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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 5, 2015	2014_215123_0013	H-001220-14	Complaint

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

MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 11, 12, & 15, 2014

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), registered staff, the Wound Care Nurse, the Manager of Resident Care (MoRC), the Director of Care (DOC) and the Administrator.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM were provided the opportunity to participate fully in the development and implementation of the plan of care as evidenced by:

The record including the progress notes of identified resident #001 were reviewed and it was noted that in August, 2014 the resident sustained a large skin tear and it was surrounded by an area of dark purple bruising. The was a moderate amount of bleeding from the wound and it was tender. The wound was washed and a dressing was applied. The resident's progress note documentation also indicated that, the resident's SDM visited the resident three days later and was concerned about how the injury happened and questioned why they were not made aware of the wound.
There was no documentation found in the resident's record of the staff informing the resident's SDM of the resident's injury and the required treatment and or dressing prior to the SDM visiting the home.

The home's records were reviewed including the home's Investigation Reports and the Client Service Response Form and it was noted that the resident's SDM visited the resident and was surprised to discover the skin tear covered with dressing. They questioned the staff about when the injury occurred and why they were not informed. The Recommended Actions section of the Client Services Response Form indicated that the staff were to maintain proper communication and to inform the SDM of any changes in the resident health status or of any issues. Also, that proper communication was to be reinforced with staff members.

The Director of Care (DOC) and the Manager of Resident Care (MoRC) were interviewed and they confirmed that that the SDM was not notified of the resident's wound and required dressing.

The SDM of resident #001 was not provided the opportunity to participate fully in the development of the plan of care for the resident's leg injury. [s. 6. (5)]

Issued on this 2nd day of September, 2015

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

Original report signed by the inspector.