Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Aug 8, 2019	2019_803748_0006	014967-19	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

EMMY HARTMANN (748)

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): July 30, 31, August 2, 6, 2019.

The following intake was completed during this Critical Incident Inspection:

Log #014967-19, Critical Incident System (CIS) #M536-000023-19, was related to resident to resident abuse.

This inspection was completed concurrently with Complaint Inspection #2019_803748_0005.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Senior Nurse Manager (SNM), Acting Manager of Resident Care (AMRC), Behaviour Support Team Lead, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW).

During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, and policies.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 VPC(s)
0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the provision of the care set out in the plan of care, was documented for resident #004, resident #006, and resident #007.

A: Log #014967-19, Critical Incident System (CIS) #M536-000023-19, was submitted to the Director, in July 2019, for an incident which described resident #004 demonstrating responsive behaviours, towards resident #005.

During a review of resident #004's clinical records, it was identified that they had a medical condition, and that they had several behaviours.

Resident #004's interventions, prior to the incident, included but was not limited to, routine monitoring.

During an interview with the AMRC #112, they stated that documentation for routine monitoring was completed on the Point of Care (POC) task. They indicated that it was an expectation that staff recorded their action as soon as the task was completed. In review of the documentation with the AMRC #112, it was identified that it did not include routine monitoring documentation at the date and time of the incident.

B. During an interview with RN #108, they identified that resident #006 required routine monitoring.

A review of resident #006's clinical records, identified that they had a medical condition, and that they demonstrated responsive behaviours.

A review of resident #006's documentation for routine monitoring on the POC, for a period of a week during an identified month, revealed various gaps in documentation, up to two hours.

C. During an interview with RN #108, they identified that resident #007 also required routine monitoring.

A review of resident #007's clinical records, identified that they had a medical condition, and that they demonstrated responsive behaviours. The interventions in place, included but was not limited to, routine monitoring.

A review of resident #007's routine monitoring documentation on POC, for a period of a

week during an identified month, revealed various gaps in documentation, up to three hours.

The home's policy, titled "Documentation of Care and Service", last reviewed July 2019, stated that "documentation must be completed during or as soon as possible after service provision or within a timeframe defined by the program area".

During an interview with SNM #102, it was identified that it was an expectation that staff recorded routine monitoring of residents when the task completion occurred, to be able to reflect that the action was completed.

The home failed to ensure that the provision of care was documented for resident #004, resident #006, and resident #007, related to routine monitoring. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance , to be implemented voluntarily.

Issued on this 30th day of August, 2019

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

Original report signed by the inspector.