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

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119 King Street West 11th Floor
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 22, 2021	2020_555506_0032	021365-20, 022109-20, 022116-20, 001077-21	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

LESLEY EDWARDS (506), JESSICA PALADINO (586)

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): November 11, 12 and 13, 2020 and March 3, 4, 5, 8 and 10, 2021.

This inspection was completed with registered nursing student Olive Mameza Nenzeko in attendance on March 3, 4 and 5, 2021.

The following intakes were completed:

Log # 021365-20, Critical Incident System (CIS) #M536-000028-20 related to medication management;
Log # 022109-20, CIS #M536-000030-20 related to falls prevention and management;
Log # 022116-20, CIS #M536-000029-20 related to falls prevention and management; and,
Log # 001077-21, CIS #M536-000004-21 related to hospitalization and change in condition

During the course of the inspection, the inspector(s) spoke with the Administrator, Senior Nursing Manager, Managers of Resident Care (MORCs), Clinical Resource Nurse, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and families.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed the provision of care, reviewed resident health records, observed a medication pass, internal investigation notes, employee records, conducted staff interviews and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation

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

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs
Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A review of a CIS submitted to the Director identified that a resident was administered an intervention and further assessment was required.

Through an internal investigation it was determined that a medication error had occurred.

Specifically, the resident had a physician's order to administer a specified medication daily and to adjust the dose of the medication accordingly.

A review of the medication incident report (MIRS) and the medication administration record on a specified date in 2020 identified that the resident was given the incorrect dose of the specified medication for several days.

The incorrect administration could have resulted in the resident experiencing a severe change in condition.

Sources: CI Report, resident's clinical record including medication records, medication incident and interview MORC #102 and staff. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 :

The licensee has failed to ensure the Medication Incident Reporting policy and procedure was complied with.

In accordance with O. Reg. 79/10, s. 114. (2) the licensee was required to ensure that written policies and procedures were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the home's policy and procedure for "Medication Incident Reporting", dated August 2018.

A medication error was made on an identified date in 2020, by an RPN, which resulted in the resident receiving the wrong dose of an identified medication for several days. The error was then discovered by another RPN four days later. The RPN confirmed in an interview that they reported the incident to the nurse in charge but did not complete a medication incident report, document the incident in the resident's clinical record, notify the physician, family or senior management at the time when the incident was discovered as per the MIRS policy.

By not following the home's MIRS policy staff put the resident at risk as the appropriate disciplines were not able to assess the resident after the medication error and determine if there was a negative outcome from not receiving their medication as prescribed.

Sources: CI Report, resident's clinical record including medication records, medication incident and interview with RPN and MORC #102 and the home’s policy for “Medication Incident Reporting” (August 2018).

2. The licensee has failed to ensure that the identified policy and procedure was complied with.

In accordance with O. Reg. 79/10, s. 114. (2) the licensee was required to ensure that written policies and procedures were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A medication incident and adverse event occurred for a resident on a specified date in 2020, where they were administered an intervention and required further assessment.

A review of the policy identified that when a resident had an incident or change in condition from a medication error or the use of an intervention, the registered staff will document the error as a medication incident in MIRS.

A. It was identified during a review of the resident's clinical record that the resident sustained a reaction on two specified dates in 2020 and MIRS were not completed on either of these dates.

The risk for the policy not being followed was not all of the appropriate disciplines were notified allowing for further assessment and follow-up.

Sources: CI Report, resident's clinical record including medication records interview with RPN and MORC and the home’s policy.

B. Review of the policy also identified that standardized treatments would be initiated when readings drop below a certain level and to notify the physician if readings after 30 minutes are still below a certain level and referring to the Registered Dietitian (RD).

i. A review of resident #002's clinical record confirmed on several dates in 2020, the resident's identified readings were below a specific range.

On specified dates in 2020, three RPNs confirmed that they did not follow the home's policy and complete all the required interventions that were required when the resident's

readings were below a specific range.

MORC confirmed that staff did not follow the home's policy for management of the identified diagnosis on the above noted dates by not providing the proper treatments.

By not following the home's policy for management of the identified condition, this could put residents at risk by not receiving the required treatments nor assessments by the physician or RD, as they were not notified.

Sources: CI Report, resident #002’s clinical record including medication records, interview with MORC #102 and staff and the home’s policy.

ii. A review of resident #007's clinical record confirmed that on several specified dates in 2021, the resident's readings were below a specific level.

MORC #109 confirmed that staff did not follow the home's policy for management of the identified condition on the above noted dates by not providing the proper treatments.

By not following the home's policy for management of the identified condition, this could put residents at risk by not receiving the required treatments nor assessments by the physician or RD, as they were not notified.

Sources: resident #007’s clinical record including medication records, interview with MORC #109 and staff and the home’s policy. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

Issued on this 26th day of March, 2021

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

Original report signed by the inspector.

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LESLEY EDWARDS (506), JESSICA PALADINO (586)
Inspection No. / No de l'inspection :	2020_555506_0032
Log No. / No de registre :	021365-20, 022109-20, 022116-20, 001077-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 22, 2021
Licensee / Titulaire de permis :	The Regional Municipality of Halton 1151 Bronte Road, Oakville, ON, L6M-3L1
LTC Home / Foyer de SLD :	Allendale 185 Ontario Street South, Milton, ON, L9T-2M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sean Weylie

To The Regional Municipality of Halton, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with s. 131. (2) of O. Reg. 79/10.

Specifically, the licensee must:

Ensure that any resident on a high risk medication is administered their medication in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A review of a CIS submitted to the Director identified that a resident was administered an intervention and further assessment was required.

Through an internal investigation it was determined that a medication error had occurred.

Specifically, the resident had a physician's order to administer a specified medication daily and to adjust the dose of the medication accordingly.

A review of the medication incident report (MIRS) and the medication administration record on a specified date in 2020 identified that the resident was given the incorrect dose of the specified medication for several days.

The incorrect administration could have resulted in the resident experiencing a severe change in condition.

Sources: CI Report, resident's clinical record including medication records, medication incident and interview MORC #102 and staff.

An order was made by taking the following factors into account:

Severity: The resident receiving the wrong dose of their specified medication for several days put them at actual risk by not receiving medications as specified by the prescriber.

Scope: One out of three residents were reviewed as part of the inspection to determine scope of NC.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 131 (2) and two Voluntary Plans of Correction (VPC) were issued to the home.
(506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 05, 2021

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8. (1) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that all staff who discover a medication error complete a medication incident report at the time the medication error was discovered.

2. Ensure that when a resident experiences a change in condition related to a specific medical diagnosis or requires the use of a specific medication, the registered staff will complete a medication incident report as per the home's policy.

3. Ensure that staff follow the home's policy and procedure if resident #007's readings drops below a certain level, including initiating their standardized treatments and documenting these interventions and treatments.

4. Training is to be provided to all registered staff on their roles and responsibilities for when a medication error occurs or when a resident experiences a change in condition related to a specific medical diagnosis or requires the use of a specific medication. The licensee is to retain documented evidence of the specific content of training provided as well as attendance records of staff participating in the training.

5. Training is to be provided to all registered staff on their roles and responsibilities for when a resident's reading drops below a certain level, including initiating their standardized treatments and documenting these interventions and treatments. The licensee is to retain documented evidence of the specific content of training provided as well as attendance records of staff participating in the training.

6. Develop and implement an auditing process and schedule to regularly audit residents who receive a specific medication and if their readings drop below a certain level, that the home's policy is followed. The licensee is to maintain a copy of the audit tools used and audit results.

Grounds / Motifs :

1. The licensee has failed to ensure the Medication Incident Reporting policy

and procedure was complied with.

In accordance with O. Reg. 79/10, s. 114. (2) the licensee was required to ensure that written policies and procedures were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the home's policy and procedure for "Medication Incident Reporting", dated August 2018.

A medication error was made on an identified date in 2020, by an RPN, which resulted in the resident receiving the wrong dose of an identified medication for several days. The error was then discovered by another RPN four days later. The RPN confirmed in an interview that they reported the incident to the nurse in charge but did not complete a medication incident report, document the incident in the resident's clinical record, notify the physician, family or senior management at the time when the incident was discovered as per the MIRS policy.

By not following the home's MIRS policy staff put the resident at risk as the appropriate disciplines were not able to assess the resident after the medication error and determine if there was a negative outcome from not receiving their medication as prescribed.

Sources: CI Report, resident's clinical record including medication records, medication incident and interview with RPN and MORC #102 and the home's policy for "Medication Incident Reporting" (August 2018).

2. The licensee has failed to ensure that the identified policy and procedure was complied with.

In accordance with O. Reg. 79/10, s. 114. (2) the licensee was required to ensure that written policies and procedures were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A medication incident and adverse event occurred for a resident on a specified date in 2020, where they were administered an intervention and required further assessment.

A review of the policy identified that when a resident had an incident or change in condition from a medication error or the use of an intervention, the registered staff will document the error as a medication incident in MIRS.

A. It was identified during a review of the resident's clinical record that the resident sustained a reaction on two specified dates in 2020 and MIRS were not completed on either of these dates.

The risk for the policy not being followed was not all of the appropriate disciplines were notified allowing for further assessment and follow-up.

Sources: CI Report, resident's clinical record including medication records interview with RPN and MORC and the home's policy.

B. Review of the policy also identified that standardized treatments would be initiated when readings drop below a certain level and to notify the physician if readings after 30 minutes are still below a certain level and referring to the Registered Dietitian (RD).

i. A review of resident #002's clinical record confirmed on several dates in 2020, resident's identified readings were below a specific range.

On specified dates in 2020, three RPNs confirmed that they did not follow the home's policy and complete all the required interventions that were required when the resident's reading were below a specific range.

MORC confirmed that staff did not follow the home's policy for management of the identified diagnosis on the above noted dates by not providing the proper treatments.

By not following the home's policy for management of the identified condition, this could put residents at risk by not receiving the required treatments nor

assessments by the physician or RD, as they were not notified.

Sources: CI Report, resident #002's clinical record including medication records, interview with MORC #102 and staff and the home's policy.

ii. A review of resident #007's clinical record confirmed that on several specified dates in 2021, the resident's readings were below a specific level.

MORC #109 confirmed that staff did not follow the home's policy for management of the identified condition on the above noted dates by not providing the proper treatments.

By not following the home's policy for management of the identified condition, this could put residents at risk by not receiving the required treatments nor assessments by the physician or RD, as they were not notified.

Sources: resident #007's clinical record including medication records, interview with MORC #109 and staff and the home's policy. [s. 8. (1) (b)]

Severity: Staff not following the home's policies and procedures around completing medication incident reports posed a potential risk of harm as the resident was not assessed for potential negative outcome. Not following the home's policy for management of a condition posed a potential risk of harm as the resident was not treated according to the home's policy.

Scope: the MIRS policy was not followed for one out of three residents and two out of three residents were reviewed for management of a condition as part of the inspection to determine scope of NC.

Compliance History:

This subsection was issued as a VPC on December 10, 2019, during inspection #2019_803748_0012 and VPC on June 18, 2019, during inspection #2019_543561_0008, and a CO on November 15, 2018, during inspection 2018_543561_0014 were issued to the home in the past 36 months. (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 25, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) Commission d'appel et de revision des services de santé 151, rue Bloor Ouest, 9e étage Toronto ON M5S 1S4	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of March, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lesley Edwards

Service Area Office /
Bureau régional de services : Hamilton Service Area Office