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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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: March 27, 2023

Inspection Number: 2023-1556-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: The Regional Municipality of Halton

Long Term Care Home and City: Allendale, Milton

Lead Inspector	**Inspector Digital Signature**
Emmy Hartmann (748)	EmmyLou Hartmann Digitally signed by EmmyLou Hartmann Date: 2023.03.28 14:04:02 -04'00'

Additional Inspector(s)
Waseema Khan (741104)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s), February 27-28, March 1-3, 6-9, 2023.

The following intakes were inspected:

- Intake: #00020903, related to Resident Care and Support Services.
- Intake: #00019071, related to Staffing.
- Intake: #00006886, related to Resident Care and Support Services.
- Intake: #00003177, related to Prevention of Abuse and Neglect.
- Intake: #00018494, related to Prevention of Abuse and Neglect.
- Intake: #00019271, related to Falls Prevention and Management.

The following intakes were completed during the inspection:

- Intake: #00005804, related to Falls Prevention and Management.
- Intake: #00001478, related to Falls Prevention and Management.
- Intake: #00002458, related to Falls Prevention and Management.
- Intake: #00005167, related to Falls Prevention and Management.
- Intake: #00012855, related to Falls Prevention and Management.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls 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)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement any standard issued by the Director with respect to infection prevention and control (IPAC). Specifically, the IPAC Standard related to additional requirements for additional precautions.

The IPAC Standard stated that the licensee shall ensure that additional precautions were followed in the IPAC program. At minimum, additional precautions shall include Personal Protective Equipment (PPE) requirements including appropriate selection application, removal and disposal.

On an identified date and time, the inspector observed that a resident's room was on additional precautions. All required PPE was at the entrance of the door, except for surgical masks. An RPN identified that the resident was placed on additional precautions as they had symptoms and was awaiting results of a diagnostic test.

A PSW identified that they doffed PPE upon exit out of the room, which included the n95 mask worn in the room. After doffing, a new surgical mask would be applied. The PSW verified that there was no surgical mask available at the entrance to apply after doffing the n95 mask.

The Supervisor of Resident Services acknowledged that there should have been a box of surgical masks available at point of care.

On the same date, it was observed that a box of surgical masks was available.

Sources: Observation; IPAC Standard, April 2022; interview with PSW, RPN, and Supervisor of Resident Services.

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