surgical mask and interacting with other staff members while assembling Christmas decorations.
ii) A Personal Support Worker (PSW) was observed with their mask off in a Trafalgar resident home area (RHA) hallway.
iii) A second PSW was observed with their mask lowered at the nursing sub-station on Bronte RHA while sitting with other PSWs.
iv) A housekeeper was observed with their mask lowered leaving the dining room in Adams RHA. The housekeeper stated that they were eating and did not want to get their mask wet or dirty. The IPAC lead

confirmed that the dining room was not a designated area for staff to either remove their mask or eat/drink.
v) A second housekeeper was observed with their mask lowered while talking with a resident in Trafalgar RHA. The housekeeper was in close proximity to the resident for several minutes. As they left the RHA, they lowered their mask again to speak with the resident's visitor.

Failure to ensure that staff wore medical masks for the entire duration of their shift had the potential to spread the COVID-19 virus to residents, visitors and/or staff.

Sources: observations; Minister's Directive: COVID-19 response measures for long-term care homes (August 30, 2022), COVID-19 guidance document for long-term care homes in Ontario (October 14, 2022); interviews with IPAC Lead and other staff. [720920]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

In accordance with the IPAC Standard, the licensee was required to ensure that Additional Precautions are followed in the IPAC program and, at a minimum, shall include point-of-care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary
Progress notes indicated that a resident was placed on isolation due to possible symptoms of COVID-19.

The following day, a personal protective equipment (PPE) caddy was observed hanging on the resident's door; however no additional precautions sign was posted indicating which additional precautions were required.

A PSW stated that the resident was placed in isolation as they were not feeling well the night before and were showing symptoms. They confirmed that there was no sign posted directing staff on which additional precautions were required.

The RHA's registered practical nurse (RPN) stated that they did not have the appropriate signage on the unit and that the IPAC Lead was obtaining it.

Approximately 38 hours later, an additional precautions sign was still not posted on the resident's door which was confirmed by the IPAC Lead. The IPAC Lead stated that it was the unit registered nurse's or RPN's responsibility to ensure the appropriate point-of-care signage was posted.

The home's policy on Precaution Systems stated that for all additional precautions (contact, droplet/contact and airborne) the appropriate signage was to be posted on the resident's door or bed space in a shared room.

Failure to post point-of-care signage indicated which additional precautions were required for the resident may have resulted in staff and/or visitors being unaware of what PPE was required prior to entering the resident's room.

Sources: observations; a resident's clinical records, Precautions Systems (IPC 03-03-01, February 2020) IPAC Standard for Long-Term Care Homes (April 2022); interviews with the IPAC Lead and other staff. [720920]

WRITTEN NOTIFICATION: Reports Regarding Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed when an outbreak of a disease of public health significance occurred in the home, specifically COVID-19 outbreaks.

Rationale and Summary
CI (critical incident) report M536-000044-22 was submitted to the Director and indicated that public health declared a COVID-19 outbreak on November 6, 2022. The report was submitted on November 7, 2022, at 1714 hours.

CI (critical incident) report M536-000045-22 was submitted to the Director and indicated that public health declared a COVID-19 outbreak on December 15, 2022. The report was submitted on December 16, 2022, at 1352 hours.

The IPAC lead confirmed that they were aware that reports were to be submitted via CI system or after-hours line, if necessary.

Failure to submit CI reports within the appropriate timeline may have resulted in the Director being unaware of the outbreaks and taking actions if necessary.

Sources: CI #M536-000044-22 and #M536-000045-22; interview with IPAC Lead. [720920]