Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 20, 2020	2020_638542_0007	016440-19, 021211-19, 021549-19	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

JENNIFER LAURICELLA (542), LISA MOORE (613)

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): February 10 - 12, 2020.

The following intakes were completed in this Critical Incident inspection:

One intake related to a fall with an injury, one intake related to an unexpected death and one intake related to an alleged staff to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing and Personal Care, Manager of Resident Care, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspectors observed the provision of care to the residents, reviewed relevant health care records, employee files and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others who provided direct care to resident #001 were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director, identifying that resident #008, had a fall and sustained an injury.

A review of the resident’s most current care plan on Point Click Care (PCC), last updated in January 2019, indicated that staff were to ensure a specific fall prevention intervention was in place when resident #001 was in bed.

During observations of the resident on two separate occasions, the resident was lying in their bed without the fall prevention intervention in place.

During an interview with PSW #103, they stated that resident #001 required the use of the specific fall prevention intervention when they were in bed. The PSW further stated that they did not have access to the care plan on PCC and that they only had access to a paper copy of the care plan, which was kept in a binder on the unit. PSW #103 showed the Inspector resident #001’s paper copy of the care plan. The PSW stated that this care plan did not show that resident #001 required the use of the specific fall prevention intervention and that this was not the most current care plan.

During an interview with the RAI Coordinator #104, they stated that resident #001 required the use of the specific fall prevention intervention and that the paper copy of the care plan should have been current with this intervention. The RAI Coordinator stated that the paper copy of the care plan that was used by the care staff should have been up to date so that staff were aware of resident #001’s planned care.

During an interview with the Director of Nursing and Personal Care, they confirmed the paper copy of the residents’ care plans were in a binder on the units. The DONPC stated the paper copy of the care plan was to direct the care that staff were to provide to resident #001 and it should have been updated to show the use of the specific fall prevention intervention. The DONPC further stated that the responsibility to update the care plans and print off the paper copy was the registered staff in collaboration with the RAI Coordinator.

[s. 6. (8)]

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 staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #2: 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 the abuse or neglect investigation were reported to the Director.

Inspector #542 reviewed a CI report that was submitted to the Director, which identified alleged staff to resident abuse. The CI report indicated that resident #003 had reported they had fallen and that PSW #107 had responded to their call but failed to assist them.

Inspector #542 reviewed the CI report which had not been amended to include the outcome of the home’s investigation.

On February 12, 2020, Inspector #542 interviewed the Director of Nursing and Personal Care and the Manager of Resident Care who indicated that they did not include the outcome of the home’s investigation. [s. 23. (2)]

Issued on this 20th day of February, 2020

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

Original report signed by the inspector.