Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 15, 2021	2021_848748_0003	003352-20, 012772-20, 014493-20, 016350-20, 020026-20, 021366-20, 002387-21	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

Post Inn Village
203 Georgian Drive Oakville ON L6H 7H9

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): February 17, 18, 19, 22, 23, 24, 25, March 1, 2, 3, 4, 2021.

The following intakes were completed during this inspection:

Log #012772-20, CIS #M620-000010-20 was related to an injury of unknown cause.
Log #003352-20, CIS #M620-000004-20 was related to staff to resident abuse.

These intakes were related to falls prevention and management:
Log #016350-20, CIS #M620-000012-20
Log #020026-20, CIS #M620-000013-20
Log #021366-20, CIS #M620-000015-20
Log #002387-21, CIS #M620-000005-21
Log # 014493-20, CIS #M620-000011-20

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Senior Nurse Manager (SNM), Manager of Resident Care, Housekeeping Manager, Housekeepers, Life Enrichment Staff, Social Service Worker, Physiotherapist (PT), Halton Region Public Health Nurse, Screeners, registered nurses (RN), registered practical nurses (RPN), and 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:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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. (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 a resident's falls intervention was in place, as specified in their plan of care.

A resident's written plan of care identified that they were high risk for falls and that they were to have falls interventions in place.

Their progress notes identified that they had a fall on an identified date. The resident was found on the floor by a PSW. The resident was subsequently sent to the hospital where they were diagnosed with an injury and where they had treatment. The resident declined in health status and passed away in hospital. The progress notes did not identify that a specific falls intervention was in place at the time of the fall. There was also no documentation of the intervention being in place on that day.

A PSW identified that they responded to the resident after they fell and that they did not have a specific falls intervention in place.

There was actual harm to the resident as they sustained an injury related to their fall, and declined in health status following their fall.

Sources: A resident's care plan, progress notes, interview with PSW #106. [s. 6. (7)]

2. The licensee failed to ensure that a resident's plan of care was reviewed and revised when their fall risk level changed and when the care set out in the plan was no longer necessary.

The home's "Fall Prevention and Management Policy, 19-01-01", last revised May 2018, identified that registered staff were to assess residents using a validated Fall Risk Assessment Tool, determine the level of risk, and document level of risk in the resident's plan of care".

A. A resident's fall incidents and falls risk assessments identified that the resident had two falls in the same month. The resident's falls risk level changed from moderate to high risk subsequent to their two falls.

The resident's progress notes identified that they were found on the floor two months after their falls risk level changed from moderate to high risk, and that they sustained injuries and pain. The resident was sent to hospital for further assessment.

PSW and PT staff identified that residents that were high risk for falls had specific falls prevention interventions implemented.

However, the resident's written plan of care at the time of their fall, did not reflect the resident as high risk for falls, and specific falls prevention interventions were not initiated until after they had their fall.

PT staff acknowledged that specific falls prevention interventions were not implemented for the resident when their risk level changed from moderate to high risk two months prior.

There was actual harm related to this non-compliance as the resident did not have interventions in place that could have prevented them from falling, and subsequently sustaining injuries and pain.

Sources: A resident's progress notes, care plan, and assessments, interviews with PSW #102, and PT #121.

B: A resident's current plan of care identified that they were high risk for falls and that they had several interventions to address their falls risk.

Observation of the resident identified that not all of the interventions were in place.

A PSW and RPN identified that the resident no longer needed some of their falls interventions as their needs had changed, but that the resident's written plan of care was not updated to reflect the change.

The SNM identified that the care plan was used to communicate a resident's care needs related to falls, and that they expected the staff to update the care plan when the resident's care needs changed.

The resident was at risk for not having their plan of care followed as their written plan of care was not updated.

Sources: A resident's care plan, resident observations, interviews with PSW #110, RPN #109, and SNM. [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, and to 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, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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Issued on this 16th day of March, 2021

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

Original report signed by the inspector.