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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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 25, 2022	2022_848748_0002	006049-21, 007675-21, 008500-21, 011908-21, 012970-21, 013401-21, 013470-21, 016955-21	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

EMMY HARTMANN (748), LEAH CURLE (585)

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): January 25, 26, 28, 31, February 1, 2, 3, 4, 7, 8, 15, 2022. February 15, 2022, was conducted off-site.

The following intakes were completed during this Critical Incident inspection:

Log #006049-21 was related to a fall with injury.
Log #007675-21 was related to a hypoglycemic incident of a resident.
Log #008500-21 was related to a fall with injury.
Log #011908-21 was related to an allegation of staff to resident abuse.
Log #012970-21 was related to an injury of unknown cause.
Log #013401-21 was related to an unexpected death of a resident.
Log #013470-21 was related to a fall with injury.
Log #016955-21 was related to an allegation of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care (DOC), Clinical Resource Nurse/Infection Prevention and Control (IPAC) Lead, Rapid Antigen Tester, Halton Region Public Health Case Investigator, Halton Region Acting Infection Control Coordinator, Physiotherapist, Occupational Therapist, Wound Care Nurse, Managers of Resident Care, Resident Support Aides (RSA), registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

This inspection was conducted concurrently with Complaint Inspection (CO) #2022_848748_0001, and inspector #705243 was also present.

PLEASE NOTE: Written Notifications and Compliance Orders related to s.6(7) of the LTCHA, were identified in this inspection; and have been issued in Inspection Report #2022_848748_0001, dated February 25, 2022, which was conducted concurrently with this inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **3 VPC(s)**
- **1 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

From January 25, 2022 to February 8, 2022, the home was in a COVID-19 outbreak. According to the Management of Respiratory Outbreaks in Long Term Care Homes, 2018, eye protection was to be removed immediately after the task for which it was used and discarded into waste or placed in an appropriate receptacle for cleaning and disinfection. If they were re-used, eye protection should be cleaned and disinfected between use according to the manufacturer's recommendations using a minimum of a low level disinfectant. It also stated that masks were to be removed immediately after completion of task and discarded into an appropriate waste receptacle; and that the mask should be removed when leaving the residents dedicated environment.

The IPAC lead for the home identified that they expected staff to doff all Personal Protective Equipment (PPE), including eye protection and n95 mask, and apply new PPE as required and applicable, when exiting a room that was on droplet and contact precautions. The Halton Region Acting Infection Control Coordinator identified that the home was not given any direction to reuse eye protection and/or n95 masks, as the home had sufficient supply on hand. However, they identified that if supplies were reused, eye protection should be cleaned and disinfected in between use.

During an observation in three identified home areas, on different dates, staff in the unit were observed exiting four resident rooms, which were under droplet and contact precautions, and doffing their PPE except their eye protection or face shield and n95 mask. The staff were not observed cleaning their eye protection.

The DOC verified that there was no shortage of supplies in the home and they expected staff to doff all PPE upon exit of a room in droplet and contact precautions and apply new PPE as required and applicable.

There was an increased risk for infectious disease transmission related to this non-compliance as proper infection prevention and control measures were not followed during an active COVID-19 outbreak.

Sources: Observations of care; The Management of Respiratory Outbreaks in Long Term Care Homes, 2018; interviews with IPAC lead, and DOC. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

During an observation of care on an identified date, in an identified home area, a staff member was observed not wearing eye protection while they were assisting a resident with eating in the dining room. The home area was identified to be in active outbreak.

An RPN and an RN were also observed not wearing eye protection while they were providing treatments and/or care, and were within 2 metres of residents in the dining room.

As per Directive #3, effective December 24, 2021, appropriate eye protection (goggles or face shield) was required for all staff and essential visitors when providing care to residents with suspect/confirmed COVID-19 and in the provision of direct care within 2 metres of residents in an outbreak area.

The IPAC lead and the DOC both identified that staff were expected to wear eye protection.

Sources: Observation of care; Directive #3, effective December 24, 2021; interviews with RN #123, IPAC Lead, and DOC. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident had a written plan of care for a behaviour that placed them at risk; which included the goals intended to achieve, and clear directions to staff.

A resident was noted to have engaged in a behaviour that resulted in a change in condition. They were transferred to the hospital, and subsequently passed away.

The resident had a history of the behaviour, and a PSW identified that this was still current and that there were interventions to manage the behaviour. An RPN identified that they were not aware that the resident had this behaviour prior to the incident, which resulted a change in the resident's condition. The RPN indicated that this information should have been added into their care plan.

The DOC identified that the care plan was used to direct the care of residents in the home; and the Administrator verified that there was no written plan of care for the resident's behaviour.

There was risk related to this non compliance as there was no written plan of care on how to manage the resident's behaviour, which may have contributed to interventions not being implemented to manage the behaviour.

Sources: A resident's progress notes, care plan, the home's investigation notes; interviews with PSW, RPN, DOC, and administrator. [s. 6. (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 a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: 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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a policy, the policy was complied with.

In accordance with the LTCHA 2007 section 8. (1) a., every licensee of a long-term care home was to ensure that there was an organized program of nursing services for the home to meet the assessed needs of the residents and in accordance with O. Reg. 79/10, s. 30 (1) 1., the licensee was to ensure that there were written policies for the organized program of nursing services.

Specifically, staff did not comply with the licensee’s policy for an organized program of nursing service, which indicated that equipment for a treatment machine was easily accessible.

A resident was noted to have a behaviour that placed them at risk, on an identified date. They had a change in condition and was transferred to the hospital, and subsequently passed away.

A nurse identified that they wanted to perform a treatment on the resident but were unable to, as they could not locate a part of the equipment for the treatment machine.

The administrator acknowledged that the home's equipment for the treatment machine was not easily accessible.

There was actual risk to this non-compliance as the resident did not receive the treatment they needed as a result of the home not following their policy.

Sources: A resident's progress notes; the home's investigation notes, home's policy, last reviewed July 2019; interviews with RPN #132; and Administrator. [s. 8. (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 where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place a policy, the policy is complied with, to be implemented voluntarily.

Issued on this 15th day of March, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	EMMY HARTMANN (748), LEAH CURLE (585)
Inspection No. / No de l’inspection :	2022_848748_0002
Log No. / No de registre :	006049-21, 007675-21, 008500-21, 011908-21, 012970-21, 013401-21, 013470-21, 016955-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 25, 2022
Licensee / Titulaire de permis :	The Regional Municipality of Halton 1151 Bronte Road, Oakville, ON, L6M-3L1
LTC Home / Foyer de SLD :	Post Inn Village 203 Georgian Drive, Oakville, ON, L6H-7H9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Angela Archer

To The Regional Municipality of Halton, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must comply with section 229 (4) of the Long Term Care Homes Act (LTCHA)

Specifically, the licensee shall ensure that staff exiting rooms that are in droplet and contact precautions doff their eye protection or face shield, and n95 mask, in three identified home areas.

An audit is completed twice a week to ensure that staff are doffing their eye protection, and n95 mask upon exit from a room in droplet and contact precautions. The audits are to be completed for a minimum of one month, or until all staff are compliant with the process.

Documentation of the audit is kept, including when the audit was completed, what the findings were, the corrective actions taken, and who completed the audit.

Grounds / Motifs :

1. The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

From January 25, 2022 to February 8, 2022, the home was in a COVID-19 outbreak. According to the Management of Respiratory Outbreaks in Long Term Care Homes, 2018, eye protection was to be removed immediately after the task for which it was used and discarded into waste or placed in an appropriate receptacle for cleaning and disinfection. If they were re-used, eye protection should be cleaned and disinfected between use according to the manufacturer's recommendations using a minimum of a low level disinfectant. It also stated that masks were to be removed immediately after completion of task and discarded

into an appropriate waste receptacle; and that the mask should be removed when leaving the residents dedicated environment.

The IPAC lead for the home identified that they expected staff to doff all Personal Protective Equipment (PPE), including eye protection and n95 mask, and apply new PPE as required and applicable, when exiting a room that was on droplet and contact precautions. The Halton Region Acting Infection Control Coordinator identified that the home was not given any direction to reuse eye protection and/or n95 masks, as the home had sufficient supply on hand. However, they identified that if supplies were reused, eye protection should be cleaned and disinfected in between use.

During an observation in three identified home areas, on different dates, staff in the unit were observed exiting four resident rooms, which were under droplet and contact precautions, and doffing their PPE except their eye protection or face shield and n95 mask. The staff were not observed cleaning their eye protection.

The DOC verified that there was no shortage of supplies in the home and they expected staff to doff all PPE upon exit of a room in droplet and contact precautions and apply new PPE as required and applicable.

There was an increased risk for infectious disease transmission related to this non-compliance as proper infection prevention and control measures were not followed during an active COVID-19 outbreak.

Sources: Observations of care; The Management of Respiratory Outbreaks in Long Term Care Homes, 2018; interviews with IPAC lead, and DOC.

An order was made by taking the following factors into account:

Severity: The home was in COVID-19 outbreak for the duration of the inspection, and there was a risk for COVID-19 transmission related to this non-compliance.

Scope: This was a widespread issue involving three of three home areas that were observed.

Compliance History: 11 written notifications (WN), and nine voluntary plans of correction (VPC), were issued to the home related to different sections of the legislation in the past 36 months.

(748)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 24, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 25th day of February, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Emmy Hartmann

Service Area Office /
Bureau régional de services : Hamilton Service Area Office