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
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Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
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Public Copy/Copie du rapport public

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_0001	015046-21, 018850-21, 020000-21, 020725-21	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), ANGELA FINLAY (705243)

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): January 25, 26, 28, 31, February 1, 2, 3, 4, 7, 8, 2022.

The following intakes were completed during this Complaint Inspection:

Log #015046-21 was related to falls prevention and management.
Log #018850-21 was related to a fall with injury.
Log #020000-21 was related to falls prevention and management, and allegation of improper transfer.
Log #020725-21 was related to Infection Prevention and Control (IPAC).

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, Acting infection Control Coordinator for the Halton Region, 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 completed concurrently with Critical Incident Inspection (CIS) #2022_848748_0002, and inspector #585 was also present.

PLEASE NOTE: A Written Notification and a Compliance Order related to s.6(7) of the LTCHA, were identified in a concurrent inspection #2022_848748_0002 (Log #006049-21, CIS #M620-000007-21, Log #007675-21, CIS #M620-000010-21, Log #008500-21, CIS #M620-000012-21, Log #011908-21, CIS #M620-000015-21, Log #012970-21, CIS #M620-000016-21, Log #013401-21, CIS #M620-000018-21, Log #013470-21, CIS #M620-000020-21, Log #016955-21, CIS #M620-000026-21), and were issued in this report.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Reporting and Complaints

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

- **1 WN(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

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 care set out in the plan of care for a resident related to the provision of occupational therapy, physiotherapy and resident transferring was provided as specified in the plan of care.

A) The resident's plan of care stated that they were to receive one to two weekly sessions of occupational therapy. As per the schedule the occupational therapy team provided, the resident did not receive any occupational therapy for two identified weeks.

During an interview with the occupational therapy assistant, they stated that there were no occupational therapy services provided to any residents on the identified dates, as both the occupational therapist and occupational therapy assistant were off on isolation. The home did not have a plan in place to cover the absence.

There was a risk of decline in the resident's functional abilities by not providing occupational therapy as specified in the plan of care.

Sources: A resident's clinical records, occupational therapies schedule, and interview with the occupational therapy assistant.

B) The resident's plan of care stated that they were to receive three weekly sessions of physiotherapy. As per the schedule provided by the physiotherapist, the resident did not receive physiotherapy three times per week on three identified weeks.

During an interview with the physiotherapist, they acknowledged the resident did not

receive physiotherapy as per their assessed needs of three times per week on the weeks noted.

There was a risk of decline in the resident's functional abilities by not providing physiotherapy as specified in the plan of care.

Sources: A resident’s clinical records, physiotherapies schedule, and an interview with the physiotherapist.

C) The resident’s plan of care stated that they were a two-person assist with transfers. On two identified dates, the resident was transferred by staff with a one-person assist.

During an interview with a staff member, they stated that the home had completed an investigation into this incident and the result of this was that the staff in question had failed to follow the resident's care plan.

Staff not following the resident's assessed transfer needs presented a risk of injury to the resident.

Sources: A resident's clinical records, the home’s investigation notes, and interview with Staff #106. [s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care for a resident related to the provision of occupational therapy was provided as specified in the plan of care.

The resident's plan of care stated that they were to receive two weekly sessions of occupational therapy. As per the schedule the occupational therapy team provided, the resident did not receive any occupational therapy for an identified week.

During an interview with the occupational therapy assistant, they stated that there were no occupational therapy services provided to any residents on the identified dates.

There was a risk of decline in the resident's functional abilities by not providing occupational therapy as specified in the plan of care.

Sources: A resident’s clinical records, occupational therapies schedule, and interview with the occupational therapy assistant.

3. The licensee failed to ensure that a resident's plan of care related to transferring was followed.

The resident was dependent on two staff assistance and a mechanical lift for transfers.

In the morning of an identified date, a staff member did not check the resident's care plan and transferred the resident on their own. In the afternoon, another staff transferred the resident on their own, prior to reporting to the nurse that they observed a change in condition on the resident.

The resident was sent to hospital for further investigation, and was later diagnosed with an injury.

The nurse, and the DOC both identified that the resident's plan of care was not followed in the transfers leading up to the resident's change in condition.

There was actual risk to the resident's safety when the staff did not provide the resident's care as required.

Sources: A resident's progress notes, MDS assessments, care plan, the home's investigation notes; interviews with RN #116, and the DOC. [s. 6. (7)]

4. The licensee failed to ensure that a resident’s plan of care had been revised when their care needs related to their ambulation equipment and ambulation status had changed.

The resident’s care plan stated that their ambulation equipment needed to be beside them at all times when in their chair as they were able to get up on their own.

On an identified date, the inspector observed the resident in their chair with their ambulation equipment on the other side of the resident’s bedroom.

During separate interviews with two staff members, they stated that the resident had a change in care needs related to their ambulation equipment and ambulation status. One of the staff stated that the care plan needed to be updated to reflect this.

The care plan not being updated to reflect the resident's current ambulation status

presented a risk of injury to the resident.

Sources: A resident's clinical records, observations, and interviews with Staff #115, Staff #106, Staff #101, and the physiotherapist.

Additional Required Actions:

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

Issued on this 14th 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), ANGELA FINLAY (705243)
Inspection No. / No de l’inspection :	2022_848748_0001
Log No. / No de registre :	015046-21, 018850-21, 020000-21, 020725-21
Type of Inspection / Genre d’inspection:	Complaint
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:

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must comply with section 6 (7) of the LTCHA.

Specifically, the licensee shall ensure that the plan of care is followed related to:

1. Resident #001's frequency of occupational therapy (OT), and physical therapy (PT) sessions.
2. Resident #010's frequency of OT sessions.
3. Resident #001, and resident #005's transfer assistance received from staff.

4. A weekly audit is completed to ensure that resident #001's frequency of OT and PT sessions; resident #010's frequency of OT sessions; and resident #001 and resident #005's transfer assistance from staff, are being followed as per plan of care.

5. 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. The audits are to be completed for a minimum of one month, or until all staff are compliant with the process.

6. Develop a plan to ensure that residents #001, and #010, and all residents receive care as per their plan of care when staff are absent, including occupational and physiotherapy staff.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care for a resident related to the provision of occupational therapy, physiotherapy and resident transferring was provided as specified in the plan of care.

A) The resident's plan of care stated that they were to receive one to two weekly sessions of occupational therapy. As per the schedule the occupational therapy team provided, the resident did not receive any occupational therapy for two identified weeks.

During an interview with the occupational therapy assistant, they stated that there were no occupational therapy services provided to any residents on the identified dates, as both the occupational therapist and occupational therapy assistant were off on isolation. The home did not have a plan in place to cover the absence.

There was a risk of decline in the resident's functional abilities by not providing occupational therapy as specified in the plan of care.

Sources: A resident's clinical records, occupational therapies schedule, and interview with the occupational therapy assistant.

B) The resident's plan of care stated that they were to receive three weekly sessions of physiotherapy. As per the schedule provided by the physiotherapist, the resident did not receive physiotherapy three times per week on three identified weeks.

During an interview with the physiotherapist, they acknowledged the resident did not receive physiotherapy as per their assessed needs of three times per week on the weeks noted.

There was a risk of decline in the resident's functional abilities by not providing physiotherapy as specified in the plan of care.

Sources: A resident's clinical records, physiotherapies schedule, and an interview with the physiotherapist.

C) The resident's plan of care stated that they were a two-person assist with transfers. On two identified dates, the resident was transferred by staff with a one-person assist.

During an interview with a staff member, they stated that the home had completed an investigation into this incident and the result of this was that the staff in question had failed to follow the resident's care plan.

Staff not following the resident's assessed transfer needs presented a risk of injury to the resident.

Sources: A resident's clinical records, the home's investigation notes, and interview with Staff #106. (705243)

2. The licensee failed to ensure that the care set out in the plan of care for a resident related to the provision of occupational therapy was provided as specified in the plan of care.

The resident's plan of care stated that they were to receive two weekly sessions of occupational therapy. As per the schedule the occupational therapy team provided, the resident did not receive any occupational therapy for an identified week.

During an interview with the occupational therapy assistant, they stated that there were no occupational therapy services provided to any residents on the identified dates.

There was a risk of decline in the resident's functional abilities by not providing occupational therapy as specified in the plan of care.

Sources: A resident's clinical records, occupational therapies schedule, and interview with the occupational therapy assistant. (705243)

3. The licensee failed to ensure that a resident's plan of care related to transferring was followed.

The resident was dependent on two staff assistance and a mechanical lift for transfers.

In the morning of an identified date, a staff member did not check the resident's care plan and transferred the resident on their own. In the afternoon, another

staff transferred the resident on their own, prior to reporting to the nurse that they observed a change in condition on the resident.

The resident was sent to hospital for further investigation, and was later diagnosed with an injury.

The nurse, and the DOC both identified that the resident's plan of care was not followed in the transfers leading up to the resident's change in condition.

There was actual risk to the resident's safety when the staff did not provide the resident's care as required.

Sources: A resident's progress notes, MDS assessments, care plan, the home's investigation notes; interviews with RN #116, and the DOC.

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

Severity: Staff not following resident #005's plan of care placed the resident at actual risk of harm.

Scope: There was a pattern of non compliance in this area. Out of three residents reviewed, there were five of nine instances of their plan of care not being followed. There were two instances of provision of OT not followed; two instances of provision of transferring assistance not followed; and one instance of provision of PT not followed.

Compliance History: four written notification (WN), and four voluntary plans of correction (VPC), were issued to the home related to the same section 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