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 # / Registre no	Type of Inspection / Genre d'inspection
Sep 30, 2016	2016_511586_0008	027081-16	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

JESSICA PALADINO (586), YVONNE WALTON (169)

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): September 8, 9, 13, 14, 15, 16, 19 and 20, 2016.

The following Critical Incident System (CIS) Intakes were completed concurrently with the RQI:
009359-16 - Prevention of Abuse & Neglect
012045-16 - Falls Prevention
014764-16 - Hospitalization & Change in Condition
018399-16 - Falls Prevention
020957-16 - Prevention of Abuse & Neglect
024375-16 - Nutrition & Hydration

The following Complaint Intakes were completed concurrently with the RQI:
016786-15 - Prevention of Abuse & Neglect
006415-16 - Personal Support Services
009655-16 - Responsive Behaviours
013942-16 - Responsive Behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Managers of Resident Care, Social Service Worker, MDS-RAI Coordinator, Restorative Care Coordinator, Wound Care Nurse, Life Enrichment Therapist, Dietitian Specialist, registered and non-registered staff, residents, and families.

During the course of the inspection, the inspectors reviewed resident health records, investigative notes, complaints logs and files, policies and procedures; toured the home; and observed residents and care.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Nutrition and Hydration
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.

- **3 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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 the plan of care for resident #107 was reviewed and revised when the resident's care needs changed.

On an identified date in 2016, resident #107 had a fall resulting in an injury. The resident went to the hospital for assessment. Upon return to the home, the resident's care needs significantly changed. The plan of care was not updated to reflect the change in care goals. This was confirmed by lack of documentation and interview with the Administrator. [s. 6. (10) (b)]

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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

On an identified date in 2015, registered staff #304 was putting resident #101 to bed when they noticed altered skin integrity to a part of the resident's body. The area was noted to be slightly bruised and swollen. The cause was unknown.

The home's "Skin and Wound Care" Program (procedure #17-02-01, last revised February 2014) directed registered staff to notify a resident's substitute-decision maker (SDM) of any skin and wound issues.

Review of the resident's health record and the home's internal investigation notes confirmed that registered staff #304 did not alert the resident's SDM of the area of altered skin integrity until the following day, and confirmed that they should have notified the SDM upon discovery of the area.

Interview with the Administrator on September 20, 2016, confirmed that it was the expectation of the home that the registered staff member notify the resident's SDM upon knowledge of an area of altered skin integrity, especially in this case being that the area, in addition to bleeding, was bruised and swollen and the cause was unknown. The Administrator confirmed the home's policy was not followed as resident #101's SDM should have been notified on the date it was identified, rather than the following day. [s. 8. (1) (b)]

WN #3: 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 the policy named "Prevention, Reporting and Elimination of Abuse and Neglect" Number 01-05-03 was complied with.

The home's policy directed any person who has reasonable grounds to suspect abuse or neglect of a resident to immediately report the suspicion and the information upon which it is based to the Director. The reporting could be done by reporting the suspected abuse or neglect to the home's Administrator or designate who will immediately notify the Ministry of Health and Long Term Care (MOHLTC). On an identified date in 2016, resident #106 approached a PSW #305 with potential financial abuse concerns. The PSW reported this to a supervisor who immediately initiated an investigation; however, the suspicion of financial abuse was not immediately reported to the MOHLTC. The critical incident report was received at the MOHLTC thirteen days after the reported suspicion of financial abuse. The Administrator confirmed the policy, relating to reporting and notification, was not complied with. [s. 20. (1)]

Issued on this 30th day of September, 2016

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

Original report signed by the inspector.