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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: December 31, 2024

Inspection Number: 2024-1556-0005

Inspection Type:
Proactive Compliance Inspection

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): November 20-22, 25-29, 2024 and December 2-5, 2024.

The following intake(s) were inspected:

- Intake: #00129747 - Proactive Compliance Inspection (PCI) for Allendale.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement
Residents' Rights and Choices

Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to respond

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 63 (3)

Powers of Residents' Council

s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to respond to the Resident Council in writing within 10 days of receiving the advice.

Rationale and Summary

The meeting minutes from the Resident Council meetings from the last 12 months identified that the licensee did not respond to the council within 10 days of receiving the advice or concerns. This was acknowledged by the Assistant to the Resident Council.

Sources: Review of the Resident Council meeting minutes; interview with the resident council member and the Assistant to Resident Council.

WRITTEN NOTIFICATION: Duty to respond

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 66 (3)

Powers of Family Council

s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall,

within 10 days of receiving the advice, respond to the Family Council in writing.

The licensee has failed to respond to the Family Council in writing within 10 days of receiving the advice.

Rationale and Summary
The meeting minutes from the Family Council meetings from the last 12 months identified that the licensee did not respond to the council within 10 days of receiving the advice or concerns. This was acknowledged by the Administrator.

Sources: Review of the Family Council meeting minutes; interview with the Family Council Chair and the Administrator.

WRITTEN NOTIFICATION: Air temperature

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (5)
Air temperature
s. 24 (5) The licensee shall keep a record of the measurements documented under subsections (2), (3) and (4) for at least one year.

The licensee has failed to keep a documented record of the temperature measurements for at least one year.

Rationale and Summary
The home was not able to retrieve the temperature logs for the current year except May to September. During the audio recorded interview with Administrator, they confirmed that the home has an automated system to record temperatures throughout the home but they don't have an option to retrieve the report of the recorded temperatures for the last year. They confirmed that the home failed to keep the documented record of the temperature measurements for at least one

year except May to September .

There was a risk that home was not able to keep a record of temperature measurements for at least one year for the comfort and well being of the residents.

Sources: Temperature logs, Interview with Administrator.

WRITTEN NOTIFICATION: General requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that the Annual Program evaluation of the Pain Management Program for 2023 had a written record of summary of the changes made and the date that those changes were implemented.

Rationale and Summary
The written record of the Annual Program evaluation of the Pain Management Program did not contain the summary of changes made and the dates that those changes were implemented. The Administrator confirmed that these changes were implemented but the date of implementation was not captured in the annual written evaluation.

Sources: Review of the Annual Program evaluation for Pain Management ; interview with the Administrator.

WRITTEN NOTIFICATION: General requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that the Annual Program evaluation of the Skin and Wound Care Program for 2023 had a written record of summary of the changes made and the date that those changes were implemented.

Rationale and Summary
The written record of the Annual Program evaluation of the Skin and Wound Care Program did not contain the summary of changes made and the dates that those changes were implemented. The Administrator confirmed that these changes were implemented but the date of implementation was not captured in the annual written evaluation.

Sources: Review of the Annual Program evaluation for Skin and Wound Care Program ; interview with the Administrator.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 35 (4)

Nursing and personal support services

s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that the evaluation of the staffing plan for 2023 had a written record of summary of the changes made and the date that those changes were implemented.

Rationale and Summary

The written record of the annual evaluation of the staffing plan for 2023 did not contain the summary of changes made and the dates that those changes were implemented. The Administrator stated that in 2023 they had made actions related to increase in complements; however, this was not captured in the written evaluation.

Sources: Review of the staffing plan evaluation for 2023; interview with the Administrator.

WRITTEN NOTIFICATION: Skin and wound care

NC #007 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 resident's skin alteration was reassessed at least weekly.

Rationale and Summary
The resident had an altered skin integrity. Review of the Skin and Wound Evaluation for the resident in Point Click Care (PCC) showed documentation of an initial wound assessment. Subsequent reassessments were documented. 13 Reassessments were not documented within the Skin and Wound Evaluation.

An interview completed with Registered staff indicated that the Skin and Wound Evaluation were to be completed weekly and weekly wound assessments were not completed. In an interview with Skin and Wound Care Lead also confirmed that weekly wound assessments should be completed weekly and they were not completed.

Not completing the Skin and Wound Evaluation reassessment posed a moderate risk to the resident by not monitoring the healing pattern. The impact on the resident is low.

Sources: Resident's clinical records, interview with Registered staff and Skin and Wound Care Lead.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program

s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to comply with the standard issued by the Director with respect to infection prevention and control.

The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, section 9.1 (b) states that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program related to hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary
During a lunch meal service, Inspector observed the following:

-One personal support worker (PSW) was assisting a resident with eating, walked to a different table to reposition another resident, returned to the original resident and continued to assist with feeding. PSW did not perform hand hygiene (HH).
-Another PSW was assisting a resident with feeding. A resident sitting on a different table spilled a drink. While other PSW was cleaning the spilled drink, PSW grabbed the empty cup and brought it to the servery area, placed it on a cart and returned to feed the resident they were initially assisting. No HH was performed.
-PSW was assisting with feeding a resident, went to cut up food on a different resident's plate, and then they returned to assist the initial resident with eating. No HH was performed.

The Senior Nursing Manager (SNM) confirmed that it was an expectation that staff perform hand hygiene between assisting residents and performing a different

activity.

Failing to perform hand hygiene between resident and environment contact increases the risk for the spread of infections.

Sources: Observation of lunch meal service, review of "Hand Hygiene Policy" (February 2024); interview with SNM.

WRITTEN NOTIFICATION: Medication Management System

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are 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) The licensee has failed to comply with the procedure related to removal of narcotics awaiting destruction from the medication cart.
In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that the medication management system, had in place policies and procedures to ensure the accurate destruction and disposal of all drugs in the home.

Specifically, staff did not comply with the policy "Narcotics/Controlled/Monitored Drugs" (July 2019), which identified that narcotics and controlled substances that are awaiting destruction were to be stored in a separate double locked stationary cupboard in a locked medication room. The nurse who processed an order to discontinue a monitored medication was responsible for removing the medication(s) along with the count sheet(s) from the medication cart and narcotic bin.

Rationale and Summary

On an identified date and time, it was identified that narcotics awaiting destruction were kept inside the medication cart in the narcotic bin along with medications available for administration to residents. The medications belonged to a specified resident.

Registered staff indicated that the last dose of two narcotics was administered on an identified date. The remainder needed to be wasted as specified resident was in the hospital for a few days. Two new cards of the narcotics arrived and the new doses were administered from the new cards. Registered staff stated that the count at 0700 hours was completed with another nurse; however, the narcotics to be disposed off were still kept in the medication cart together along with other medications being administered.

The home's policy stated that narcotics and controlled substances awaiting destruction were to be stored in a separate double locked stationary cupboard in a locked medication room.
The Manager of Resident Care (MRC) stated that narcotics to be disposed off should be removed from the medication cart as soon as possible and as soon as another nurse is available to count and sign for the disposal. The SNM confirmed that narcotics should have been removed and not kept with medications being administered to residents.

Failing to dispose of narcotics that were awaiting destruction increases the risk of medication errors.

Sources: Observation; review of the narcotic bin in the medication cart, review of the individual narcotic count sheets for narcotics awaiting destruction, resident's electronic medication administration record (eMAR) and progress notes; interview with Registered staff, MRC and the SNM.

B) The licensee has failed to comply with the procedure Administration of Narcotic and Monitored Medication, included in the Narcotics/Controlled/Monitored Drugs policy, to sign off controlled substances in the narcotic and controlled drug administration record.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that the medication management system, had in place policies and procedures to ensure the accurate acquisition, dispensing, receipt, storage, and administration of drugs.

Specifically, staff did not comply with the policy "Narcotics/Controlled/Monitored Drugs" (July 2019), which identified that all entries were to be made on the narcotic and controlled substance administration record at the time the drug was removed from the card.

Rationale and Summary
On an identified date, Inspector observed Registered staff administer narcotics to the resident and they had not singed the amount given and remaining in the narcotic and controlled drug administration record after the medication was given. The Registered staff was interviewed after lunch and confirmed that their practice was to sign for all narcotics after the entire medication pass was completed and not after each administration. The MRC and SNM acknowledged the home's policy was to sign the narcotic and controlled drug administration record after each administration to ensure accurate count and administration.

Failing to sign the narcotic and controlled drug administration record after each administration may increase the risk of medication errors.

Sources: Observation of medication pass; review of resident's records, review of home's policy "Narcotics/Controlled/Monitored Drugs" (July 2019); interview with Registered staff, MRC and SNM.

C) The licensee has failed to comply with the procedure related to counting and signing the narcotic and controlled drug administration record at shift change.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that the medication management system, had in place policies and procedures 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 policy "Narcotics/Controlled/Monitored Drugs" (July 2019), which identified that two registered staff, one oncoming and one outgoing, were to jointly count monitored medications at shift change and both were to verify by signature the quantity of each monitored medication on hand with the narcotic and controlled substance administration record.

Rationale and Summary
On an identified date and time, it was identified that the narcotic and controlled substance administration record for the resident's monitored medication was pre-signed for shift change at 1500 hours, by the outgoing nurse. Registered staff acknowledged that they had pre-signed the narcotic and controlled drug administration record. The SNM confirmed that the count of monitored medications was to be done together with the oncoming nurse and singed to verify the count at shift changed.

Failing to follow the process for shift to shift count of monitored medications increases the risk of medication errors.

Sources: Observations on identified date; review of the narcotic and controlled drug administration record for the resident, home's policy Narcotics/Controlled/Monitored Drugs" (July 2019); interview with Registered staff and SNM.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that the medication cart in which drugs were stored was secure and locked.

Rationale and Summary
On an identified date, at lunch time medication pass, Registered staff was administering medications to residents in the dining room and failed to lock the medication cart when leaving it unattended. They acknowledged that they should have locked the medication cart. This was confirmed by MRC and the SNM.

Failing to lock the medication cart when leaving it unattended increases the risk of others having access to medications.

Sources: Observation of medication pass; interview with Registered staff, MRC and the SNM.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:

6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that the CQI initiative report contained a written record of the dates the actions that were implemented based on the documentation of the results of the survey taken during the fiscal year.

Rationale and Summary
The continuous quality improvement (CQI) initiative report completed for 2024 fiscal year did not have the dates of the actions that were implemented in the home based on the results of the survey taken. This was acknowledged by the Administrator.

Sources: Review of the CQI initiative report; interview with the Administrator.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that a copy of the CQI initiative report was provided to the Family Council.

Rationale and Summary

The meeting minutes of the Family Council meeting in 2024 did not identify if the CQI initiative report was shared with the council. The Family Council chair was not aware of the CQI initiative report and did not recall it being shared. CQI Lead stated that the CQI initiative report was not shared with the council.

Sources: Review of the Family Council meeting minutes; interview with Family Council Chair and the CQI Lead.

COMPLIANCE ORDER CO #001 Windows

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. The Administrator or the ESM will conduct a comprehensive audit of the home to ensure all windows that open to the outdoors and is accessible to residents does not open more than 15 cm.

2. The home will keep documentation of the audit including dates and names of the staff completing the audit, a comprehensive list of all the locations of the windows audited and a list of windows that need any repair and or adjustment to ensure they open no more than 15 cm.

3. The Administrator and the ESM will create a work order to carry out any identified

repairs/adjustments to the windows including the installation of the appropriate mechanisms/equipment required to prevent the windows from opening more than 15 cm.

4. All audits and documents related to this order are to be made available to the Inspector immediately upon request.

Grounds
The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimeters (cm).

Rationale and Summary
Some windows in the home in areas such as resident bedrooms, hallways, located on the first and second floor were observed to open more than 15 cm in at least seven different areas/rooms. Windows measured from 18.4 cm to 23.5 cm in the areas noted above. Measurements were taken with both the Maintenance Lead and the Inspector present utilizing the home's measuring tape. During the measurements and an interview with the Maintenance Lead, they confirmed that the windows did open further than the legislated 15 cm. Administrator and Maintenance Lead both acknowledged to this safety concern.

Failing to ensure that all windows in the home that are accessible to residents cannot be opened more than 15 cm puts the residents at an increased risk for safety.

Sources: Observations, and interview with the Maintenance Lead.

This order must be complied with by February 28, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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