Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Nov 20, 2019	2019_803748_0011	020702-19, 020990-19, 021047-19	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

EMMY HARTMANN (748)

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): October 31, November 4, 5, 6, 7, 2019.

The following intakes were completed in this Complaint Inspection:

Log #020990-19, log #020702-19, CIS #M620-000019-19, and log #021047-19, were related to falls prevention and unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Senior Nursing Manager, Resident Care Managers (RCM), Building Operator, Building Supervisor, Grand River Elevator Service Technician, Physiotherapist (PT), Occupational Therapist (OT), Administrative Assistant, registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, and policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 provision of the care set out in the plan of care was documented for resident #001 and resident #003.

Log 0320990-19 was related to an unexpected death of resident #001; log #020702-19, CIS #M620-000019-19, was related to a fall incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in their health status; and log #021047-19, was related to concerns about falls prevention.

A: A review of resident #001's records identified that they were high risk for falls, and that they were to have increased monitoring during specified times.

An interview with PT #114, identified that there were different interventions trialed for resident #001 to prevent them from falling. However, they identified that resident #001 remained at risk, as the interventions were ineffective. They identified that frequent monitoring of resident #001 was then put in place for the resident, to ensure their safety.

A review of resident #001's records identified that there was no documentation completed on the increased monitoring intervention in the resident's care plan.

Interview with PSW #117, identified that residents that were high risk for falls were monitored more frequently, and they had a task that was set up on Point of Care (POC), to alert staff that frequent checks were needed. The POC task would also allow for the

staff to document that the frequent checks were provided or completed on the residents.

During an interview with RCM #102, it was identified that there was no documentation of the frequent checks that were completed for resident #001.

The Senior Nursing Manager identified that it was an expectation that residents that were high risk for falls had their checks documented, and indicated that this should have been done for resident #001.

B: A review of resident #003's records identified that they were high risk for falls, and that they were to have increased monitoring at specified times during the day.

A review of resident #003's records identified that there was no documentation completed on the increased monitoring intervention in the resident's care plan.

Interview with PSW #117, identified that residents that were high risk for falls were monitored more frequently, and they had a task that was set up on POC, to alert staff that frequent checks were needed. The POC task would also allow for the staff to document that the frequent checks were provided or completed to the residents. However, resident #003, did not have a POC task for the frequent checks, and therefore, staff were not documenting the frequent checks, being completed on the resident.

The Senior Nursing Manager identified that it was an expectation that residents who were high risk for falls had their checks documented and indicated that this should have been done for resident #003.

The home failed to ensure that the frequent checks completed for resident #001 and resident #003 were documented. [s. 6. (9) 1.]

2. The home failed to ensure that resident #001 was reassessed and their plan of care was reviewed and revised when their care needs changed or when the care set out in the plan was no longer necessary.

An incident note documented on an identified date and time, by RN #107, identified that resident #001 had an unwitnessed fall.

Interview with OT #111, identified that they observed the resident at risk for falling while

using their mobility device. They identified that a new device was implemented to prevent the resident from falling but that they did not add the device, as one of the interventions in the care plan, when it was implemented.

An interview with PSW #112, and PSW #115, identified that resident #001 had the new device implemented.

Interview with RPN #113, identified that resident #001 had the new device implemented, and that it was missing from the resident's care plan.

The Senior Nursing Manager identified that it was an expectation that the care plan for residents were up to date, and that the device should have been added to the resident #001's care plan when it was implemented. [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 and to ensure that the provision of the care set out in the plan of care is documented, and to ensure that residents are reassessed and their plan of care is reviewed and revised when their care needs change or when the 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. 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 where the regulation required the licensee of a LTC home to have, institute, or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s.48 (1) 1 and in reference to O. Reg. s. 48 (2) b. the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and that the program must provide for assessment and reassessment instruments.

Specifically, staff did not comply with the licensee's policy "Post Fall Follow up, Assessment and Management, procedure 19-01-05", last revised, August 2017, and "Head Injury Routine procedure 19-01-08", last reviewed May 2019, where it stated to initiate a Head Injury Routine (HIR) for all un-witnessed falls and witnessed falls that have resulted in a possible head injury, at the following frequency "every 1 hours x 4 hours then, every 2 hours x 2 then, every 4 hours x 4 then, every 8 hours for the next 24 hours".

The above mentioned frequency would require a completion of the HIR routine for 48 hours, which would total 13 documentation notes of the HIR completion.

A: A review of resident #001's records identified that they had un-witnessed fall, on two identified dates.

A review of resident #001's records, identified that there was no HIR completed for the resident, after they fell on an identified date.

A review of the HIR form that was completed for resident #001's fall, on an identified date, indicated that the HIR frequency was not completed at the frequency that it was supposed to be completed, and that their HIR was only completed seven times in 48 hours.

B: A review of resident #002's records identified that they had a fall on an identified date.

A review of the HIR form that was completed for resident #002, identified that the HIR frequency was not completed at the frequency that it was supposed to be completed, and that their HIR was only completed four times in 48 hours.

C: A review of resident #003's records identified that they had a fall on an identified date.

A review of the HIR form that was completed for resident #003, identified that their HIR was only completed once, in the next 48 hours following their un-witnessed fall.

The Senior Nursing Manager identified that it was an expectation that staff followed the home's policy, and that HIR's should have been completed for resident #001, resident #002, and resident #003 in as stated in the home's policy.

The licensee has failed to ensure that where the regulation required the licensee of a LTC home to have, institute, or otherwise put in place any policy, the policy was complied with. [s. 8. (1) (a),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 where the regulation requires the licensee of a LTC home to have, institute, or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The home failed to ensure that any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A: A review of resident #001's records identified they were high risk for falls.

An incident note documented on an identified date and time, by RN #107, identified that resident #001 had an unwitnessed fall.

An interview with RCM #102, identified that residents that fell were monitored and assessed for the next 72 hours, at every shift, including taking the resident's vital signs. They identified that there should be nine notations of the resident's vital signs in total, in follow up of a fall incident.

A review of resident #001's records identified that only two of nine vital signs documentation were completed as follow-up to the resident's fall on an identified date; and five of nine vital signs documentation were completed as follow-up to another fall on an identified date.

B: A review of resident #002's records identified they were high risk for falls.

An incident note documented on an identified date and time, indicated that resident #002 had an unwitnessed fall.

A review of resident #002's records identified that four of nine vital signs documentation were completed as follow-up to the resident's fall on an identified date.

C: A review of resident #003's records identified they were high risk for falls.

An incident note documented on an identified date and time, indicated that resident #003 had an unwitnessed fall, and that a HIR was initiated.

A review of resident #003's records identified that three of nine vital signs documentation were completed as follow-up to the resident's fall on an identified date.

Interview with the Senior Nursing Manager confirmed that there was incomplete documentation of resident #001, resident #002, and resident #003's vital signs after they had a fall incident. They identified that it was their expectation that the staff documented the resident's vital signs, for the next 72 hours, following a fall.

The home failed to ensure that the post-fall assessments for resident #001, resident

#002, and resident #003 were documented. [s. 30. (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 any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 2nd day of December, 2019

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

Original report signed by the inspector.