

**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
Inspection de soins de longue durée**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de
Hamilton
119, rue King Ouest 11^{ième} étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Oct 6, 2020	2020_560632_0011	002911-20, 003476- 20, 006809-20, 017053-20	Critical Incident System

Licensee/Titulaire de permis

The 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

YULIYA FEDOTOVA (632), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 9, 10, 14, 16, 18, 22, 23, 2020.

This inspection was completed concurrently with complaint inspection #2020_560632_0012.

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

Log #002911-20 was related to falls prevention,

Log #003476-20 was related to prevention of abuse and neglect, falls prevention, skin and wound care, nutrition and hydration,

Log #006809-20 and Log #017053-20 were related to falls prevention, skin and wound care.

NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, s. 6. (7) were identified during this inspection (Log #003476-20, Log #006809-20 and Log #017053-20) and issued in a concurrent complaint inspection #2020_560632_0012's report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Senior Nursing Manager, Manager of Resident Care (MORC) #1, MORC #2, MORC #3, Minimum Data Set (MDS) - Residents Assessment Instrument (RAI) Co-ordinator, Clinical Resource Nurse, Physiotherapist, Behavior Support Ontario (BSO) Registered Practical Nurse (RPN), Occupational Therapist, Nutrition Service Supervisor, Life Enrichment Supervisor, Life Enrichment Therapist, Registered Nurses (RNs), Personal Support Workers (PSWs), Resident Care Clerk #1 and Resident Care Clerk #2.

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

**Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care**

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

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

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. 17. Communication and response system

Specifically failed to comply with the following:

- s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
- (a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
 - (b) is on at all times; O. Reg. 79/10, s. 17 (1).**
 - (c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
 - (d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
 - (e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
 - (f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
 - (g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, (b) was on at all times.

During the inspection, it was observed that an assistive device was unplugged from the wall, while the resident was in their bed.

During the inspection, the RPN confirmed the assistive device was not on, which was acknowledged by the Manager of Resident Care.

Without the assistive device being on, the resident was put at increased risk of falls.

Sources:

Care Plan, interviews with RPN #122 and the Manager of Resident Care #1. [s. 17. (1)]

Issued on this 19th day of October, 2020

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

Original report signed by the inspector.