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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 25, 2015	2015_301561_0014	H-002790-15	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

DARIA TRZOS (561), CATHIE ROBITAILLE (536), MICHELLE WARRENER (107), SUSAN PORTEOUS (560), THERESA MCMILLAN (526)

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): June 26, 29, July 2, 3, 6, 7, 8, 9, 10, 13, 14, and 15, 2015.

The following log numbers were completed during the RQI inspection: H-001359-14, H-001488-14, H-001497-14, H-002156-15, H-002836-15, H-002740-15, H-002291-15, 000014-15, and H-002299-15.

During this inspection a Follow Up Inspection was completed related to previously identified Compliance Order #001 from a Critical Incident Inspection, Inspection number 2014_275536_0030, log numbers H-000548-14, H-000970-14. Director Order #001 related to LTCHA, 2007 s. 6 (10) b, is now returned to compliance.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing and Personal Care (DONPC), Managers of Resident Care, Physiotherapist, Registered Dietitian, Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Nutrition Services Supervisor, Life Enrichment Supervisor, Staff Development Co-Ordinator, Personal Support Workers (PSWs), Maintenance Supervisor, Maintenance worker, Resident Council President, Family Council President, residents and family members.

During the course of the inspection the Inspectors also toured the home, observed dining service, observed the provision of care and services, and reviewed documents including but not limited to: clinical health records, policies and procedures and meeting minutes

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **5 VPC(s)**
- **2 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 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:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

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:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff were provided annual training in Falls Prevention and Management in 2014.

The Long Term Care Homes Inspector reviewed the Falls Prevention and Management training record provided by the DONPC. The document identified that only 75 Per cent (%) or 114 out of a total of 153 Personal Support Workers and only 56% or 35 out of 63 registered staff employed by the home received Falls Prevention and Management training in 2014. [s. 221. (1) 1.]

2. The licensee has failed to ensure that all direct care staff were provided annual training related to continence care and bowel management.

Training records for the year 2014 reflected that 42% of PSWs and 33% of registered nursing staff received training related to continence care and bowel management. The DONPC confirmed that not all staff received annual training in continence care and bowel management for the year 2014. [s. 221. (1) 3.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents

Resident #400 was admitted to the home on an identified date in 2015 after surgery. The Physiotherapist assessment indicated that the resident was non-weight bearing and required a sliding board plus one person assist for transfer in and out of bed/wheelchair. On an identified date in 2015, a PSW performed an improper transfer of a resident from the wheelchair to their bed resulting in an injury. The resident was transferred to hospital for treatment.
The investigation notes and the interview with the Manager of Resident Care confirmed that the incident occurred as a result of an improper transfer.
The licensee did not ensure that the staff used safe transferring techniques when transferring a resident from the wheelchair to their bed.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

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 every resident had the right to be treated with courtesy and respect.

A) On an unidentified date in 2014, a bruise was noted on resident #013. The registered staff brought the PSW who had provided care to resident #013's room to see if they knew what had occurred. The registered staff observed unacceptable behaviour from PSW towards the resident. The registered staff was interviewed by the LTCH Inspector. The PSW denied having caused the bruising.

B) On an unidentified date in 2014, resident #201 sustained bruising which was reported by a PSW. The same PSW who was involved with resident #013, was asked by

registered staff if they knew how resident #201 got bruising. The registered staff was interviewed by the Long Term Care Homes Inspector. The PSW denied having caused the bruising.

C) On an unidentified date in 2014, the PSW involved with resident #013 and #201 reported that resident #200 had responsive behaviours. The PSW reported that as resident #200 was approached, the resident became physically aggressive which caused altered skin integrity. The PSW denied having caused the initial injury.

D) On an unidentified date in 2014, resident #203 was scheduled for a tub bath, and was shaking their hands and head at the PSW. Resident was not able to voice their concern. The registered staff on duty concluded, that they did not want this PSW to do their bath. The registered staff was interviewed and indicated that resident was upset while care was provided by the PSW. The registered staff confirmed what was in the home's investigation notes, when stated the PSW was always in a hurry to finish tasks and it makes it look really rough. [s. 3. (1) 1.]

2. 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) During the Resident Quality Inspection (RQI), a number of documentation hubs used by PSWs throughout the home were found unlocked. The hubs contained residents' personal health information, including their individualized plans of care, flow sheets and food and fluid records.

The Administrator confirmed that the hubs should have been locked when staff were not using them or were absent from the stations. [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 to ensure that each resident has his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #4: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #400 was admitted to the home on an identified date in 2015 after surgery. The Physiotherapist assessment indicated that the resident was non-weight bearing and required a sliding board plus one person assist for transfer in and out of bed/wheelchair. On an identified date in 2015, a PSW performed an improper transfer of a resident from the wheelchair to their bed resulting in an injury.
Prior to the incident the resident had interventions in place for the transfer. The written plan of care was reviewed and did not include these interventions. The Physiotherapist and the Manager of Resident Care confirmed that it was an expectation that the written plan of care should have included the interventions. The licensee failed to ensure that the written plan of care set out the planned care for this resident. [s. 6. (1) (a)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of resident #003 collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Resident #003 fell outside of the home on an identified date in 2015. Progress notes identified the resident had sustained an injury and they were transferred to hospital for assessment. Progress notes on one of the dates in 2015, identified the resident had pain, and had dressing applied. Progress notes on a different date, identified the resident had wounds from a fall. The Post Fall Assessment stated the resident had no injuries from the fall and a pain assessment was not completed.
The assessments related to the resident's injuries were not consistent and did not complement each other. [s. 6. (4) (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 there is a written plan of care for each resident that sets out the planned care for the resident, and to ensure that the staff and others involved in the different aspects of care 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, to be implemented voluntarily.

WN #5: 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 has failed to ensure that their Falls Prevention and Management Program policy, protocol, and procedures put in place was complied with.

A) The Falls Prevention and Management Program, policy # 19-01-01, review date May 2014, Falls Risk Assessment and Prevention Procedure # 19-01-02 (FRAP), Post Fall Follow up, Assessment and Management Procedure # 19-01-05 (PFAMP) and Falling Star Protocol (FSP) were reviewed by the Long Term Care Homes Inspector.

i) The FRAP directs that the role of the Physiotherapist includes management of the Falling Star Program.
ii) The PFAMP directs registered staff to ensure the Falling Star Logo is in place, if not, refer to physiotherapy.

iii) The FSP directs that residents are added to the Falling Star Program when identified as high risk using the MORSE Falls Risk Assessment Tool.
iv) The FSP directs that the Physiotherapist initiates a Falling Star alert by placing a yellow star at the resident's hallway name board, over the bed, on any/all assistive devices used by the resident and in the resident's chart.
v) The FSP directs that the Managers of Resident Care (MRC) for each home area to put the list of all residents on the Falling Star Program into the Physician's Communication Book quarterly.

B) The Long Term Care Homes Inspector observed that the Falling Star Logo was not on the resident #100's hallway name board, over their bed, on their wheelchair or in their chart. The Physician's Communication Book (PCB) for the residents' home area was reviewed and there was no list of residents on the Falling Star Program. Registered staff confirmed there was no list in the PCB.

Staff reported during interviews with the Long Term Care Homes Inspector that the FSP with respect to the placing of a Falling Star Logo on the resident's chart and over their bed was not being followed for any residents as the FSP directs. Staff confirmed that the resident was assessed as high risk for falls and should have the Falling Star Logos in place.

The DONPC during interviews with the Long Term Care Homes Inspector confirmed that the FPMP #19-01-01, FRAP # 19-01-02, PFAMP # 19-01-05 and the FSP appendix to the FPMP are the policy and procedures currently in effect. The DONPC reported that the MRC for each home area were not placing a list of resident's on the Falling Star Program in the Physician's Communication Binder as directed by the FSP. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the Skin and Wound policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The policy called Management of Residents with Pressure Ulcers, Procedure 17-03-02, reviewed on February 2014, indicated the following: "complete a pain assessment and refer to physician for effective management".

Resident #033 had a wound as per the progress notes. The health care records were reviewed and no pain assessment could be found. The interview with registered staff indicated that the pain assessment was not completed for this resident when they had

the wound. Registered staff confirmed that the home’s policy was that a pain assessment was completed when a resident has pressure ulcers. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that the Disguising Administration of Medication in Food/Fluid policy, protocol, procedure, strategy or system, was complied with.

The home's policy, "Disguising Administration of Medication in Food/Fluid", procedure #10-01-22, reviewed November 2013, required: the Pharmacist and Registered Dietitian to be consulted if medications were required to be mixed with food; the method of and directions for covert administration of medication to be written clearly on the Medication Administration Record (MAR); and the medication to be mixed with a small amount of food or liquid rather than in a whole portion of food or drink.

This policy was not complied with for resident #023. Progress notes stated that resident refused medications that were mixed with fluids. Progress notes from a different date stated that resident did not like medications mixed with fluids.

The resident did not have a Physician's order or direction on the MAR for staff to mix the resident's medications with food or fluids. The MAR was revised with direction for staff that they may mix the resident's medication with Ensure. The MAR did not include direction for staff to mix the resident's other medication with food or beverages.

Interview with registered staff members confirmed that medications were being mixed into the resident's fluids at meals without direction from the Physician or Registered Dietitian to do so and that medications were being mixed with the resident's full beverages (not a small portion), which was not consistent with the home's policy. [s. 8. (1) (b)]

4. The licensee failed to ensure that their Pain Assessment and Management policy was complied with.

Resident #003 had a fall with an injury on an identified date in 20015. The post fall assessment included a numerical pain scale and reflected a pain score of seven out of ten.

The home's policy, "Pain Assessment and Management #18-01-01", approved May 2014, stated that when the numerical pain scale was used it must be accompanied by a PQRST (Provokes, Quality, Radiates, Severity, Time) assessment. Staff confirmed a

PQRST assessment was not completed in addition to the numerical pain score after the fall and return from hospital.

Resident #003 complained of pain after the fall. The policy stated that pain assessments (using the PAINAD, PQRST, Numerical Pain Scale) were to be completed when there was a significant change in health status; when pain was indicated by verbal complaint or non-verbal indicators; and 24 hours after the implementation of a new pain related intervention, dosage change or interval change (including all regular, as needed (prn) and adjuvant pain related medications). The resident identified pain was receiving prn medication for pain after the identified fall.

Resident #003 sustained another fall in 2015, resulting in injuries which required treatment. The Post Fall assessment did not include an assessment of the resident's pain. Staff confirmed a pain assessment was not completed at that time. [s. 8. (1) (b)]

5. The licensee has failed to ensure that their Expiry and Dating of Medications policy was complied with.

The home’s policy called “Expiry and Dating of Medications”, policy 5-1, dated January 2014 indicated the following:
“2. Remove any expired medications from stock and order replacement if necessary.
3. Designated medications i.e. eye drops, insulin, must be dated when opened and removed from stock when expired.”

During the RQI, Long Term Care Homes Inspector found eye drops that expired in a medication cart. The registered staff indicated that the eye drops should have been disposed of when they expired. There were also two eye drops LATANOPROST 0.005% and another bottle of Isopto tears 0.5% that did not have open dates on them.

The licensee failed to ensure that the expired medications were disposed of when expired and the eye drops did not have open dates written on the bottles as per home's policy. [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 that the Falls Prevention and Management Program policy, and the Skin and Wound Care policy, put in place are complied with and to ensure that the Skin and Wound policy is in compliance with and is implemented in accordance with applicable requirements under the Act, to be implemented voluntarily.

WN #6: 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 has failed to ensure that where bed rails were used that residents were assessed in accordance with prevailing practices to minimize risk to residents. A document developed by the US Food and Drug Administration titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003" has been adopted by Health Canada and endorsed by the Ministry of Health and Long Term Care as the current prevailing practice.

A) Resident #037 was observed in bed with two quarter rails up while in bed. The health care records indicated that the bed rail assessment was not completed for the bed rail use for this resident. The interview with DONPC confirmed that the bed rail assessment

was not completed for this resident.

B) Resident #040 had three quarter rail on one side of the bed and one quarter on the opposite side of the bed applied. The health records were reviewed and the bed rail assessment could not be found. The DONPC confirmed that the bed rail assessment was not completed for this resident.

The DONPC reported that they had not completed a bed rail assessment for any residents that were admitted to the home before 2013. All residents that were admitted to the home after 2013 were being assessed using a Bed Rail Risk Assessment form developed by the licensee. The Bed Rail Risk Assessment form was reviewed and was not developed in accordance with the prevailing practice guideline identified above. The DONPC acknowledged that their current assessment tool did not include many of the required questions and strategies in the guideline and was currently re-evaluating the assessment tool.

2. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During stage 1 of the RQI resident #040's three quarter rail was tested for stability and noted to be loose. The bed system entrapment audit sheet provided by the licensee, dated September 2014 was reviewed and indicated that the bed failed zone 4, the area at the end of the rail. A maintenance worker reported that all of the beds in the home equipped with three quarter rails were tested in September 2014 and failed entrapment zone 4. No follow up action was taken. The Long Term Care Homes Inspector was informed by the DONPC that there were at least 30 beds in the home that failed zone 4. A discussion with the Administrator, DONPC and the Maintenance Supervisor revealed that they had plans to change all of the three quarter rails in the home. In the meantime the home implemented a plan and immediate strategies to mitigate the risk to residents. The home is aware that they are required to re-test the beds to ensure that the beds pass all 4 entrapment zones around each rail once the rails are changed.

The licensee failed to ensure that steps were taken to prevent resident entrapment after the bed system audit was completed in September 2014 and results revealed that all three quarter rails failed entrapment zone 4. [s. 15. (1)]

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,
a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices to minimize risk to residents,
b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment., to be implemented voluntarily.

WN #7: 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements:
(10) Proper techniques to assist resident with eating, including safe positioning of residents who required assistance.

During the RQI, resident #300 was observed being fed by a visitor at lunch time on one of the home areas. The resident was seated in a tilt wheel chair; the chair was fully reclined as the resident was being fed.

Long Term Care Homes Inspector observed that there were multiple PSW and dietary staff attending to residents in the dining area at the time of the occurrence.

Long Term Care Homes Inspector immediately notified the registered staff on site, who confirmed that the resident was not in a safe feeding position. Registered staff immediately responded to the resident and tilted their chair upright to 90 degrees with their chin facing downwards.

Resident's written plan of care indicated that the resident was at increased risk for choking and aspiration. The written plan of care further stated that staff were to promote safe, adequate, and enjoyable intake and to ensure resident was upright and head was in a safe feeding position. The resident was not seated upright, nor was his head in a safe feeding position. [s. 73. (1) 10.]

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 home has a dining and snack service that includes, at a minimum, the following elements:
(10) Proper techniques to assist resident with eating, including safe positioning of residents who require assistance., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of the organized program of Continence Care and Bowel Management required required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The home's Continence Care and Bowel Management policy did not include relevant policies, procedures, and protocols and provide for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. The home's Continence Care and Bowel Management program included only a program description with identified goals and objectives. The DONPC identified the program was currently under revision; however, the new policies and procedures had not yet been implemented. [s. 30. (1) 1.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #003, who exhibited altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #003 had a fall on an identified date in 2015 resulting in transfer to hospital. The resident did not receive a skin assessment by a member of the registered nursing staff upon their return to the home.

Registered staff confirmed the resident did not receive a head to toe skin assessment when they returned from hospital after the fall.

Resident #003 sustained another fall in 2015 and required assessment at hospital. A skin assessment was not completed after return from hospital and documentation in the progress notes did not identify the resident had wounds. Registered staff confirmed a skin assessment was not completed upon return from hospital. [s. 50. (2) (b) (i)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff received retraining annually related to the Residents' Bill of Rights.

During a review of the annual retraining for all staff, it was identified, that the self-study annual staff education booklet for both 2014 and 2015, had the following training information for the Residents' Bill of Rights: "The Ministry of Health and Long Term Care has legislated a Resident Bill of Rights for people living in Long Term Care (LTC). It is required for all LTC homes in Ontario to have the Bill of Rights posted in French and English in a visible location." The Long Term Care Homes Inspector asked the Staff Development Co-Ordinator if this was the only training material on the Residents' Bill of Rights in the training booklets and after reviewing the self-study booklet with the Long Term Care Homes Inspector, she confirmed it was. She also confirmed that when staff completed the self–study booklet, they signed the back page stating they had completed training on Residents' Bill of Rights. The Staff Development Co-Ordinator informed the Inspector that staff were able to attend additional training on the Residents' Bill of Rights in the classroom; however, classroom training was not mandatory. The Long Term Care Homes Inspector completed a review of the 2014 classroom attendance records, and it was identified that 165 out of 291 employees, or 57% of all employees completed the self-study annual education booklets and did not attend any classroom training. The Administrator confirmed that the education provided in the self-study booklets did not provide any direct training on any of the Residents' Bill of Rights. [s. 76. (4)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed within 3 business days of an incident that caused an injury to the resident for which they were taken to hospital and that resulted in a significant change in the resident's health condition.

On an identified dated in 2015, resident #102 fell and sustained an injury and was transferred to hospital. This injury resulted in a significant change in the resident's health condition. The home submitted a Mandatory Critical Incident report 10 days after the incident occurred. The interview the DONPC confirmed that the critical incident report was submitted late. [s. 107. (3.1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

Resident #100's medication was discontinued on an identified date in 2014. The medication was administered in error after it was discontinued. A medication incident form was completed which described the incident. The resident had no injuries from the incident. The registered staff responsible for the error was spoken to by the Manager of Resident Care. [s. 131. (1)]

Issued on this 6th day of October, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére 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
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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARIA TRZOS (561), CATHIE ROBITAILLE (536), MICHELLE WARRENER (107), SUSAN PORTEOUS (560), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2015_301561_0014
Log No. / Registre no:	H-002790-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 25, 2015
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

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

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

Ministére 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all staff who provide direct care to residents receive training in all areas identified in the legislation:

The plan is to include but not limited to:

A) A schedule of ongoing staff training to ensure that all staff who provide direct care to residents receive training annually.
B) Prepare in writing: the content of training sessions, schedules and evidence that staff have attended training sessions.
C) Training and retraining all staff at the home according to legislative requirements, specifically, s.76 (Training) and O.Reg 216 to 222 inclusive (Training and Orientation) including but not limited to the following areas:

1. Falls Prevention and Management
2. Continence Care and Bowel Management

The plan is to be submitted electronically to Long Term Care Homes Inspector, Daria Trzos by October 16, 2015 to: Daria.Trzos@ontario.ca. The plan is to be complied with by December 31, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that direct care staff were provided annual training in Falls Prevention and Management in 2014.

The Long Term Care Homes Inspector reviewed the Falls Prevention and Management training record provided by the DONPC. The document identified that only 75 Per cent (%) or 114 out of a total of 153 Personal Support Workers (PSWs) and only 56% or 35 out of 63 registered staff employed by the home received FPM training in 2014. (560)

2. The licensee has failed to ensure that all direct care staff were provided annual training related to continence care and bowel management.

Training records for the year 2014 reflected that 42% of PSWs and 33% of registered nursing staff received training related to continence care and bowel management. The DONPC confirmed that not all staff received annual training in continence care and bowel management for the year 2014. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the staff use safe lift, transferring and positioning devices or techniques when assisting residents.
The plan shall include but is not limited to:

1. The development and implementation of a process to ensure that all staff are aware of and are trained in safe transferring of residents in the convalescent unit including hip precautions and transfer boards.
2. Prepare in writing: the content of training sessions, schedules and evidence that staff have attended training sessions.
3. The development and implementation of a process to ensure that the care plans are up to date and include details of safe transferring techniques for each resident.

The plan is to submitted electronically to Long Term Care Homes Inspector, Daria Trzos by October 16, 2015 to: Daria.Trzos@ontario.ca.
The plan is to be complied with by December 31, 2015.

Grounds / Motifs :

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

Resident #400 was admitted to the home on an identified date in 2015 after surgery. The Physiotherapist assessment indicated that the resident was non-weight bearing and required a sliding board plus one person assist for transfer in and out of bed/wheelchair. On an identified date in 2015, a PSW performed an improper transfer of a resident from the wheelchair to their bed resulting in an injury. The resident was transferred to hospital for treatment.
The investigation notes and the interview with the Manager of Resident Care confirmed that the incident occurred as a result of an improper transfer.
The licensee did not ensure that the staff used safe transferring techniques when transferring a resident from the wheelchair to their bed.
(561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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
Ontario, ON
M5S-2B1
Fax: 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 25th day of September, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

Service Area Office /
Bureau régional de services : Hamilton Service Area Office