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 sions 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
Dec 14, 2016; Jan 4, 2017	2016_265526_0016	028240-16, 030486-16, 031658-16	Complaint

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

THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 4, 8, and 29, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care (MRC), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behaviour Supports Ontario (BSO) staff, residents and family.

During the course of the inspection, the inspector toured the home, observed residents and staff, reviewed health records, policies and procedures and investigative notes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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. 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 a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) According to their health records, resident #001 was incontinent of bowel and bladder. The document the home referred to as their care plan indicated the assistance and type continence product the resident needed.

During inspection, the Long Term Care Homes (LTC) Inspector viewed a video that demonstrated Personal Support Worker (PSW) #106 assisting resident #001 to the bathroom. During interview, PSW's #105 and #107 stated that the type of assistance and continence product described in the resident's care plan was not currently in place since the resident's care needs had changed. The PSW's and Manager of Resident Care (MRC) confirmed that resident #001's plan of care had not been updated when their care needs changed in relation to type of continence, continence products used and toileting assistance required.

B) According to their health record, resident #001 had sustained a fall with injury in 2014, and had a fall without injury in 2016. During interview the resident's family member expressed concern that on a specified day in 2016, the resident was left unattended, at which time they stood up and walked unassisted; this placed them at risk for falling. The family member stated that they addressed their concerns to the MRC at that time and requested specific falls prevention interventions be put in place.

During interview, the MRC confirmed that they addressed the issue with the family member and staff at the time of the complaint but had not updated the document the home referred to as the care plan, to include the falls prevention strategies that were discussed when the resident's care needs had changed.

C) During interview, resident #001's family member complained to the LTC Inspector that they thought the resident would benefit from an additional bath each week, that they had requested this during a specified month in 2016, and that it had not been provided. On a specified day in 2016, the Nurse Practitioner documented that they had identified a skin and wound condition, and that resident #001's family member requested that the resident be given an extra bath day each week. Staff were to discuss with day staff to meet this request. The document the home referred to as resident #001's care plan after that time, directed staff to bathe the resident twice per week rather than three times per week as per the family's request.

Review of flow sheets completed by PSWs revealed that resident #001 received two baths per week following the family's request. During interviews, The MRC and Director of Care (DOC) confirmed that an additional bath per week would have been appropriate for resident #001 but that it had not been provided. The MRC confirmed that the plan of care was not reviewed and revised when resident #001's care needs changed in relation to bathing and meeting their hygiene needs. [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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 failed to ensure that actions were taken to meet the needs of the resident with responsive behaviours including assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

According to their health record and interview with the Manager of Resident Care (MRC), resident #001 had dementia and exhibited responsive behaviours over a six to 12 month period and included resistance to care. The MRC, and PSWs #105, #107, and #108 stated that it was difficult to identify triggers for the resident's behaviours. PSWs #105 and #107, the MRC, and DOC confirmed that the resident exhibited resistance to care and other responsive behaviours and that the plan of care was not effective. The document the home identified as resident #001's care plan did not directed staff regarding the resident resisting care.

Review of resident #001's health record and interview with the Behaviour Supports Ontario (BSO) RPN #110 indicated that the resident had not been assessed by them or an external care provider when their behaviours worsened. While progress notes indicated several incidents of responsive behaviours, the BSO RPN #110 confirmed that the RAI MDS assessment did not reflect the resident's day to day behaviours. During interview, the BSO RPN #110 stated thinking that the staff had normalized the resident's behaviours.

According to the home's investigative notes, review of the video clip, and interviews with the Manager of Resident Care (MRC), Administrator, and the resident's family, PSWs #107 and #108 held down resident #001 while RN #109 provided. During interviews, PSWs #107, #108 and RN #109 confirmed that resident #001 was held down during care due to their resistance to care and that holding them down was not part of their plan of care.

The BSO RPN and MRC confirmed that resident #001 had not been reassessed, that BSO should have been consulted when behaviours worsened, so that strategies could be developed and evaluated to help prevent, minimize or respond to the responsive behaviours. [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 to ensure that, for each resident demonstrating responsive behaviours, (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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's "Prevention, Reporting and Elimination of Abuse and Neglect" policy number 01-05-03, last reviewed March 2016, directed staff to do the following:

"Any person who has reasonable grounds to suspect abuse or neglect of a resident shall immediately report the suspicion and the information upon which it is based to the Director, Performance Improvement and Compliance Branch MOHLTC.... can be done by reporting the suspected abuse or neglect to the Home's Administrator or designate who will immediately notify the MOHLTC". The home's policy also stipulated an exclusion to physical abuse that "Physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances".

On a specified day in 2016, resident #001's family provided the home with a video clip (with no sound) that revealed PSW's #107 and #108 had used excessive force by holding resident #001 down while RN #109 provided care. The home's investigation and report by the resident's family revealed that the resident developed a localized injury to an extremity where care was being provided.

During interviews, the Manager of Resident Care (MRC) and the Administrator stated that they viewed the video on the day they received it, and identified staff's actions as a violation of the home's Responsive Behaviour Program and of Resident's Bill of Rights and did not interpret the force and injury of resident #001 as abuse. They stated that they submitted a report to the Critical Incident System approximately two weeks later, after being notified by police . The Administrator confirmed that the home's policy identified that excessive use of force during care was physical abuse and that staff had used excessive force to provide unwanted care to resident #001 as indicated in the video clip. They confirmed that the home's policy had not been followed when a suspected, alleged or witnessed abuse in the form of excessive use of force during care of resident #001 was not immediately reported to the Director according to the home's policy. [s. 20. (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and to ensure that the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

According to resident #001's health record and interviews with PSWs #100, #105, #106, #107 and #108, and Registered Nurse (RN) #109, resident #001 had cognitive impairment and a history of responsive behaviours that included resistance to care. The document the home referred to as the most recent care plan did not include written strategies directing staff to manage or reduce resistance to care.

Resident #001's Substitute Decision Maker (SDM) complained to the MOHLTC Action line that they noticed an injury on the resident's extremity. During interview, the SDM stated that they spoke to RN #109 who said that the resident was held down to provide care that the resident didn't want.

On a specified day in 2016, resident #001's family provided the home with a video clip (that had no sound) that revealed PSW's #107 and #108 using excessive force while RN #109 initiated care. After the resident pulled away from the RN, PSWs were observed to pause, reposition their grip on the resident's arms and hands and held them down while the RN completed the care. The MRC and Administrator confirmed this.

During interviews, PSWs #107 and #108 confirmed that the resident indicated that they did not want the care. They said that they knew that holding the resident down was wrong but took direction from RN #109. RN #109 stated that afterward, they realized that holding down resident #001 was improper as they should have stopped when the resident resisted and contacted their family member to assist. During interview, the Behaviour Supports Ontario (BSO) RPN #110 stated that staff should have stopped what they were doing, left and returned, used gentle persuasive techniques, took time to explain the procedure to the resident, called the resident's family member, and consulted BSO to develop strategies if the plan of care was not effective.

The MRC and Administrator confirmed that staff had not managed resident #001's responsive behaviours according to the home's expectations, and that holding down a resident to provide care that the resident clearly did not want, constituted excessive use of force under the circumstances. The MRC stated that the resident's skin was assessed after the incident and an injury to their extremity where care was provided was noted. As a result of the internal investigation three (3) staff members were disciplined. [s. 19. (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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff; and for the purposes of clause a) of the definition of "physical abuse" in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive under the circumstances, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

The home's Continence Care and Bowel Management Program policy (number and date not provided) directed staff to complete a continence assessment on admission and when there were changes in resident status that impacted continence. This was confirmed during interview with the Manager of Resident Care (MRC) who stated that residents' continence should be assessed when there were changes in continence.

Review of health records for residents #001, #002 and #003 revealed that they had not received a continence assessment using a clinically appropriate assessment instrument specifically designed for this purpose when their continence worsened. During interview, the MRC confirmed that residents #001, #002, and #003 had not had a continence assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, that was conducted using a clinically appropriate assessment instrument specifically designed for assessment of incontinence where the condition or circumstances of the resident required. [s. 51. (2) (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, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #6: 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.

The home's expectation that residents be treated with respect and dignity during transfers was supported by the home's "Lift, Transfer and Repositioning" policy number 24-05-01, last reviewed April 2016, that directed staff to ensure that resident's dignity was preserved when preparing to transfer a resident.

Resident #001's family member provided a video to the home that demonstrated PSWs #105 and #106 removing resident #001's clothing prior to transferring them to the bathroom using a walker. PSW #105 confirmed that they should have covered the resident during transfer between the bed and the bathroom.

According to the home's investigative notes, and interviews with the Manager of Resident Care and the Administrator, PSW's #105 and #106 actions were not consistent with treating resident #001 with respect and dignity in that they did not ensure that resident #001 was covered in a dignified manner during the transfer; both PSWs were disciplined. The Administrator and MRC confirmed that staff had not complied with the home's expectations as supported by the "Lift, Transfer and Repositioning" policy. [s. 8. (1) (b)]

Issued on this 25th day of January, 2017

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

Original report signed by the inspector.