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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 1, 2014	2014_343585_0018	H-001337-14	Resident Quality Inspection

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

POST INN VILLAGE
203 Georgian Drive, OAKVILLE, ON, L6H-7H9

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

LEAH CURLE (585), CATHIE ROBITAILLE (536), DARIA TRZOS (561)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 7, 8, 9, 14, 15, 16, 17, 2014

Two Critical Incident inspections were completed concurrently with this RQI H-000584-14 and H-000972-14
Four complaint inspections were completed concurrently with this RQI H-000434 -14, H-000524-14, H-000741-14 and H-000700-14.

During the course of the inspection, the inspector(s) spoke with residents, families, Registered staff, unregulated staff, the Administrator, Director of Care (DOC), Managers of Resident Care (MORC), the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) coordinator, Social Worker, life enrichment therapist, Occupational Therapist, Occupational Therapy Assistant, laundry services staff, Registered Dietitian (RD) specialist, Nutrition Services Supervisor, and dietary staff.

During the course of the inspection, the inspector(s) observed residents, including care and services by staff provided to residents, toured the home, reviewed clinical records, training records, policies and procedures, and food services documentation.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident had his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

A) On an unspecified date in October 2014, during an observation of the medication pass, it was noted that discarded medication pouches that identified residents by name and their prescribed medications were being disposed of in the regular garbage container on the medication cart. The Registered staff, Director of Care (DOC) and the Administrator confirmed that the medication pouches were disposed of with the regular garbage and not separated to protect residents' personal health information. (536)

B) On an unspecified date in October 2014, six out of twelve documentation hubs used by personal support workers (PSWs) throughout the home were found unlocked. The hubs contained resident's personal health information, including their individualized plans of care that outlined medical diagnoses, restraint use and behaviour tracking documents, and food and fluid records. The home areas found have documentation hubs unlocked were:
i) Birch Crescent – south west
ii) Birch Crescent – north west
iii) Linden Crescent – south east
iv) Cedar Crescent – north east
v) Spruce Avenue – north west
vi) Maple Avenue – north west

On an unspecified date in October 2014, two documentation hubs were found to have resident care plan binders sitting out on the counter. The DOC confirmed the binders contained resident's personal health information and were to be locked in the cabinets at the stations when staff were not using them or absent from the stations. (585) [s. 3. (1) 11. iv.]

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 and ensuring that resident personal health information within the meaning of the Personal Health Information Protection Act, 2004, be kept confidential in accordance with that Act, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's plan of care provided clear direction to staff and others who provide direct care to staff.

A) The licensee has failed to ensure that resident #027, #028 and #039's plan of care in relation to grooming of facial hair provided clear direction to staff and others who provide direct care to staff.

i) Resident #027's was observed with ungroomed facial hair on an unspecified date in October 2014. On a later date in October 2014, the resident appeared groomed. Interviews with multiple PSW's revealed that their knowledge and expectation was to groom resident's facial hair unless otherwise indicated in their plan of care. The resident's plan of care was reviewed and did not provide direction as to whether or not the resident was to receive care in the removal of facial hair.

ii) Resident #028 was observed with ungroomed facial hair on multiple unspecified days in October 2014. Interviews with multiple PSW's revealed that their knowledge and expectation was to groom residents facial hair unless otherwise indicated in their plan of care. The resident's care plan was reviewed did not provide direction as to whether or not the resident was to receive care in the removal of facial hair.

iii) Resident #039 was observed with ungroomed facial hair on two unspecified days in October 2014. A PSW stated that their practice would be to shave or groom the resident if they observed the resident with facial hair. The resident's plan of care was reviewed and did not provide direction as to whether or not the resident was to receive care in the removal of facial hair.

Interviews with Registered nursing staff indicated facial hair should not be removed unless outlined on their plan of care. The DOC confirmed there was no documented direction in the home for staff on expectations on grooming of facial hair.

B) The licensee has failed to ensure that resident #039's plan of care in relation to nutritional care provided clear direction to staff and others who provide direct care to staff.

Resident #039 was noted to have a significant weight loss. The resident had a plan of care to receive an unspecified amount of a therapeutic beverage at each meal. On an unspecified date in October 2014, during a meal service, the resident was served a beverage that appeared to be less than what was identified on their plan of care. A PSW reported they provided the resident a therapeutic beverage that was less than the specified amount in their plan of care available to the PSW. Dietary staff produced information located in the servery, titled 'Summary of Resident Diet Information', that indicated the resident was to receive a lesser amount of the therapeutic beverage that what was noted in the plan of care. The Registered Dietitian confirmed the resident was to receive the higher amount of beverage listed in the resident's current plan of

care, that the amount stated on the information sheet in the servery was incorrect, and the documentation for direct care staff was not clear. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) On an unspecified date in May 2014, resident #303 sustained an injury following care that was provided by one PSW. The resident's plan of care stated they required care from two staff rather than one for the care that was being provided to the resident at the time they sustained the injury. Following this event, the home investigated and confirmed that the staff did not follow the plan of care. This was confirmed by the DOC. (536)

B) On an unspecified date in October 2014, a PSW took resident #302 to their room to provide assistance with personal care. The PSW got called away to assist another staff and left the resident in the doorway to their room. The resident, who had heightened fall precautions in place, slid out of their wheelchair when unsupervised. The plan of care for the resident stated that they were not to be left in their wheelchair alone in their bedroom. This was confirmed by both the PSW and the DOC. (536)

C) On two unspecified dates in October 2014, resident #028 was observed sitting in a tilt wheelchair in a tilted position. Review of the resident's clinical records indicated that they had a tilt wheelchair, however the plan of care did not state the resident was to be tilted. A PSW and multiple registered staff confirmed the resident was not to be tilted. (585)

D) Resident #039 was noted to have significant weight loss. The resident had a plan of care to receive an unspecified amount of a therapeutic beverage at each meal. On an unspecified date in October 2014, during a meal service, the resident was served a therapeutic beverage that appeared to be less than what was identified on their plan of care. A PSW stated the resident received an incorrect serving of the beverage. The Registered Dietitian confirmed the resident was to receive the amount identified on their plan of care, and that the amount served during the meal was incorrect. (585) [s. 6. (7)]

3. The licensee has failed to ensure that the plan of care was revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A) On an unspecified date in October 2014, resident #008 was observed sitting in a tilted wheelchair that had a seat belt, which was not applied. A review of clinical records indicated the seat belt was previously used as a restraint, and was discontinued on an earlier date in 2014. A PSW that provided direct care to the resident and was a regular staff on the unit reported that the resident no longer used the seat belt. The resident's written plan of care and the Resident Assessment Protocol (RAP) note from October 2014 indicated that the seat belt with the tilt chair was still used for resident's safety and comfort. The PSW reported that on number of occasions, staff that were unfamiliar with the resident reached for the seat belt to apply it, but were stopped. Both Registered staff and the PSW confirmed that the written plan of care was not updated when the seat belt was discontinued. The plan of care was not revised when the care needs changed for this resident. [s. 6. (10) (b)]

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 and ensuring that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, care set out in the plan of care is provided to the resident as specified in the plan, and the resident's plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were standardized recipes for all menu items.

On an unspecified date in October 2014, potato and bacon soup was on the supper menu. The therapeutic menu stated the soup was to be pureed for all diet textures. During supper, in a third floor dining room, the potato and bacon soup at the beginning of meal service had a chunky texture. The dietary aide reported they did not have a recipe indicating how to prepare the soup. The Food Service Supervisor confirmed there was no recipe available for soup. [s. 72. (2) (c)]

2. The licensee has failed to ensure food was served using methods to prevent contamination.

On an unspecified date in October 2014, during supper meal service on third floor, a dietary staff was observed on two occasions taking soiled dishes into the servery and placing them on the surface where food was being plated. The dietary staff did not wash their hands between handling the soiled dishes and returning to plating meals for residents. The dietary staff reported the home's expectation was to not place soiled dishes in a food preparation area, and that their hands should have been washed between the two tasks. The home's policy "Safe Food Handling – Procedure #10-04-03", last reviewed August 2011, stated "Hand washing with soap and water following proper hand washing techniques is expected between handling of dirty dishes (i.e. clearing resident's plates) or equipment and handling clean food or utensils". [s. 72. (3) (b)]

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 and ensuring that there are standardized recipes for all menu items, and that food is served using methods to prevent contamination, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who apply personal assistance services devices (PASDs) or monitor residents with PASDs, received annual training in the application, use and potential dangers of the PASDs.

Information provided by the home confirmed that 78 of 268 staff who provided directed care to apply or monitor residents with PASDs did not receive training in the application, use and potential dangers of PASDs in 2013. [s. 221. (1) 6.]

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 and ensuring that for the purposes of paragraph 6 of subsection 76 (7) of the Act, training shall be provided to all staff who provide direct care to residents, for staff who apply personal assistance services devices (PASDs) or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that food served to residents was safe.

On an unspecified date in October 2014, during supper meal service on third floor, puree potato bacon soup was on the menu for all textures. During an observation of meal service, the dietary staff blended the soup in the servery, however the puree soup that was served appeared to have lumps in it. The Food Service Supervisor confirmed that puree soup was expected to be served at a smooth texture without lumps. [s. 11. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that foods were served at a temperature that was both safe and palatable to the resident.

A) During Stage 1 of the RQI, three residents reported that some foods at mealtime were not hot enough.

B) On an unspecified date in October 2014, during supper meal service on third floor, foods were found to be served at temperatures below 60 degrees Celcius, and practices to maintain food temperatures were not implemented.

i) At 1745 hours, regular chicken burger was probed and measured at a temperature of 58.3 degrees Celcius. One resident eating the chicken burger confirmed they did not find the burger was hot enough.

ii) At 1810 hours, a dietary staff was plating a tray for room service, which included minced vegetarian chili. The chili was probed and measured at a temperature of 41.8 degrees Celcius. The dietary staff did not check the temperature of the food prior to plating the tray, and confirmed they turned off their steam table approximately 25 minutes earlier. The resident who received the tray stated the chili was not hot enough.

The dietary staff reported that hot foods were to be served at a minimum temperature of 60 degrees Celcius to residents for safety and palatability. The Food Service Supervisor confirmed that foods were to maintain a minimum temperature of 60 degrees during meal service. The Registered Dietitian also identified that the steam table should have remained on until all meals were served to residents, including residents receiving tray service. [s. 73. (1) 6.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Care, the pharmacy provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home.

On an unspecified date in October 2014, the DOC confirmed that an annual evaluation of the effectiveness of the medication management system was not completed. [s. 116. (1)]

Issued on this 5th day of December, 2014

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