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

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Public Report

Report Issue Date: December 31, 2024

Inspection Number: 2024-1556-0006

Inspection Type:
Complaint
Critical Incident

Licensee: The Regional Municipality of Halton

Long Term Care Home and City: Allendale, Milton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 5, 6, 9, 10, 11, 13, 16, 17, 19, 2024.

The following intake(s) were inspected:

- Intake: #00121693, Critical Incident (CI) M536-000041-24 - related to prevention of abuse and neglect.
- Intake: #00123408, CI M536-000043-24 - related to prevention of abuse and neglect.
- Intake: #00125949, CI M536-000046-24 - related to falls prevention and management.
- Intake: #00126396 - Complaint related to concerns regarding prevention of abuse and neglect.
- Intake: #00126863, CI M536-000049-24 - related to prevention of abuse and neglect.
- Intake: #00129684, CI M536-000056-24 - related to falls prevention and management.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's falls prevention plan of care was revised when the resident's care needs changed and care set out in the plan was no longer necessary.

Rationale and Summary
A critical incident report (CI) was submitted to the Director for a fall of a resident which resulted in injury and transfer to the hospital.
Resident's clinical records indicated that the resident's fall risk was high and an intervention was used to prevent fall injury. During an observation the resident did not have the intervention in place. Interview with a staff confirmed that this intervention has been removed from the Tasks in point of care (POC) but care plan

was not updated. The resident's care needs changed and they no longer required the intervention.

Failure to revise resident's plan of care related to falls prevention interventions when the intervention in the plan of care was no longer necessary, there was a risk that care would not be provided according to the resident's needs and preferences.

Sources: CI, clinical records for the resident, interviews with staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
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,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident exhibiting altered skin integrity received at least a weekly skin assessment.

Rationale and Summary
A resident had altered skin integrity and a review of the weekly skin assessments documented within progress notes on point click care (PCC) indicated that the weekly skin assessment was not conducted for an identified time period.
A staff acknowledged that a weekly skin assessment should have been completed anytime during the identified time period for this resident.

Failure to ensure that a resident exhibiting altered skin integrity was at least assessed weekly may place the resident at risk of not receiving appropriate skin and wound care.

Sources: Resident's records, interview with staff.