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

Original Public Report

Report Issue Date: February 21, 2024
Inspection Number: 2024-1556-0001
Inspection Type: Complaint Critical Incident
Licensee: The Regional Municipality of Halton
Long Term Care Home and City: Allendale, Milton

Lead Inspector	**Inspector Digital Signature**
Barbara Grohmann (720920)	
Additional Inspector(s) Olive Nenzeko (C205)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 24-26, 29-31, 2024 and February 1, 2, 5-8, 2024.

The following intake was inspected during this complaint inspection:

- Intake: #00104657 was related to an injury of unknown cause.

The following intakes were inspected during this Critical Incident (CI) inspection:

- Intake: #00093060, CI M536-000026-23 was related to diabetes management and hyperglycemia,
- Intake: #00096397, CI M536-000035-23 was related to allegations of staff to resident emotional abuse,
- Intake: #00102088, CI M536-000040-23 was related to disease outbreak,
- Intake: #00104396, CI M536-000044-23 was related to disease outbreak,

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- Intake: #00104794, CI M536-000045-23 was related to allegations of physical abuse; and
- Intake: #00106119, CI M536-000003-24 was related to allegations of neglect.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 78 (2) (d)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu;

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Observations in two different resident home areas (RHA) during lunch showed dietary staff making pureed texture with each one appearing to follow a different process. One added thickener to a blender of soup, while the other used whole wheat bread. There also appeared to be inconsistencies with the amount of regular texture soup used to create a portion. A dietary aide stated that they learned the process in training and then went from memory. No written process was found in the servery.

The Nutrition Services Supervisor (NSS) explained that the home's practice was to make pureed soup in RHA servery by adding one slice of whole wheat bread to one four ounce (oz) ladle of regular texture soup to make one portion. The staff would blend the mixture to the desired consistency.

The NSS acknowledge that there maybe a knowledge gap related to making pureed soup and were unsure whether a written copy of the process was still in each servery. They stated that they would ensure the staff were retrained on the process and have access to a copy of the process for making pureed soup.

A follow up observation showed dietary staff following the process for making pureed soup as provided by the NSS.

Sources: observations; 2023 Fall/Winter Therapeutic Menu, Process for Pureed Soup; interviews with the NSS and other staff. [720920]

Date Remedy Implemented: February 7, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes section 10.1 stated that the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

During an initial tour of the home, three bottles of ABHR that expired in 2022, and five bottles with unreadable or no expiry dates were observed in three RHAs.

The IPAC Lead acknowledged that expired ABHR may not have the required 70-90% alcohol content, as the expiry dates of ABHR determines the product's efficacy.

All bottles of expired ABHR and those with unreadable or no expiry dates were removed.

Sources: observations; Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (revised September 2023); interview with the IPAC Lead.
[720920]

Date Remedy Implemented: February 7, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure that a resident received the care consistent with their needs.

Rationale and Summary
A resident's care plan identified that incontinence was a responsive behaviour trigger. The care plan directed staff to assist the resident with toileting each shift and when requested.

A personal support worker (PSW) reported to their supervisor concerns that another PSW redirected a resident, who was seeking assistance, back to their room without providing care or assistance. The PSW overheard the interaction and was concerned that the resident did not receive the needed care when they requested it.

An investigation into the incident determined that the PSW had redirected the resident back to their room without providing care or assistance and did not communicate the resident's needs to the Registered Practical Nurse (RPN) or other PSWs. The Resident Services Supervisor (RSS) stated that the resident had experienced incontinence and was provided care after the incident by a different PSW.

The Senior Nursing Manager (SNM) acknowledged that, as a result of the home's investigation, the PSW received disciplinary action for not meeting the home's expectations regarding providing care and communicating with team members.

Failure to provide a resident care consistent with their needs resulted in agitation and had the potential for those behaviours to escalate.

Sources: resident's clinical records; home's investigation notes; interviews with the SDM, RSS and other staff. [720920]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

A. The licensee has failed to ensure that the care set out in the plan of care was provided for three residents as specified in the plan related to medical directives.

Rationale and Summary
The home's Medical Directives for 2023 specified that residents with a diagnosis of diabetes mellitus were to have their glycated hemoglobin (HbA1c) tested every three months, which reflects average blood glucose levels over a three month period. The home's pharmacy completed Resident Medication Assessments and identified that two residents had not had their HbA1c tested since 2021. A third resident had a five month gap between HbA1c tests.

Email correspondance between the home's medical professionals noted that several residents had not had a recent HbA1c as per the medical directives.

A registered Nurse (RN) explained that when residents with a diagnosis of diabetes mellitus were admitted to the home, the medical directives around HbA1c testing were automatically applied.

Failure to follow the medical directives with regards to testing HbA1c may have resulted in physicians being unaware of a resident's glycemic control.

Sources: residents' clinical records, email correspondance, 2023 Medical Directives, Pharmacy Chart Review; interview with RN #125 and other staff. [720920]

B. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan related to pain management.

Rationale and Summary
A resident was found with an injury from an unknown cause.

The Treatment Administration Record (TAR) showed that the resident was prescribed a pain assessment for the injury. Staff were to ensure the assessment was completed under the assessment tab in Point Click Care (PCC) every shift.

A review of the assessment tab in PCC identified that the pain assessment was not completed under the assessment tab, as required, three times, which was also confirmed by the SNM.

Sources: resident's clinical record, TAR 2023, interview with the SNM. [C205]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 1.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The licensee has failed to comply with the nursing and personal support services program's hyperglycemia policy regarding the referral of a resident to specialized resources where required.

In accordance with Ontario Regulations (O. Reg.) 246/22, s. 11 (1) (b), the licensee is required to ensure that there is a nursing and personal support services program that included the referral of residents to specialized resources where required and must be complied with.

Specifically, staff did not comply with the policy "Hyperglycemia Procedure", dated July 2019 and February 2023, which was included in the licensee's Nursing and Personal Support Services Program.

Rationale and Summary

The home's Hyperglycemia Procedure policy specified that the registered staff were to monitor capillary blood glucose (CBG) values if they were within a specific elevated range and, if the issue was ongoing, refer to the Registered Dietitian (RD).

A resident's CBG was measure daily for five months and was within the elevated range on multiple occasions for several consecutive days. When the CBG monitoring was changed to weekly, the values measured within the elevated range for 28 consecutive weeks.

A review of the dietary referrals during that 12 month time frame, no referral was sent to the RD related to hyperglycemia. The RD explained that they assessed residents every quarter unless they received a dietary referral.

The Professional Practice Lead acknowledged that hypoglycemia was typically monitoring more closely compared with hyperglycemia and that it was a gap they were addressing. The SNM agreed that the registered staff should have sent a referral to the RD related to hyperglycemia when the resident's CBG values were within the elevated range.

Failure to send a referral to the RD regarding hyperglycemia, as per the home's policy, may have delayed determining whether implementing a nutrition intervention to address the resident's ongoing condition would be appropriate.

Sources: resident's clinical records, Hyperglycemia Procedure policy (06-03-11, July 2019 and February 2023); interviews with the SNM and other staff. [720920]

WRITTEN NOTIFICATION: General requirements

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (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.

The licensee has 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 are documented.

Rationale and Summary
An allegation of neglect of a resident was reported to the Director by the Long-term Care Home (LTCH).

A review of the resident's care plan and Point of Care (POC) record indicated that the resident was on a check and change program for toileting, to occur seven time throughout the day and when needed.

The resident's POC record identified check and change documentation was not completed several times, as required, on three separate days.

A PSW acknowledged that they were to document in POC every time they checked and changed the resident. They confirmed that they only documented the "check and change" task once during their shift on two separate days, which was also verified by the SNM.

Sources: resident's clinical record; interview with PSW and SNM. [C205]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (b)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(b) the identification of any risks related to nutritional care and dietary services and hydration;

The licensee has failed to comply with the hydration program through the identification of any risks related to hydration regarding a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that there is a hydration program that included the identification of any risks related to hydration and must be complied with.

Specifically, staff did not comply with the policy "Hydration Program", dated November 2021, which was included in the licensee's Nutrition and Hydration Program.

Rationale and Summary
The Hydration Program specified that when a resident consumed less than their fluid goal, a hydration alert would trigger requiring a dehydration assessment be completed. It also stated that a RN or RPN may initiate a sips task, an intervention to offer fluids frequently throughout the day, at any time the resident was at risk,

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including any disease progress that would be improved with increased fluids.

A review of a resident's fluid intake showed that they did not meet their fluid goal on 17 consecutive days and had intake of less that 1000 millilitres (ml) on four days. During that time, dehydration assessments were completed 10 times; however, a sips task was never initiated. An RPN acknowledged that documented fluid intake may represent the amount provided and not necessarily what was consumed. The RD verified that the registered staff did not initiate a sips task and no dietary referrals regarding fluid intake were received.

When the Nurse Practitioner (NP) was contacted to assess the resident's condition, they ordered the registered staff to start a procedure that provided fluids to a resident whose oral fluid intake was poor. The NP explained that they noted signs/symptoms that may have resulted from reduced fluid intake during their assessment.

The SNM acknowledged that the nursing staff could have started the sips task for the resident even if the assessments did not indicate dehydration and should have sent a referral to the RD.

Failure to follow the hydration program policy and use their clinical judgement to either initiate a sips task intervention or send a dietary referral to the RD may have contributed to the resident's reduce fluid intake and resulting condition.

Sources: resident's clinical records, Hydration Program policy (10-01-01; November 2021); interviews with the SNM, NP and other staff. [720920]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 109 (1)
Additional requirements, s. 26 of the Act
s. 109 (1) A complaint that a licensee is required to immediately forward to the Director under clause 26 (1) (c) of the Act is a complaint that alleges harm or risk of harm, including, but not limited to, physical harm, to one or more residents.

The licensee has failed to ensure that a complaint alleging harm or risk of harm was immediately forwarded to the Director.

Rationale and Summary
A resident began experiencing a change in condition which was not resolving despite several immediate interventions. Two days later, they were transferred to the hospital. The resident's family voiced their concerns to the home, believing the resident's change in condition should have been identified and treated sooner.

In a response to the family's complaint, the home's medical director performed a medical chart review and provided their findings and recommendations to the Administrator and SNM a month later.

The CI was first submitted to the Director five weeks after the family first spoke with the RPN. The Administrator acknowledged that they submitted the CI after their conversation with the Medical Director rather than when the complaint was first brought forth.

Failure to immediately notify the Director of a complaint alleging harm or risk of

harm had the potential for the Director to be unaware of the incident and to take actions as needed.

Sources: resident's clinical records, CI M536-000026-23, Client Services Response Form; interview with the Administrator. [720920]

WRITTEN NOTIFICATION: Records

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record was kept up to date at all time.

Rationale and Summary
A resident experienced a change in condition which resulted in a hospital transfer two days later. The NP came to the home on two consecutive days to assess the resident. They expressed having difficulty finding any documentation from the resident's in-home physician at all, including information regarding the resident's lab values and course of treatment.

A review of the resident's lab report indicate that a specific test resulted in a value above the reference value four consecutive times. During the same time frame, there were no prescriber digiorder sheets authored by the physician which documented or evaluated those lab values and/or the resident's condition related to those tests.

The Senior Nursing Manager acknowledged that if the resident's physician documented, it would only be on the prescriber digiorder sheets, not in the home's electronic medical record keeping system, PCC. A review of PCC progress notes verified that there was no additional documentation from the doctor during that time frame.

Failure to keep the resident's written record up to date resulted in allied health professionals not having all the information needed to make an assessment or understand the resident's course of treatment.

Sources: resident's clinical records; interviews with the SNM, NP and other staff. [720920]