

**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
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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 10, 2019	2019_803748_0012	013109-19, 013110- 19, 021164-19	Complaint

Licensee/Titulaire de permisThe 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**

EMMY HARTMANN (748)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 25, 28, 29, December 3 and 4, 2019.

This Complaint inspection was completed concurrently with a Follow-Up inspection.

The following intakes were completed in this Complaint Inspection:

Log #021164-19, was related to a complaint regarding improper care of resident #001.

Log #013110-19, was related to a follow-up to compliance order #001 from inspection #2019_560632_0011, regarding s. 19. (1), with a compliance due date of September 20, 2019.

Log #013109-19, was related to a follow-up inspection to compliO#002 from inspection #2019_560632_0011, regarding s. 6. (7), with a compliance due date of September 20, 2019.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Senior Nursing Manager, Manager of Resident Care, Administration Assistant, registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, and policies.

The following Inspection Protocols were used during this inspection:

**Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours**

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

**4 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_560632_0011	748
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2019_560632_0011	748

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with s. 8 (1) a, the licensee was required to ensure that there was an organized program of nursing services for the home to meet the assessed needs of the residents. Specifically, staff did not comply with the licensee's "Transfer to Hospital Policy, procedure #06-01-09", last reviewed June 10, 2019, which is part of the licensee's Nursing and Personal Support Program.

Log #021164-19, was related to a complaint regarding improper care of resident #001.

A review of resident #001's records identified that they had a plan of treatment form that was signed by the resident to attempt Cardiopulmonary Resuscitation (CPR). The form identified that CPR would include chest compressions and defibrillation, 911 would be called and more advanced procedures may be undertaken if determined.

A review of resident #001's progress notes documented on an identified date, indicated that the resident had a change in condition, and that the doctor was notified and had informed the nurse that they would come in to assess the resident.

Progress notes documented on an identified date and time, by RN #112, indicated that the doctor had come in to assess the resident and that according to the doctor, the resident had symptoms of a medical condition.

Progress Notes documented on an identified date and time, by RN #113, indicated that

the resident had symptoms of a medical condition. The note identified that RN #113, reviewed the resident's plan of treatment, and called the doctor on-call, who then asked for the resident to be transferred to hospital due to the medical condition.

The home's "Transfer to Hospital Policy, procedure #06-01-09", identified that the registered staff on each shift will "with the exception of emergency cases, obtain a physician order to transfer resident to hospital from the attending physician or the physician on-call".

During an interview with the Senior Nursing Manager (SNM), it was identified that the home considered the change in condition, in resident #001, to be an emergency case. The SNM identified that when they spoke with RN #112, the RN was aware of the symptoms of the medical condition and had suspected that the resident had the medical condition. The SNM identified that the resident's plan of treatment included being sent to the hospital by the nurse, without calling the doctor.

The home failed to ensure that where the Act or Regulation required the licensee to have, institute, or otherwise, put in place any policy, that the policy was complied with. [s. 8. (1) (b)]

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 where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 81. Every licensee of a long-term care home shall ensure that no medical directive or order is used with respect to a resident unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 81.

Findings/Faits saillants :

1. The licensee failed to ensure that no medical directive or order was used with respect to a resident unless it was individualized to the resident's condition and needs.

During a review of resident #004, resident #005, and resident #006's plan of care in relation to a treatment, the inspector had identified that the home did not have a medical directive that was individualized to the resident's condition and needs.

During an interview with RPN #109, they showed the inspector the home's Medical Directive document that was used. The Medical Directives listed various medical conditions, which included but was not limited to, low blood sugar, nausea or vomiting, chest pain, and scabies treatment. The directives also included contraindications for each condition. RPN #109 identified that the physicians in the home would write the order that a resident may use the home's medical directives and that this was usually done on admission. The physicians would then renew this order on a quarterly basis, but they would not review the content of the medical directives including the different contraindications, as it applied to each resident. RPN #109 indicated that it was the nurses that would determine, at the time of medication or treatment administration, if a medical directive could be used.

During an interview with the Senior Nursing Manager, they confirmed that the medical directives being used in the home were not individualized to the resident's condition and needs, by the physicians.

The home failed to ensure that no medical directive was used with respect to a resident unless it was individualized to the resident's condition and needs. [s. 81.]

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 no medical directive is used with respect to a resident unless it is individualized to the resident's condition and needs, to be implemented voluntarily.

**WN #3: 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. (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,**
- (a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
 - (b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
 - (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

Findings/Faits saillants :

1. A review of resident #002's records identified that they had a cognitive impairment.

A review of resident #002's care plan identified that they had a history of interaction with resident #003, and that an external consultant's recommendation included a change in the resident's environmental location. The care plan indicated that resident #002's family member had declined this recommendation, and other interventions were implemented, which included redirection and close monitoring of resident #002 and resident #003.

A review of resident #002's progress notes documented on an identified date and time, indicated that a meeting was held with resident #002's family member, where the family member had informed the team that they were open to transferring resident #002 to another location when the opportunity became available.

Progress notes documented on an identified date and time, indicated that resident #002 was transferred to another location.

Interview with RPN #110, identified that resident #002's care plan was not updated when the resident moved locations, and that the resident no longer needed the interventions listed in their care plan.

Interview with the Senior Nursing Manager identified that it was the home's expectation that resident #002's care plan was updated when the resident's care needs changed or when the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. Log #021164-19, was related to a complaint submitted to the MOLTC by the licensee related to a complaint by a family member regarding improper care of resident #001.

The letter was addressed to the Administrator and the Senior Nursing Manager, and identified that a meeting was held to discuss resident #001's quality of life, following hospitalization related to resident #001 suffering from a medical condition.

A review of the home's investigation notes related to the complaint, identified that there had been several meetings with the family member related to the resident's change in condition. The letter identified the family member's reason for requesting the meeting with the team, was to discuss the events that led to resident #001's current quality of life. The letter indicated that resident #001's current condition was a result of delay in sending the resident to the hospital, when they initially presented with a medical condition, and further outlined a request by the family member for the home to provide resident with a specific treatment. It was identified that a response to the family member was not in the investigation package.

During an interview with the Administrator, they indicated that the home met with the family member, on an identified date, and that the letter was provided to the home, after the issues were discussed in the meeting. They identified that the family member was provided a response but that it was not in writing, and they could not find any documentation of it.

The home failed to ensure that a response was provided to the complainant which included what the licensee has done to resolve the complaint. [s. 101. (1) 1.]

Issued on this 8th day of January, 2020

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

Original report signed by the inspector.