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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 6, 2019	2019_674610_0019	016355-18, 024216-18, 030269-18, 030356-18, 032968-18, 006661-19	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

NATALIE MORONEY (610), AYESHA SARATHY (741), KRISTEN MURRAY (731)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 24, 25, 26, 29, 2019

The following Critical incidents (CI) Reports were completed concurrently during the inspection:
CI #M620-000015-18, Log #030269-18, related to Prevention of Abuse and Neglect.
CI #M620-000009-18, Log #016355-18, related to Medication Management.
CI #M620-000016-18, Log #030356-18, related to Medication Management.
CI #M620-000011-18, Log #024216-18, related to Falls Prevention and Management.
CI #M620-000003-19, Log #006661-19, related to Falls Prevention and Management.
CI #M620-000021-18, Log #032968-18, related to Falls Prevention and Management.

During the course of the inspection, the inspector(s) spoke with The Administrator, Acting Director of Care, Manager(s) of Resident Care, Registered Nurse(s), Registered Practical Nurse(s), Housekeeper, and Personal Support Worker(s)

Inspectors also observed resident care areas, medication rooms and storage of medications.Conducted interviews and reviewed relevant record documentation, and health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

s. 6. (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. (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 :

A) The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident (CI) Report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in relation to a fall of a specific resident. The resident was sent to the hospital and had a significant change in status.

During observations of the resident's room on three different days, the inspector observed one quarter bed rail on the window side in the up position. Signage on the bed frame indicated that bed rails were to be tied down.

The residents' plan of care showed there was no documentation to indicate the use of a quarter bed rail.

During staff interviews, they said that the bed rails were used for bed mobility. The staff further said they would expect the use of bed rails to be in the resident's care plan. In another interview, Acting DOC said that the resident used bed rails for bed mobility but the bedrails were not included in the care plan and should have been.

B) A Critical Incident (CI) Report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in relation to the fall of a specific resident that resulted in a transfer to the hospital and had a significant change in health status.

In an interview with the staff they said that the first place that they would look to find out the transfer status of a resident is inside the resident's bathroom cupboard door. They also said that every resident should have a transfer logo posted. During an observation of the resident's room the inspector found no evidence of a transfer logo posted in the resident's bathroom cupboard door.

The home's Fall Prevention and Management Policy, was reviewed and stated, in part, that Registered Staff must ensure that the logos above the resident's bed/care cupboard are updated according to the results of their assessment related to bedrails, transfer and lifting needs.

Further review of resident current care plan showed that the Falling Star Awareness was documented as one of the interventions under Falls Prevention.

A review of the home's "Falling Star Protocol", stated that residents were added to the Falling Star program if they had two or more falls in the last 30 days and they were determined to be at risk based on their individual circumstances. It was also stated that residents would be discharged from the program if they did not have any falls in a three month period and if they had a significant change in status.

A review of the home's Residents on Falling Star List showed that the resident was not a part of the program on the January-March 2019 list.

During an interview staff said that the resident was no longer part of the Falling Star program as they had likely been reassessed and did not need to be on it anymore.

The licensee failed to ensure that there was a written plan of care for the residents that set out clear directions, related to falls prevention, to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

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

The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) regarding a fall of a specific resident, which resulted in a fracture and required surgical repair.

Review of record documentation showed that the resident's plan of care stated that staff

were to ensure the resident's bed was in the lowest position when the resident was in bed, staff were to ensure that fall mats were on both sides of the bed when the resident was in bed.

In a review of the home's investigation notes, it was identified that a falls mat was not in place on the side of the bed where the resident fell. The home's investigation notes identified that staff told management that the resident's bed was not in the lowest position and fall mats were not in place at the time the resident fell. Another staff told the home that resident's bed was in mid-position and was not in the lowest position when the resident sustained their fall.

In an interview with staff they said that the resident had fell out of bed and their hand was caught in the hand rail. Staff further stated they released the resident hand from the rail. When asked if the resident's bed was in the lowest position, staff stated it was not.

During an interview with the nursing staff, when asked if the fall mats were in place at the time of the fall, the nursing staff stated they were not.

In an interview with Acting Director of Care (DOC) and Manager of Resident Care (MORC) when asked if the interventions for falls prevention were in place for the resident at the time of the fall, MORC stated they were not.

In an interview with the Administrator they, stated that it was noted as a result of the internal investigation that staff did not follow the plan of care for the resident related to falls prevention strategies.

The licensee failed to ensure that the falls prevention interventions set out in the plan of care were in place for the resident at the time of the fall, as specified in the plan.

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 set out clear directions to staff and others who provided direct care to the resident, and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident (CI) Report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) , in relation to the fall of a specific resident that resulted in a transfer to the hospital and a significant change in health status.

The CI report documented that the resident had a fall and they were found on the floor in their room. The Resident was sent to the hospital after their second fall and returned back to the home on the same day with a diagnosis of a fracture.

Record documentation showed that the resident was assessed to be moderate risk for falls. The resident's risk level changed to high risk of falls after a second fall with transfer

to hospital.

A review of the resident's record documentation showed that there was no documented evidence that a post-fall assessment had been completed after two identified falls.

The home's "Falls Prevention and Management" Policy stated, in part, that the Manager of Resident Care/Designate was responsible for ensuring that Post Fall Assessments are completed and any recommended actions implemented after each fall.

The home's "Post Fall Follow up, Assessment & Management" Procedure last revised, was reviewed and stated, in part, that for all witnessed, unwitnessed or near miss falls, registered staff in the home area are required to complete the Risk Management Report in the electronic health record and a comprehensive Post-Fall Assessment.

In an interview with the Acting DOC, they said that after a resident has a fall, registered staff are required to complete Risk Management, which includes the Post-Fall Huddle. Acting DOC, stated that when completing the Risk Management section, the Post-Fall Huddle is triggered and registered staff are required to complete it as a part of the Post Fall Assessment. They further said that if the Post-Fall Huddle was not complete in Risk Management, the Post-Fall Assessment would be considered incomplete. Acting DOC, stated that it would be the home's expectation to have done Post-Fall Huddles for those falls.

The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

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 when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #3: 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 is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A) This inspection was completed related to Critical Incident (CIS) report received by the Ministry of Health (MOH), from the home related to medication administered to a specific resident that was not prescribed and resulted in an adverse reaction and the resident was sent to hospital.

Review of record documentation showed that the resident had been administered medication that were prescribed for another identified resident. Further review of documentation showed that the medication was administered by mistake to the wrong resident during the morning medication pass.

The homes internal investigation notes showed that they were monitoring the resident's vitals. On the same day the resident the had been transferred to the hospital related to a significant change in health status.

B) A second CIS report received by the MOHLTC from the home was related to medication being administered to an identified resident that was not prescribed and resulted in an adverse reaction to the resident and the resident was sent to hospital.

Review of record documentation showed that, the resident was administered medication that were prescribed for another resident.

Further documentation showed that the resident had a significant change in status. The Resident was sent to the hospital. There was no documented evidence, that the resident had an adverse reaction to receiving the wrong medication, and returned to the home after a CT scan.

The physician's documentation showed that the resident had received a double dose of a specific medication and was very tired. The resident had a change in health status and was sent to hospital.

The home's "Medication Incident Reporting" procedure 06-03-51, stated in part that a medication incident is defined as an act of omission or commission whether it results in harm, injury or death of a resident".

The Administrator said that it was the expectation of the home was that all medication administrations were given as prescribed for all resident's.

The licensee failed to ensure that no drug was used by or administered to residents in the home unless the drug has been prescribed for the resident. [s. 131. (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 The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of every investigation undertaken were reported to the Director.

The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) regarding a fall of a specific resident that resulted in a fracture.

A review of the CIS report identified that an identified resident was found on the floor of their room on their left side between the bed and door entrance by a PSW. The CIS report stated that resident's used two quarter bed rails for bed mobility, and falls prevention strategies in place included bed in lowest position with fall mats on both sides.

In an interview with the Acting Director of Care (DOC) and Manager of Resident Care (MORC), they said the home updated the CIS report with the outcome of the internal investigation. MORC stated the CIS was not updated to include information about the residents hand being caught. When asked if the CIS report was updated with the names of staff who were involved with or discovered the incident following the home's internal investigation, MORC stated it was not. When asked if the CIS report was updated with fall prevention interventions in place for the resident at the time of the fall, MORC stated the falls prevention interventions were listed.

The licensee has failed to ensure that the results of the home's internal investigation related to CIS report were reported to the director. [s. 23. (2)]

WN #5: 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) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an injury in respect of which a person was taken to hospital and that resulted in a significant change in the resident's health condition no later than one business day after the occurrence of the incident, followed by the report required.

A Critical Incident (CI) Report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) recod documention showed that the resident had an unwitnessed fall and was sent to hospital after complaints of left sided pain from hip to below the knee and had surgical repair of their left hip on.

The home's falls prevention policy titled "Fall Prevention and Management" stated that the home must initiate the online CI report to the MOHLTC within 24 hours, if a resident's fall results in a transfer to hospital and a significant change in health status.

During an interview, the Acting Director of Care (ADOC) said that if a resident has a fall on the weekend, is sent to the hospital and has a significant change in health status, they would submit the CI report to the MOHLTC on the Monday following the weekend. The Acting DOC acknowledged that the CI report for resident #004's fall was submitted late

The licensee has failed to ensure that the Director was informed of an injury in respect of which a person was taken to hospital and that resulted in a significant change in the resident's health condition no later than one business day after the occurrence of the incident, followed by the report required. [s. 107. (3) 4.]

Issued on this 6th day of May, 2019

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

Original report signed by the inspector.