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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
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Original Public Report

Report Issue Date October 4, 2022
Inspection Number 2022_1615_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Regional Municipality of Halton

Long-Term Care Home and City
Post Inn Village, Oakville

Inspector who Amended
Yuliya Fedotova (632)

Additional Inspector(s)
Parminder Ghuman (706988)
Emily Robins (741074)
Sydney Withers (740735)

Inspector Digital Signature
Yuliya Fedotova
Digitally signed by Yuliya Fedotova
Date: 2022.10.05 10:39:06 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 27-29, August 2-5, 8-12, 15 (on-site) and on August 25 and September 6 (off-site), 2022.

The following intake(s) were inspected:

- Log # 008928-22 (CIS # M620-000007-22) related to a fall incident resulted in an injury.
- Log # 010432-22 (CIS # M620-000008-22) related to a fall incident resulted in an injury.
- Log # 015053-22 (Complaint) related to alleged abuse.
- Log # 002829-22 (Complaint) related to alleged retaliation.
- Log # 005286-22 follow up to CO #001 from inspection # 2022_848748_0001/015046-21, 018850-21, 020000-21, 02072 regarding s. 6 (7), compliance due date June 24, 2022.
- Log # 005287-22 follow up to CO #001 from inspection # 2022_848748_0002 / 006049-21, 007675-21, 008500-21, 011908-21, 012970-21, 013401-21, 013470-21, 016955-21 regarding s. 229. (4), compliance due date June 24, 2022.

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Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s. 6 (7)	2022_848748_0001	001	748
O. Reg. 79/10	s. 229 (4)	2022_848748_0002	001	748

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Resident Care and Support Services

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)
O. Reg. 246/22, s. 102 (2) b

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 6.1 Additional Requirement under the Standard indicated that the licensee should make Personal Protective Equipment (PPE) available and accessible to staff appropriate to their role and level of risk.

During an inspection in July 2022, there were no gowns observed in the PPE cart located near the room for a resident on additional precaution.

The Registered Practical Nurse (RPN) confirmed that the gowns should be available in the PPE cart for the resident's room and they were going to refill it.

On a day in August 2022, gowns were observed available and accessible in the PPE cart located near the resident's room.

There was minimal risk of impact on the infection prevention and control for residents in the home as there were no gowns available for the resident's room on Contact Precaution during an inspection in July 2022.

Sources: Observations and interview with the RPN #116 and other staff.

Date Remedy Implemented: August 2, 2022.

[#632]

WRITTEN NOTIFICATION FALLS PREVENTION AND MANAGEMENT

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with s. 49 (2) of O. Reg. 79/10 under the Long-Term Care Homes Act (LTCHA), 2007 and s. 54 (2) of O. Reg. 246/22 under the Fixing Long-Term Care Act (FLTCA), 2021.

On April 11, 2022, the FLTCA, 2021 and O. Reg. 246/22 came into force, which repealed and replaced the LTCHA, 2007 and O. Reg. 79/10. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 49 (2) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 54 (2) of O. Reg. 246/22.

The licensee has failed to ensure that when residents #001 and #003 had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

(A) Rationale and Summary

Resident #001's assessment records indicated that a post-fall and fall risk assessments were not completed following their fall on a day in January 2022. RN #108 confirmed that these assessments were not completed and that they should have been completed as required by legislation and the home's post-fall program.

Failure to complete post-fall assessment and documentation as required resulted in an increased risk of missing contributing factors to the resident's fall and reviewal of potential strategies to prevent recurring falls.

Sources: Resident #001's falls assessment documentation; interview with RN #108.
[#740735]

(B) Rationale and Summary

Resident #003 had a near miss fall on a day in May 2022, and on a day in June 2022. A post-fall assessment was not completed for either of these falls. The DOC confirmed that, per the home's Falls Prevention and Management Policy and Post Fall Follow-Up, Assessment, and Management Procedure, a post-fall assessment was required but not completed following the incidents in May and in June 2022. RPN #130 confirmed that they did not complete a post-fall assessment following the incident on a day in June 2022, because they did not know that it was required.

The resident was at increased risk of subsequent injury from a fall since the effectiveness of the falls interventions in place were not being evaluated.

Sources: Resident #003's progress notes, list of assessments in Point Click Care (PCC), Falls Prevention and Management Policy #19-01-01, Post Fall Follow-Up, Assessment, and Management Procedure #19-01-05; interview with the DOC and RPN #130.

[#741074]

WRITTEN NOTIFICATION PLAN OF CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 6(4)(b)*

The licensee has failed to ensure that Physiotherapist (PT) #114 and the others involved in the prevention and management of falls for a resident collaborated with each other,

(b) in the development and implementation of specified fall prevention measure in the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Rationale and Summary

A resident had a number of falls in May 2022. They were assessed on a day in May 2022 by PT #114 who recommended the use of a specified fall prevention measure. This recommendation was not captured in the care plan. Neither PT #114 nor any of the registered nursing staff interviewed could confirm if this specified fall prevention measure was in place. PT #114 advised that the typical procedure for implementation following PT assessment was for PT to communicate any recommendations in the 24 hour communication book, or to the nurse in charge directly. PT #114 did not speak to the nursing staff about this recommendation on a day in May 2022. They also stated that it was nursing's responsibility to add the specified fall prevention measure to the care plan. In an interview with RPN #130 they stated that it was the PT's responsibility to add it to the care plan. In an interview with the DOC on a day in August 2022, it was confirmed that the lack of communication between PT #114 and the other's involved in the prevention and management of falls for this resident was the reason for the specified fall prevention measure not being added to the care plan.

The resident's risk of injury in the event of a fall was increased due to the lack of communication between staff providing care to the resident in the development and implementation of the specified fall prevention measure in the resident's plan of care.

Sources: The resident's progress notes, care plan; Interview with the DOC and PT #114, RPN #105, Registered Nurse (RN) #132, and RPN #130.

[#741074]

WRITTEN NOTIFICATION PLAN OF CARE

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 6(11)(b)*

The licensee has failed to ensure that when a resident was reassessed and the plan of care reviewed and revised, (b) where the plan of care was being revised because care set out in the plan was not effective, that different approaches were considered in the revision of the plan of care.

Rationale and Summary

A resident fell on some days in May 2022. Documentation showed that a post-fall huddle was completed and that the care plan was reviewed following each of these incidences. No changes were made to the plan of care. At the time of these falls, specified interventions to manage fall risk were included. RPN #113 confirmed that the intervention mentioned above was ineffective and alternative approaches, were not tried.

The resident was at increased risk of injury from a fall because different approaches were not considered when the care set out in the plan was not effective.

Sources: The resident's progress notes, Risk Management Reports, Post-fall huddles notes, care plan; interview with RPN #113.

[#741074]

WRITTEN NOTIFICATION

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with s. 49 (1) of O. Reg. 79/10 under the Long-Term Care Homes Act (LTCHA), 2007 and s. 54 (1) of O. Reg. 246/22 under the Fixing Long-Term Care Act (FLTCA), 2021.

On April 11, 2022, the FLTCA, 2021 and O. Reg. 246/22 came into force, which repealed and replaced the LTCHA, 2007 and O. Reg. 79/10. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the

requirement was under s. 49 (1) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 54 (1) of O. Reg. 246/22.

The licensee has failed to ensure the home's falls prevention and management program was followed for a resident, specifically where staff were required to:

(a) refer a resident to PT/OT following a fall;
(b) refer a resident to the Registered Dietitian (RD) following a fall resulting in an injury;
(c) complete a Head Injury Routine (HIR) when a resident had fallen and had a specified treatment.

In accordance with O. Reg. 79/10 s. 8 (1) (b) and O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a falls prevention and management program and that it was complied with.

Specifically, staff did not comply with the "Post-Fall Follow-up, Assessment & Management" policy and the "Head Injury Routine" policy.

Rationale and Summary

(A) Risk Management for a resident's fall on a day in January 2022, indicated that a PT/Occupational Therapist (OT) referral was not processed post-fall. RN #108 confirmed that a referral should have been completed and the PT #114 stated the referral was not done. As per "Post Fall Follow-up, Assessment & Management" policy, the Registered Staff would complete an OT/PT referral following a resident's fall.

Not receiving a post-fall assessment by the home's PT resulted in their lack of awareness of the resident's fall on a day in January 2022, which may have impacted their specified transfer assessment and recommendations. This posed an increased risk to the resident, as a specified transfer was determined as a contributing factor to their fall on a day in January 2022.

Sources: Policy #19-01-05 "Post Fall Follow-up, Assessment & Management", the resident's PT/OT referral history and Risk Management; interviews with RN #108 and PT #114. [#740735]

(B) A resident fell on a day in April 2022 and the home became aware of their specified injury on a day in May 2022. The resident's RD referral history indicated that a referral to the RD was not processed after the home became aware of the specified injury. As per "Post Fall Follow-up, Assessment & Management" policy, the Registered Staff would refer to the RD if a specified injury occurred following a resident's fall. RN #108 stated that an RD referral should have been completed after this fall. RPN #117 and the RD confirmed that a referral was not processed.

Failure to complete an RD referral post-injury posed a low risk to the resident, as they were seen one week following notice of their specified injury for a quarterly nutrition review by the food services supervisor and were receiving specified nutritional supplementation.

Sources: Policy #19-01-05 "Post Fall Follow-up, Assessment & Management", the resident's RD referral history; interviews with RN #108, RPN #117 and RD.

[#740735]

(C) A resident's electronic Medication Administration Record (eMAR) indicated a specified daily treatment, when the resident fell in April 2022. As per "Head Injury Routine" and "Post Fall Follow-up, Assessment & Management" policies, the registered staff would complete a specified assessment with every resident who had a fall and was on a specified treatment. RN #108 verified that the specified assessment was not initiated for the resident following their fall on a day in April 2022, and that should have been completed.

The absence of the specified assessment following the resident's fall on a day in April 2022 did not significantly impact the resident, as they had specified examinations the date of the fall.

There was a moderate risk to the resident of specified injury, secondary to specified treatment, being undetected due to the specified assessment was not conducted.

Sources: Policy #19-01-08 "Head Injury Routine", the resident's eMAR and Risk Management; interview with RN #108.

[#740735]

(D) On a day in May 2022, a resident fell and sustained a specified injury. There was no record of referral made to the RD. Per the home's Post-fall Follow-up, Assessment and Management Procedure, a referral to the RD was required when the resident had a fall resulting in a specified injury. The RD confirmed that a referral was not submitted for this resident for post-specified injury assessment.

The risk of negative impact to the resident's nutritional status and healing of a specified injury was increased because the required falls preventions and management program was not complied with.

Sources: The resident's progress note, list of assessments in PCC, Post Fall Follow-Up, Assessment, and Management Procedure #19-01-05; interview with RD.

[#741074]

WRITTEN NOTIFICATION

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 115 (3) 4

The licensee has failed to ensure that a critical incident was reported to the Ministry of Long-Term Care no later than one business day after the occurrence of an incident where a resident fell, resulting in specified actions and a significant change in their health condition.

Rationale and Summary

A resident fell, resulting in specified actions and a significant change in their condition on a day in April 2022 and a critical incident report was submitted on a day in May 2022 – five business days following the time of the incident. The DOC indicated that the critical incident should have been reported one business day following the incident.

Sources: CIS #M620-000007-22, the resident's progress notes; interviews with DOC and MRC #118.

[#740735]

COMPLIANCE ORDER CO#001 PLAN OF CARE

NC#07 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 6 (7)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021, s. 6 (7).

Specifically, the licensee must:

1. Ensure resident #001 has a specified fall prevention measure in place as per their care plan.
2. Perform daily audits for resident #001 to ensure the specified fall prevention measure is in place.
3. Document the audits, including the names of staff who completed each audit, the outcome of the audit and corrective action taken, if required, for two weeks or until compliance is achieved
4. Educate nursing staff providing care for resident #008 on using specified techniques.
5. Ensure staff use specified techniques related to the specified care as per resident #008's care plan.

6. Perform daily audits for resident #008's care to ensure that specified techniques are practiced.
7. Document the audits, including the names of staff who completed each audit, the outcome of the audit and corrective action taken, if required for two weeks or until compliance is achieved.

Grounds

Non-compliance with: FLTCA, 2021 s. 6 (7)

The licensee has failed to ensure that the care set out in resident #001's plan of care related to falls preventions and in resident #008's plan of care related to interventions during specified care routine was provided to the residents as per their plan of care.

Rationale and Summary

(A) A documentation of an incident on a day in July 2022 identified that staff did not practice specified technique when provided care for resident #008. The resident exhibited behavior during care activities.

Resident #008's care plan directed staff to practice a specified technique during the resident's care.

The MRC #128 confirmed that staff to practice interventions as per the resident's plan of care. The actions of the staff caused minimal impact on the specified status of the resident.

Sources: Resident #008's care plan and other documentation; interview with MRC #128 and other staff.

[#632]

(B) Resident #001's care plan included a specified fall prevention measure in place to reduce the risk of injury. On a number of days in July and August 2022, resident #001 was observed in a location with no specified fall prevention measures in place. PSW #106 and #111 confirmed these observations. RN #108 confirmed that resident #001 should have a specified fall prevention measure in place.

The absence of the specified fall prevention measure posed an increased risk of injury to the resident.

Sources: Resident #001's care plan, MORSE falls assessment, resident #001's room observations; interviews with PSW #106 and #111, RN #108 and MRC #118.

[#740735]

This order must be complied with by October 17, 2022

COMPLIANCE ORDER CO#002 PLAN OF CARE

NC#08 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 6 (10) b

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with LTCHA, 2007, s. 6 (10) b and FLTCA, 2021, s. 6 (10) b.

Specifically, the licensee must:

1. Update a resident's care plan to reflect their specified care needs.
2. Review and revise if required the home's process for updating care plans when the home's physiotherapist and/or registered nursing staff identify changes in residents' specified care needs.
3. Provide education to all registered nursing staff on the home's process.
4. Maintain documentation of education provided to registered nursing staff, including the education material, the names of the participants and the dates the education was completed.

Grounds

Non-compliance with: FLTCA, 2021 s. 6 (10) b

On April 11, 2022, the FLTCA, 2021 and O. Reg. 246/22 came into force, which repealed and replaced the LTCHA, 2007 and O. Reg. 79/10. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 6 (10) (b) of the LTCHA, 2007. Non-compliance with the applicable requirement also occurred after April 11, 2022, which fell under s. 6 (10) (b) of the FLTCA, 2021.

The licensee has failed to ensure that the plan of care was revised when a specified care set out in the care plan for a resident around the unit, was no longer necessary.

Rationale and Summary

(A) A resident's care plan indicated specified transfer interventions. On a day in February 2022, an assessment note written by PT #114 provided directions on specified transfer interventions. This intervention was not revised when the resident's care plan was reviewed on a day in February 2022. PT #114 stated that the resident's care plan did not capture that they required a change in their transfer status in February 2022, following their assessment of the resident.

MRC #118 stated it was the responsibility of registered staff to update a resident's care plan if they identified a change in their specified needs. They indicated that there was a need for communication to registered staff clarifying the process of care plan updates being made following PT assessment and recommendation or when registered staff identified changes in a resident's care requirements.

The risk and impact to the resident was low due to their care plan contained a specified level of assistance for transfer than what was required.

Sources: The resident's care plan, PT assessment notes, Documentation Survey Report; interviews with PT #114 and MRC #118.

[#740735]

(B) On a day in July 2022, the resident was observed performing specified activity. The staff provided support to the resident. The resident's care plan directed staff to provide support to the resident during this activity.

A PT assessment note indicated that the resident could perform activity in a specified location. The care plan was not revised to reflect the outcome of this assessment. RN #108 stated that the resident's care plan should be revised to reflect specified current requirements.

The impact and risk to the resident were low due to their care plan detailing a specified level of assistance.

Sources: The resident's care plan, PT assessment notes, resident #001 observation; interviews with RN #108 and PT #114.

[#740735]

This order must be complied with by November 10, 2022

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Review/Appeal Information

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
email: MLTC.AppealsCoordinator@ontario.ca

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