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 le Loi de 2007 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
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Mar 05, 2015;	2014_275536_0030 (A2)	H-000548-14, H-000970-14	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

CATHIE ROBITAILLE (536) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

As per Appeal #037, a Directors Review of Compliance Order #001 in regards to s. 3(1)4 has been removed but, will remain a Written Notification. A Directors order 6(10)(b) has been issued. Amendments have been made to the licensee report and the order report in relation to s. 3(1) 4.

Issued on this 5 day of March 2015 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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POST INN VILLAGE
203 Georgian Drive OAKVILLE ON L6H 7H9

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

CATHIE ROBITAILLE (536) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 21, 24, 25, 26 and 27, 2014

During this inspection the following Critical Incident System (CIS) were inspected concurrently: Log #H-001074-14 and H-0001243-14

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Staff, Managers of Resident Care and the Director of Nursing and Personal Care

The following Inspection Protocols were used during this inspection:

Falls Prevention

Pain

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Safe and Secure Home

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During the course of this inspection, Non-Compliances were issued.

3 WN(s)
2 VPC(s)
[redacted] CR March 5, 2015
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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s.3. (4) The Lieutenant Governor in Council may make regulations governing how rights set out in the Residents' Bill of Rights shall be respected and promoted by the licensee. 2007, c. 8, s. 3 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A) On an identified date and time in 2014, the Personal Support Worker (PSW) went to provide care to resident #001. Resident #001 was totally dependent for all aspects of care, including transfers by a mechanical lift. The PSW staff attempted to turn resident #001 onto their back from their side, and the resident screamed when they were moved. A second PSW came into assist and noticed swelling, and a bruise on resident #001's lower leg. Resident #001 stated "I think it's broken" twice; however, was unable to articulate what had occurred. The Registered Nurse (RN) on duty was called to do an assessment, and according to the homes investigation notes, stated to the PSW's that it looked like the leg was broken. The PSW staff asked the Registered Nurse if they should get resident up for their meal, and the RN advised the staff they could get the resident up in their wheelchair. Resident #001 was gotten up and taken to the dining room. The Power of Attorney (POA) was called; however, was unavailable. Following the meal, resident #001 was then returned to their room and transferred back into bed. The POA was called again, and was updated on resident's status. The POA agreed to send resident to the hospital for further assessment. Resident #001 was transferred to the hospital. The resident was diagnosed with a fracture. Resident #001 waited almost 4 hours before care was provided in a manner consistent with his or her needs. This information was confirmed by the Director of Nursing and Personal Care.

B) On an identified date and time in 2014, the PSW staff went to provide morning care to resident #002. Resident #002 was totally dependent for all aspects of care, including transfers by a mechanical lift. The PSW attempted to do care on resident #002; however, any attempt to move resident, would cause resident to grimace and yell out. The Registered Practical Nurse (RPN) on duty was called to do an assessment, and noted the resident's leg to be bent and swollen. The resident was unable to articulate what had happened. Consultation was done with the RN on duty and the Nurse Practitioner (NP) was then called to come to the home to do an

assessment. Resident #002 was left in bed. When staff rolled up the bed, resident #002 grimaced with pain. The NP came to the home, conducted an assessment then contacted the POA. The POA was updated by the NP, and agreed to send the resident to the hospital for further assessment. Resident #002 was transferred to the hospital. The POA notified the home that resident #002 had been admitted with a fracture. Resident #002 waited almost 8 hours before care was provided in a manner consistent with his or her needs. This information was confirmed by the Director of Nursing and Personal Care.

C) On an identified date and time in 2014, resident #003 while being transferred by mechanical lift back to bed complained to staff about pain in their leg. Resident #003 was totally dependent for all aspects of care, including transfers by a mechanical lift. The RN in charge was called and completed an assessment. The decision was made with family member who was present at the time, to transfer resident to hospital. Resident #003 was transferred to hospital. On an identified date in 2014, the home was notified that resident #003 sustained a fracture of the hip and would be having surgery. Inspector reviewed the resident's clinical record and the home's investigation notes. The investigation notes, as well as the resident's progress notes, identified that the resident had responsive behaviours during care and transferring on the identified date in 2014. This was also confirmed by the homes investigation notes. The staff interviewed by the home, also stated that this was normal behaviour and it occurred all the time. The residents' plan of care which the home refers to as the care plan, identified interventions when dealing with the resident's responsive behaviours. Review of the progress notes during a five month period, only identified one incident of responsive behaviours. The home failed to ensure care was provided in a manner consistent with his or her needs. This information was confirmed by the Manager of Resident Care. [s. 3. (4)]

Additional Required Actions:

[redacted] CR March 5, 2015

(A1)(Appeal/Dir# DR# 037)
The following order(s) have been rescinded:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #003 was provided to the resident as specified in the plan.

On an identified date and time in 2014, resident #003 while being transferred by mechanical lift back to bed complained to staff about pain in their hip. Resident #003 was sent to the hospital for assessment. The home was notified that resident #003 sustained a fracture. The investigation notes, as well as the resident's progress notes, identified that the resident had exhibited responsive behaviours during care. This was also confirmed in the home's investigation notes. The homes investigation notes with the staff, also stated that this was normal behaviour that occurred all the time. The residents' plan of care which the home refers to as the care plan, identified interventions when dealing with the resident #003's responsive behaviours. Resident #003 did not receive the care as specified in the plan of care. [s. 6. (7)]

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 care set out in the plan of care for resident's is provided as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 who was demonstrating responsive behaviours had actions taken to respond to the needs of the resident, including assessment, re-assessment and interventions that the resident's responses to interventions are documented.

On an identified date and time in 2014, resident #003 while being transferred by mechanical lift back to bed, complained to staff about pain in their hip. The Registered Nurse in charge completed an assessment, and decision was made with family member who was present at the time, to transfer resident to hospital. Resident #003 was transferred to hospital. The home was notified that resident #003 sustained a fracture and would be having surgery. Review was completed of the resident's clinical record and the home's investigation notes. The investigation notes, as well as the resident's progress notes, identified that the resident had exhibited responsive behaviours during care and transferring that day. This was also confirmed by the home's investigation notes. The staff interviewed during the investigation, also stated that this was normal behaviour that occurred all the time. The residents' plan of care which the home refers to as the care plan, identified interventions when dealing with the resident #003's responsive behaviours. Review of the progress notes during a five month period, identified only one incident of responsive behaviours. During inspection it was also noted that resident #003 had spent time away from the home for assessment, and had been seen by Behavioural Support Ontario (BSO) Registered Practical Nurse (RPN) once in 2014, with no follow up identified in the plan of care. The home failed to ensure that resident #003 who was demonstrating responsive behaviours had actions taken to respond to the needs of the resident, including assessment, re-assessment and interventions that the resident's responses to interventions are documented. [s. 53. (4) (c)]

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's who demonstrate responsive behaviours have actions taken to respond to the needs of the resident including assessment, re-assessment and interventions that the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 5 day of March 2015 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Health System Accountability and Performance Division
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Division de la responsabilisation et de la performance du système de santé
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : CATHIE ROBITAILLE (536) - (A2)

Inspection No. / No de l'inspection : 2014_275536_0030 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-000548-14, H-000970-14 (A2)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Mar 05, 2015;(A2)

Licensee / Titulaire de permis : THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1

LTC Home / Foyer de SLD : POST INN VILLAGE
203 Georgian Drive, OAKVILLE, ON, L6H-7H9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : ~~Marg Pattillo~~ Patti Coates

CR March 5, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To THE REGIONAL MUNICIPALITY OF HALTON, you are hereby required to comply with the following order(s) by the date(s) set out below:

(A1)(Appeal/Dir# DR# 037)
The following Order has been rescinded:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s.3. (4) The Lieutenant Governor in Council may make regulations governing how rights set out in the Residents' Bill of Rights shall be respected and promoted by the licensee. 2007, c. 8, s. 3 (4).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5 day of March 2015 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHIE ROBITAILLE - (A2)

Service Area Office /
Bureau régional de services : Hamilton