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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 29, 2018	2018_573581_0002	029297-17	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

DIANNE BARSEVICH (581), JESSICA PALADINO (586), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 8, 9, 15, 16 and 17, 2018.

During the course of the inspection the following inspections were completed concurrently:
Inquiries:
002163-17- related to prevention of abuse
006387-17- related to prevention of abuse
007434-17- related to prevention of abuse

Critical Incident System:
028006-16- related to falls prevention

Complaint:
011778-17- related to improper care and alleged abuse
011332-17- related to improper care and alleged abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Senior Nursing Manager (SNM), Manager of Resident Care, registered nurses (RN), registered practical nurses (RPN), Resident Assessment Instrument (RAI) Coordinator, Physiotherapist (PT), Occupational Therapist (OT), Corporate Human Resource staff, personal support workers (PSW), family members and residents.

During the course of the inspection, the inspectors observed the provision of care and services, toured the home, reviewed relevant policies and procedures, meeting minutes and clinical health records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **6 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. Review of the plan of care and the post falls assessment for resident #040 identified they fell on an identified day in September 2016 and sustained an injury. Review of the Minimum Data Set (MDS) assessment on an identified day in September 2016, did not identify the resident had a fall in the past 30 days. Interview with the RAI Coordinator stated the resident did fall in the past 30 days and confirmed that the MDS assessment and post fall assessment were not integrated and consistent with each other.

B. Review of the MDS admission assessment in May 2017, for resident #044 identified the resident was frequently incontinent of bladder, tended to be incontinent daily but with some control. Review of the admission Continence Assessment completed during the same time period indicated that the resident was incontinent two or more times a week but not daily. The admission three day voiding record was reviewed and revealed the

resident was incontinent on all three shifts for three days.

Interview with RN #115 stated the resident was incontinent daily during the admission assessments time period and confirmed that the MDS assessment, three day voiding record and the Continence Assessment were not integrated and consistent with each other. [s. 6. (4) (a)]

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

On an identified day in January 2018, resident #048 was transferred from bed to wheelchair with two staff assistance using a specific mechanical lift. Review of the written plan of care and the logos at bed side identified the resident was to be transferred with the mechanical lift from bed to wheelchair and back and required total assistance with two staff. Interview with PSW #112 stated the resident was transferred with a specific mechanical lift from bed to wheelchair with two staff assistance. They stated the bed side logo was part of the plan of care, confirmed the resident should of been transferred with the mechanical lift and that the care set out in the plan of care was not provided as specified in the plan. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Review of the written plan of care for resident #044 indicated that staff were to provide a device when the resident was in bed. Interview with the resident and PSW #113 both stated that they did not use the device. Interview and review of the clinical health record with RPN #114 stated the resident used the device when they were first admitted to the home but they no longer required it and confirmed that the plan of care was not reviewed and revised when the care set out in the plan was no longer necessary. [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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

A. The home's policy, Continence Care and Bowel Management Program, last reviewed in March 2016, identified that registered staff would complete a Continence Assessment on admission (within seven days) and when there were changes in resident status impacting continence. Initiate and ensure completion of the three day voiding record and seven day bowel record. Review the completed voiding and bowel records and develop individualized resident care plans to address bowel and bladder incontinence. PSW's were to complete the three day voiding monitoring record and seven day bowel monitoring record and report concerns or changes to the registered staff.

Review of the seven day Bowel Monitoring Record for resident #044 indicated that the

documentation was initiated but was not completed by the PSW staff other than the one section. There was no documentation completed to identify if the resident was incontinent, or if they used the toilet or product and if any bowel protocol items were given.

Interview with RN #115 stated the record should have been fully completed by the PSW staff during the first seven days after admission and confirmed that the documentation was not completed and the home's policy was not complied with.

B. The home's Lift Transfer and Repositioning policy, number 24-01-01, revised October 2016, identified that the purpose of the program included but was not limited to ensure that transfer techniques used were based on a mobility assessment completed by the Physiotherapist or Registered staff and to ensure that all staff followed transfer logos (if applicable) placed in the resident's room to guide all transfers.

The Physiotherapist would complete a mobility assessment within 24 hours of admission, readmission or with any change in health status. Respond promptly to referrals of change in status requested for reassessments to ensure resident and staff safety. They would ensure that any mobility and transfer updates were communicated to registered staff and documented in the resident progress notes.

On an identified day in January 2018, resident #048 was transferred from bed to wheelchair with a specific mechanical lift by PSW #112 and #113. Review of the written plan of care identified the resident required the mechanical lift with two staff for transfers from bed to wheelchair. On an identified day in November 2017, registered staff updated the written plan of care which indicated that during the day, staff were using a specific mechanical lift for toileting. Interview with PSW #112 stated they were told by registered staff approximately one and half months ago that the resident was now a specific mechanical lift for toileting; however, confirmed there was no change in the transfer logos in the resident's room. Interview with PSW #113 stated that all reassessment for transfers were completed by the Physiotherapist.

Interview with the Physiotherapist stated they reassessed all residents in the home for any changes in transfer status. They were to receive a referral from registered staff and confirmed they did not receive a referral to reassess the transfer status for resident #048 related to using a specific mechanical lift for toileting transfers. They stated they assessed the resident on an identified day in November 2017, as a mechanical lift for all transfers.

Review of the clinical record with RN #118 revealed that on an identified day in November 2017, the resident's written plan of care related to transferring to the toilet was updated by registered staff. They stated that registered staff did not complete a mobility assessment when they changed the written plan of care and they did not send a referral electronically to the PT/OT for the resident to be reassessed for a change in transfer status as per the home's policy.

They confirmed the home's policy on Lift, Transfers and Repositioning was not complied with. [s. 8. (1) (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 to ensure where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Resident #012 was observed on an identified day in January 2018, sleeping in bed with two bed rails raised.

The resident was admitted to the home on an identified day in April 2017 and was to be assessed for bed rail usage when admitted. Review of the resident's health record and interview with RPN #103 confirmed they opened the assessment and closed it in error; therefore, the resident was not assessed for the need for bed rails upon admission.

Upon further review of the resident's health record it was identified under both the documented plan of care and the MDS assessment that the resident required the use of two bed rails as of an identified day in September 2017. RPN #103 stated that the bed rails would have been tied down until that time and that another nursing bed rail assessment should have been completed when it was determined that the resident required the use of the rails. RPN #103 confirmed that the resident was not assessed for the use of bed rails prior to their use. [s. 15. (1) (a)]

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 ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A. On an identified day in January 2018, PSW #112 and #113 were observed entering resident #048's room, who was still in bed and they were pushing a specific mechanical lift. Shortly after the resident was observed being pushed down the hall in their wheelchair. Review of the plan of care identified that the resident required total assistance with two staff with the mechanical lift for transfers from bed to wheelchair. The clinical health record also revealed that on an identified day in November 2017, registered staff added to the written plan of care that staff were transferring the resident for toileting on a specific mechanical lift. Observation of the logo above the bed and in the washroom revealed the resident was to be transferred with the mechanical lift.

Interview with PSW #113 confirmed the resident was transferred with a specific mechanical lift with two staff out of bed and into their wheelchair and stated the resident used to be transferred with the mechanical lift but was reassessed and this mechanical lift was discontinued. They stated that this change happened a few months ago as the resident required a different lift to provide specific care and identified that the physiotherapist completed all reassessments of residents' transfers in the home.

Interview with PSW #112 confirmed the resident was transferred from the bed to wheelchair with the specific mechanical lift with two staff. They revealed they were directed by registered staff approximately a month and half ago that the resident was to be transferred by the specific mechanical lift for a specific task. They confirmed that the logos at bed side and in the washroom identified they were a mechanical lift, that the logos were part of the plan of care and they did not follow the logo when they transferred the resident with the specific mechanical lift from bed to wheelchair.

Interview with the Physiotherapist (PT) stated that the resident was currently receiving physiotherapy treatment. They identified that they did not receive a referral from the registered staff to assess the resident for a change in their transfers. The PT indicated that when they completed a transfer assessment they would observe the PSW staff performing the transfer and determine if the resident was safe to be changed to a specific type of transfer. At the time of the assessment the resident would be assessed as safe and appropriate to be transferred in a specific way either by a specific mechanical lift or one to two person staff assistance and they would document their findings in the

progress notes, inform the registered staff who would then update the written plan of care. Review of the physiotherapists last quarterly assessment completed on an identified day in November 2017, indicated they were transferred with a mechanical lift for all transfers.

Interview with RN #118 stated that the home's policy was for a referral to be sent to PT and Occupational therapist (OT) to assess any resident that required a change in transfer status. They stated that no referral was sent and that registered staff should not have updated the written plan of care with the change in transfer status related to a specific task on an identified day in November 2017, without the resident being assessed and the assessment documented. RN#118 further indicated that PSW staff were to follow the plan of care and the logos posted in the resident's room related to transfers which indicated the resident was to be transferred using a mechanical lift.

PSW #112 and PSW #113 did not use safe transferring techniques when assisting resident #046 on an identified day in January 2018.

B. On an identified day in January 2018, resident #044 was transferred by PSW #113 onto the toilet with one person assistance and was transferred off the toilet with PSW #112 with one person assistance. Review of the plan of care and logos in the resident's room identified the resident was transferred in and out of bed with the mechanical lift and was transferred on and off the toilet with two person assistance. Interview with PSW #112 and #113 both identified the resident was a two person transfer for toileting but confirmed they both transferred the resident with one person. They stated they were short staffed.

PSW #112 and #113 did not use safe transferring techniques when assisting resident #044 to the toilet. [s. 36.]

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 ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the PASD used under section 33 of the Act was applied by staff in accordance with the manufacturer's instructions.

On an identified day in January 2018, resident #010 was observed in their wheelchair with a specific physical device applied greater than ten finger widths from their torso. Observation and interview with RPN #101 and #102 stated that the physical device was not a restraint but a PASD and were both unaware of how the device was to be applied. They stated the home only has one restraint device and it would be applied snug so the resident would not slide.

Review of the Manufacturer's instructions from AliMed inc. identified that the device needed to be secured around the patient and pictures identified that it should be snug to the resident.

Interview and observation of the loose physical device with the Senior Nursing Manager confirmed the device was too loose and should of been applied two finger widths from the resident's torso and had the device adjusted.

The PASD device was not applied by staff according to manufacturer's instructions. [s. 111. (2) (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 to ensure that the PASD used under section 33 of the Act is applied by staff in accordance with the manufacturer's instructions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that for every medication incident which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the

Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

On request the home provided Medication Incident Reports for specific incidents which occurred in the home from an identified day in July 2017, until an identified day in September 2017. A review of three Incident Reports identified that not all incidents included documentation of action taken to assess and maintain the resident's health or that the incidents were reported to the required parties.
i. Resident #031 was involved in a medication incident in September 2017, which was reported the following day. A review of the incident report and clinical record did not include documentation that the resident or the physician were notified of the incident as confirmed during an interview with the Senior Nursing Manager (SNM).
ii. Resident #032 was involved in a medication incident in August 2017. The resident was not able to make decisions and had a SDM. A review of the incident report and clinical record did not include documentation of actions to access and maintain the resident health nor that the SDM or the physician were notified of the incident as confirmed during an interview with the SNM.
iii. Resident #033 was involved in a medication incident in June 2017, which was reported the same day. A review of the incident report and clinical record did not include documentation that the resident was notified of the incident as confirmed during an interview with the SNM. [s. 135. (1)]

2. The licensee failed to ensure that all medication incidents and adverse drug reactions were reviewed and analyzed and corrective action was taken as necessary, and a written record was kept of everything required under clauses (a) and (b).

On request the home provided Medication Incident Reports for specific incidents which occurred in the home from an identified day in July 2017, until an identified day in September 2017. A review of three Incident Reports identified that not all incidents included documentation that every incident was reviewed, analyzed or corrective action was taken.
i. Resident #032 was involved in a medication incident in August 2017. A review of the incident report and clinical record did not include documentation that the incident was reviewed, analyzed or corrective action was taken as necessary as confirmed during an interview with the SNM.
ii. Resident #033 was involved in a medication incident in June 2017. A review of the incident report and clinical record did not include documentation that the incident was

reviewed, analyzed or corrective action was taken as necessary as confirmed during an interview with the SNM. [s. 135. (2)]

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 ensure that all medication incidents and adverse drug reactions are reviewed and analyzed and corrective action is taken as necessary, and a written record is kept of everything required under clauses (a) and (b), to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy, Prevention, Reporting & Elimination of Abuse & Neglect, policy number 01-05-03, last revised January 2017, indicated that any person who had reasonable grounds to suspect abuse or neglect of a resident should immediately report the suspicion and the information upon which it was based to the Director; to be done by any person through the Ministry of Health and Long-Term Care (MOHLTC) Action Line, or to the home's Administrator or delegate who would immediately notify the MOHLTC.

On an identified day in January 2017, resident #021's SDM reported to RPN #109 allegations of abuse that the resident told them about pertaining to a particular PSW. The RPN wrote an e-mail to the Manager of Resident Care around 1800 hours informing them of the allegations. The e-mail was received the following day by the Manager of Resident Care and was then immediately reported to the Director. RPN #109 did not immediately report the alleged abuse to the Director as per the home's policy. This was confirmed by the Administrator. [s. 20. (1)]

Issued on this 1st day of February, 2018

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

Original report signed by the inspector.