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**
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# Original Public Report

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| **Report Issue Date:** September 10, 2024 |
| **Inspection Number:** 2024-1556-0004 |
| **Inspection Type:**<br>Complaint<br>Critical Incident |
| **Licensee:** The Regional Municipality of Halton |
| **Long Term Care Home and City:** Allendale, Milton |
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## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 7-9, 12-19-23, 2024.

The following intake was completed in this complaint inspection:

- Intake: #00119811 was related to skin and wound care and residents' bill of rights.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake #00118918/CI M536-000036-24 was related to allegations of physical abuse,
- Intake #00119743/CI M536-000038-24 was related to a medical incident,
- Intake #00119838/CI M536-000037-24 and Intake #00122230/CI M536-000042-24 were related to disease outbreaks; and,
- Intake #00119969/CI M536-000040-24 related to allegations of neglect.

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

Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Residents' Rights and Choices
Skin and Wound Prevention and Management

# 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. 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 licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to carry out every standard or protocol issued by the Director with respect to infection prevention and control, the Director's issuance was complied with.

In accordance with the Infection Prevention and Control (IPAC) Standard for long-

term care homes, Standard 10.3, the licensee was required to ensure that hand washing facilities were provisioned with appropriate supplies.

**Rationale and Summary**
During the investigation, a hand soap dispenser was not functional and there was no portable hand soap available at the entrance of a resident home area. This was acknowledged by a personal support worker (PSW).

A few days later, the hand soap dispenser remained non-functional; however, a portable hand soap bottle and hand sanitizer bottle were available at the identified hand washing station.

**Sources**: observations, interview with staff, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022).

**Date Remedy Implemented:** August 20, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
**Non-compliance with: O. Reg. 246/22, s. 272**
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings from the Chief Medical Officer of Health, specified that alcohol based hand rub (ABHR) must not be expired.

During the inspection, a bottle of ABHR with an expiry date of May 2024 was observed in the main entrance, next to the visitor's log. A second bottle with the same expiry date was observed at the reception desk. The IPAC Lead was informed and stated that they would remove the expired bottles and review their inventory. During a follow up observation, the two expired bottles of ABHR were replaced with ones that had expiry dates in 2025.

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

**Sources:** observations; Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (Ministry of Health, April 2024); interview with the IPAC Lead.

**Date Remedy Implemented:** August 8, 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) 25.**
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:
25. Every resident has the right to be provided with care and services based on a palliative care philosophy.

The licensee has failed to ensure that a resident was provided care based on a palliative care philosophy.

**Rationale and Summary**

A resident was discharged from the home six months following their admission and experienced an ongoing decline in their condition. Their meal intake steadily decreased, and meal refusal increased, resulting in a body weight loss of over 10% during their stay.

On admission, a palliative performance scale (PPS) assessment was completed for the resident which scored above 30%; the score that would trigger a palliative care conference. In the assessment, registered staff identified food intake as "normal to reduced". Three subsequent PPS assessments were completed; each continued to identify food intake as "normal to reduced" despite an ongoing decline in intake and weight.

The resident was prescribed multiple medications to treat a medical condition, one in particular was adjusted to a higher dosage several times. As a result the resident experienced two medical incidents.

The resident's substitute decision maker (SDM) inquired about palliative care when a registered nurse (RN) and a registered practical nurse (RPN) had contacted them about the two hypoglycemic events. Neither staff member documented those conversations, started the palliative care process, or initiated another PPS assessment.

A manager of resident care (MRC) stated that the registered staff failed to identify the resident's decline and the need to begin the palliative care process sooner. They also acknowledged that the resident's medical condition was aggressively treated, which likely would not have occurred if the resident was receiving palliative care.

Failure to identify the resident's decline and initiate the palliative care process

sooner may have contributed to the resident's aggressive medical treatment and resulting medical incidents.

**Sources:** resident's clinical records, home's investigation interview notes; interviews with MRC and other staff.

## 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.

The licensee has failed to ensure that the care set out in the plan of care is provided to a resident as specified in the plan, related to treating hypoglycemia.

**Rationale and Summary**
The home's 2024 Medical Directives outline specific treatment for a medical incident. The treatment involved having the resident ingest carbohydrates in the form of sugar or juice. Once the incident was resolved, staff were to give the resident a meal or snack that contained protein as well as carbohydrates to prevent reoccurrence.

When a resident experienced a medical incident, an RPN gave the resident orange juice, water with sugar and two packages of strawberry jam. The RPN acknowledged that they also gave the resident their scheduled dose of a nutritional supplement before they were transferred to hospital; however, the medical incident had not resolved at that time. That nutrition supplement contained both

carbohydrates and protein, and was not listed on the medical directives as a suitable option to provide before the medical incident was resolved.

The MRC acknowledged that when a resident was experiencing a medical incident, the priority was to treat it a per the medical directives and provide food/fluids containing protein once the incident was resolved.

Failure to follow the Medical Directives when treating medical incident may have resulted in a delay in resolving it.

**Sources:** resident's clinical records, Medical Directives 2004, Nestle Health Science Resource 2.0 (https://www.nestlehealthscience.ca/en/brands/resource/resource-2-0-hcp); interviews with MRC and other staff.

## WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 26 (1) (c)**
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward to the Director any written complaint that receives concerning the care of a resident.

**Rationale and Summary**
The Administrator and MRC both received a written complaint by e-mail. A response to the email was sent seven days after the email was received. A CI was submitted to the Ministry of Long-Term Care on the same day of the email response.

The Administrator acknowledged the written e-mail complaint was not sent to the Director immediately.

**Sources:** CI report, email conversation and interview with Administrator.

## WRITTEN NOTIFICATION: Skin and Wound Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

**Rationale and Summary**
A progress notes and dietitian referral indicated a resident had altered skin integrity.

The altered skin integrity was not being monitored upon review of the resident's Electronic Treatment Administration Record (ETAR) and Documentation Survey Report (DSR), and should have been according to the Senior Nursing Manager (SNM).

The Skin and Wound program policy indicated "upon identification of a skin/wound issue, initiate a baseline wound assessment using the 'Nurse Skin and wound Assessment and Designate RN Referral'". Review of records showed there was no nurse skin and wound assessment and designate RN referral form completed upon the identification of the altered skin integrity. This was confirmed by the SNM.

Failure to complete a skin and wound assessment upon identification of a skin/wound issue hindered the timely assessment, treatment, and monitoring, which placed the resident at risk for the progression of wounds.

**Sources**: Electronic Treatment Administration Record (ETAR), Documentation Survey Report (DSR), progress notes, Skin and Wound program policy (last revised January 2020), Skin and wound assessment forms, staff interview.

## WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)**

Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure residents who require continence care products have sufficient changes to remain clean and comfortable.

**Rationale and Summary**
A resident was incontinent and a PSW provided peri care to the resident, which resulted in contaminating the PSW's gloves. During the transfer back to bed, the outside of the resident's brief was inadvertently soiled by the contaminated gloves. The PSW attempted to wipe away the soiled area, but did not provide the resident with a new continence care product. The resident's SDM noticed the soiled brief and informed the PSW, who then changed the resident's continence product with the assistance of another PSW.

The PSW acknowledged that they transferred the resident with a soiled brief. The MRC agreed that the PSW should have provided the resident with a clean continence care product prior to transferring the resident to bed.

Failure to provide a resident with a clean continence care product could have posed a health risk for infection.

**Sources:** Continence Care Policy (revised March 2018), investigation notes, and interview with PSW and MRC.

## WRITTEN NOTIFICATION: Responsive Behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)**
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that for each resident with responsive behaviours, strategies are implemented to respond to these behaviours.

**Rationale and Summary**
Two PSWs entered the resident's room to provide care. The resident began exhibiting signs of responsive behaviours. both PSWs. The resident's plan of care indicated that with any such behaviour staff are to stop, step away, and not to stand within reach of the resident. The two PSWs did not stop while providing care to the resident.

The home's responsive behaviour policy indicated that PSW's are to adhere to the interventions outlined in the plan of care.

The SNM acknowledged that both PSWs did not follow the intervention in the resident's plan of care.

Failure to ensure the strategies are implemented to respond to a resident's responsive behaviour led to a safety risk for staff and resident.

**Sources:** Investigation Notes, Responsive Behaviour Policy (revised April 2018), resident's plan of care and interview with SNM.

## WRITTEN NOTIFICATION: Responsive Behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)**
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that, for a resident, who demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including implementation of interventions and that the resident's responses to interventions were documented.

**Rationale and Summary**
A resident had multiple medications prescribed to control their behaviors, including an as needed (PRN) injection. An RN administered that injection on two separate occasions and documented it as being effective with no signs of pain or discomfort noted.

On a specific day, the resident experienced multiple responsive behaviors, resulting in several staff needing to assist with care. Interventions that were implemented were all noted to be ineffective.

Responsive behaviours were also noted on several others days where the indicated medications were provided and ineffective, but the PRN injection was not

administered.

The RPN stated that the injection was not administered, alleging the resident's behaviours escalated upon observing the injection, a potential risk of injury and that the dosing was insufficient to be effective. This was not found in any documentation during the inspection.

The SNM reported they were not aware that the PRN injection was not provided due to the reasons stated above, and that it should have been administered if the other interventions were ineffective.

Failure to administer the PRN injection when needed for the resident could have resulted in responsive behaviors escalating and harm to resident and/or staff.

**Sources**: Interviews with staff, resident's clinical records.

## WRITTEN NOTIFICATION: Nutrition Care and Hydration Programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 75 1.**
Weight changes
s. 75. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.

The licensee has failed to ensure that when a resident experienced a weight change of five per cent (%) of body weight, or more, over one month, the resident was assessed using an interdisciplinary approach with actions taken and outcomes

evaluated.

In accordance with Ontario Regulations (O. Reg.) 246/22 section (s.) 11 (1) (b), the licensee is required to ensure that residents with specific weight changes are assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated, and must be complied with.

Specifically, staff did not comply with the policy "Resident Weight and Height Monitoring Procedure", which was included in the licensee's Nutrition and Hydration Program.

**Rationale and Summary**
A resident experienced a decrease in their body weight of over 5% in one month following their admission.

The home's Resident Weight and Height Monitoring Procedure specified that registered staff were to send a referral to the registered dietitian (RD) in PCC if a weight change was unplanned and unexpected. A review of dietary referrals in point click care (PCC) indicated that one was created during that time; however, it was related to altered skin integrity, not because of the weight change.

The RD explained that the resident was deemed high nutrition risk and would therefore be assessed on a quarterly basis, unless they received a referral from the registered staff. The RD acknowledged responding to a referral related to altered skin integrity but was unaware that the resident had experienced a weight change of over 5% in one month. They stated that they do not calculate the per cent weight change for a resident, relying on significant weight change triggers generated by PCC.

In a five month period, the resident had a 5%, or more, weight loss in one month and twice had a 7.5%, or more, weight loss over three months; no dietary referrals were sent related to weight changes during that time frame.

Failure to identify and refer to the RD a resident's weight change had the potential for weight loss going unnoticed and contributing to his declining condition.

**Sources:** resident's clinical records, Resident Weight and Height Monitoring Procedure (10-01-08, December 2023); and interview with the RD.

## WRITTEN NOTIFICATION: Infection Prevention and Control

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**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 licensee failed to ensure that the IPAC Standard for Long-Term Care Homes, dated April 2022, was implemented.

**Rationale and Summary**
The IPAC standard for Long-Term Care Homes, indicated under section 9.1 that Routine Precautions were to be followed in the IPAC program which included (d) proper use of PPE including appropriate selection, application removal and disposal.

A PSW changed a resident's continence care product, contaminating their gloves in the process. They applied a new continence care product to the resident without

changing their gloves.

The home's Personal Protective Equipment (PPE) policy indicated that staff are to change or remove gloves after touching a contaminated site and before touching a clean site or the environment.

The PSW acknowledged that they did not change their gloves when putting on a clean continence product for the resident. The IPAC lead acknowledged that the PSW should have removed their gloves, washed their hands, and applied a fresh pair of gloves prior to attending to the resident.

Failure to apply new PPE posed a risk of infection to the resident.

**Sources:** Investigation Notes, PPE Policy (revised February 2024), interview with PSW staff and IPAC lead.

## WRITTEN NOTIFICATION: Records

NC #012 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 times.

**Rationale and Summary**
**A.** A nurse practitioner ordered a specimen be collected from a resident for testing.

An RPN explained that the lab report usually came back in two to four days. If delayed, the home area RPN and/or charge RN were responsible for following up with the lab to obtain the results. A corresponding lab report for the collected specimen was not located in the resident's chart which the MRC confirmed.

**B.** An RPN and RN each contacted the resident's SDM to inform them of hypoglycemic events. During both phone calls, the SDM inquired about palliative care. The RPN and RN both acknowledged that they did not document their conversations with the resident's SDM in PCC. The RPN also stated that they forgot to complete a PPS assessment after the conversation.

The MRC acknowledged that the registered staff did not document in PPC the resident's SDM inquiry regarding palliation.

Failure to keep a resident's written record up to date at all times had the potential to impede communication with the interdisciplinary team.

**Sources:** resident's clinical records, home's investigation notes; interviews with MRC and other staff.