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: February 14, 2025
Inspection Number: 2025-1556-0001
Inspection Type: Complaint Critical Incident
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): February 5, 6, 7, 10, 11, 12, 14, 2025
The inspection occurred offsite on the following date(s): February 13, 2025

The following intake(s) were inspected:

- Intake: #00130425 - Critical Incident (CI) #M536-000057-24 -related to prevention of abuse and neglect.
- Intake: #00131714 -Complainant with concerns related to neglect.
- Intake: #00134786 -Complainant with concerns related to resident care and support services.
- Intake: #00135220 - Critical Incident (CI) # M536-000066-24 - related to falls prevention and management.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control

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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)
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to implement the procedures relating to nutritional care and dietary services and hydration that stated to ensure the accuracy of diet orders in all documentation.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that the Delivery of Clinical Nutrition Procedure of the long-term care home is to be complied with.

A resident was observed to receive a specified drink . A review of resident's clinical

records indicated diet orders to provide a specified drink with all meals , however, Medication Administration Record (MAR) indicated that resident received the specified drink only with breakfast. Staff acknowledged that the diet order in MAR was not updated. On February 2025, MAR order set was updated by staff to reflect the correct diet order.

Sources: Resident's clinical records, staff interview, and Delivery of Clinical Nutrition Procedure
Date Remedy Implemented: February 2025

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from physical abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

Two resident had a physical altercation, staff confirmed that, as a result of this interaction the co-resident sustained an injury.

Sources: Both resident's clinical record; CI# M536-000057-24, Interviews with Registered Practical Nurse and Manager of Resident Care .

WRITTEN NOTIFICATION: Palliative care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (3)
Palliative care
s. 61 (3) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other person or persons designated by the resident or their substitute decision-maker are provided with an explanation of the palliative care options that are available based on the assessment of the resident's palliative care needs, which may include, but are not limited to, early palliative care and end-of-life care.

The licensee failed to ensure that the resident's palliative care needs were met when the resident and resident's substitute decision-maker were not provided with an explanation of available palliative care options based on the assessment of the resident's palliative care needs. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies and procedures developed for palliative care were complied with.

A resident was assessed to have a change in health status when their Palliative Performance Scale (PPS) was determined to be 30%. This should have prompted a palliative care conference, which did not occur for the resident. The home's palliative care and end-of-life program policy indicated that the PPS will be utilized as per the PPS procedure, which stated if a resident's PPS score is assessed at 30% or below, an end-of-life care conference should be coordinated by the registered staff.

Staff acknowledged that the process for initiating a palliative care conference should have occurred for resident.

Sources: Resident 's clinical records, the home's palliative care and end-of-life program policy and PPS procedure and staff interviews.