Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: October 24, 2024
Inspection Number: 2024-1615-0003
Inspection Type: Complaint Critical Incident
Licensee: The Regional Municipality of Halton
Long Term Care Home and City: Post Inn Village, Oakville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 9-13, 16-20, 23-24, 26, 2024.

The following intakes were inspected:

- Intake: #00115131/ Critical Incident (CI)# M620-000012-24 was related to alleged improper/incompetent treatment of a resident.
- Intake: #00117940/ CI# M620-000016-24 and Intake: #00121273/ CI# M620-000022-24 were related to alleged staff-to-resident physical abuse.
- Intake: #00125277/ CI# M620-000036-24 was related to alleged staff-to-resident sexual abuse.
- Intake: #00123325 was related to a complaint with concerns regarding fall prevention and management, safe and secure home, and staffing, training and care standards.
- Intake: #00123954/ CI# M620-000031-24 was related to safe and secure home.
- Intake #00124496/ CI# M620-000033-24 was related to fall prevention and management.

- Intake: #00122715/ CI# M620-000025-24 was related to infection prevention and control.

The following intakes were completed in this inspection:

- Intake #00120562/ CI# M620-000021-24 and Intake #00122826/ CI# M620-000027-24 were related to falls prevention and management.
- Intake: #00122515/ CI# M620-000024-24 was related to infection prevention and control.

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care

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.

An observation of a resident's room indicated that the required falls prevention intervention was not in place.

A staff acknowledged that the resident was missing the required falls preventions intervention.

A review of the resident's care plan indicated that they required the certain fall prevention interventions to be in place.

Failure to ensure that the falls prevention interventions was in place may increase the resident's risk for falls.

Later, the intervention was observed to be in place for the resident.

Sources: Observations, current care plan, interview with staff.

Date Remedy Implemented: September 20, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 11.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to live in a safe and clean environment.

The licensee has failed to ensure that a resident's right to live in a safe environment was provided as specified in the plan.

Rationale and Summary
A falls intervention stated for a resident to remove all trip hazards. During the resident's room observation, a trip hazard was noted and a staff member acknowledged the safety concern and they had notified maintenance.

Failure to put safety precautions in place puts the resident at an increased risk for falls.

Sources: Progress notes, assessments, plan of care, interview with staff.

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

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

Rationale and Summary
A resident exhibited exit-seeking behaviour and required an intervention in place. On a certain day, the resident eloped from the long term care home and the intervention did not activate. At the time, no one was at the front desk to monitor

individuals entering and exiting the building. Police were called and the resident returned to the home by police with a minor injury.

Failing to keep the resident within the home put their safety and security at risk.

Sources: Resident's clinical records, the home's post code yellow huddles notes, interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

A) The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in their plan.

Rationale and Summary
On a certain day, a resident reported to staff that they received care by one staff member but they required two staff for for a specific care. Staff indicated that they provided care to the resident alone.

Failing to follow the resident's plan of care put the resident at risk of not receiving the care they required.

Sources: Resident's clinical records, after-hours line, and interviews with staff.

B) The licensee has failed to ensure that the care set out in the plan of care was provided to resident as specified in the plan.

Rationale and Summary
On a specific day, a resident was found with a specific injury but no relevant assessments were completed.

Staff acknowledged that appropriate assessments should have been completed.

Not completing relevant assessments could have an impact on the resident's health status.

Sources: Progress notes, assessments, plan of care, interview with staff.

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
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.

The licensee failed to ensure that the provision of the care set out in the plan of care was documented.

Rationale and Summary
A resident exhibited exit-seeking behaviour and required an intervention in place. On a certain day, the resident eloped from the long term care home and no documentation that the intervention was in place was found. Staff confirmed that

the intervention was in place before they eloped and should have been documented.

Failing to ensure the intervention was documented put the resident at risk of staff not being aware if the intervention was in place.

Sources: Resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The home failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
The home's Prevention, Reporting and Elimination of Abuse and Neglect Policy, stated relevant assessment was to be completed when becoming aware of abuse or neglect.

On a certain day, a resident made an allegation of abuse by a staff member. A staff member was initially made aware of the resident's concern and stated no assessment was conducted.

Failure to follow the home's policy put the resident at risk of having other injuries that were not assessed.

Sources: Resident's clinical records, the home's Prevention, Reporting and Elimination of Abuse and Neglect Policy and interview with staff.

WRITTEN NOTIFICATION: Reporting matters to Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure when a person had reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident was reported to the Director immediately.

Rationale and Summary

A resident was noted to have an injury. A CI report was submitted late for the resident.

Administrator acknowledged that the critical incident report was not submitted on time as required.

Sources: CI #M620-000012-24, interview with Administrator.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure when a person had reasonable grounds to suspect the abuse of a resident by anyone may have occurred, it was reported to the Director immediately.

Rationale and Summary
On a specific day, a new injury was observed on a resident. A staff failed to report this finding and later when the resident vocalized injury, the home failed to report the incident in a timely manner. Staff acknowledged it was reported late.

Failure to report immediately to the Director pose the risk of action not being taken in a timely manner.

Sources: CI M620-000016-24, the home's investigation notes, resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that the complainant was provided with an acknowledgement response of the complaint within 10 business days of the receipt of the complaint.

Rationale and Summary

A family member of a resident made a complaint to the home.

Administrator confirmed that the complainant was not provided with an acknowledgement response of the complaint after receiving the complaint within 10 business days.

Sources: CI #M620-000009-24, interview with Administrator.

WRITTEN NOTIFICATION: Director of Nursing and Personal Care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 250 (1)

Director of Nursing and Personal Care

s. 250 (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:

1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week.
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week.
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week.
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

The licensee has failed to ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the 35 hours of time per week for a certain time period.

Rationale and Summary

The home has 228 beds and requires a Director of Nursing and Personal Care who works regularly in the position for 35 hours per week as per legislation. For a certain time period, the home did not have a designated Director of Nursing and Personal Care, who met the qualifications and worked regularly in that position on site at the home for the specified hours.

Administrator acknowledged that there was no Director of Nursing and Personal Care who worked regularly in that position on site at the home during that specific time period.

Failure of having a designated Director of Nursing and Personal Care in the home can affect residents' care.

Sources: Interview with staff.

WRITTEN NOTIFICATION: CMOH and MOH

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that the required Infection Prevention and Control measures are followed in the home.

Specifically, the home did not ensure that appropriate waste receptacles with lids in residents room for Personal Protective Equipment (PPE) disposal were provided as required by the 'Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings' from Ministry of Health, effective April 2024'.

Rationale and Summary

On a certain day, an observation was made of a resident's room on isolation on an outbreak home area and two open waste receptacles without lids were noted near the door of the resident room.

Another observation was made of rooms of different residents on isolation that had open waste receptacles without lids for PPE disposal.

Infection Prevention and Control (IPAC) Lead acknowledged being aware of the requirement of having waste receptacles with lids in residents' room for PPE disposal and the need for replacing the current waste receptacles without lids.

Failure to provide appropriate waste receptacles with lids in residents' rooms for PPE disposal may increase the risk of infection transmission.

Sources: Observations, interview with IPAC lead, Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings' from Ministry of Health, effective April 2024.

COMPLIANCE ORDER CO #001 Skin and wound care

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

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The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Provide education for registered staff regarding skin assessment practices, specific to residents who sustain altered skin integrity (bruises). Be clear on the directions for documentation for altered skin integrity.
2) Conduct a weekly audit on skin and wound assessments completed by Registered staff on Willow Crescent for 1 month to ensure that Registered staff understand and are following the process, specifically skin assessment practices.
3) Document and retain records of the above education including the date and who provided the education.
4) Document the date, who completed the audit, non-compliances and corrective action taken. Complete for one month. Audit records must be kept and readily available for inspector to review.

Grounds
A) The licensee has failed to ensure that a resident was assessed when they exhibited an alteration in the skin.

Rationale and Summary

A resident had a fall and sustained an alteration in the skin, however no relevant assessment was completed.

A staff member acknowledged that relevant assessment was not completed.

Failure to complete a skin assessment could put the resident at risk for infection and altered skin integrity.

Sources: Progress notes, assessments, plan of care, interview with staff.

B) The licensee has failed to ensure that a resident was assessed when they exhibited an alteration in the skin.

Rationale and Summary

Another resident was found with a skin alternation and there was no relevant assessment completed with no progress note.

Staff acknowledged that the staff who assessed the resident should have completed relevant assessment and documented.

Failure to complete relevant assessment puts the resident at risk for infection and altered skin integrity.

Sources: Progress notes, assessments, plan of care, interview with staff.

This order must be complied with by January 21, 2025

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection

prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Provide education for PSW staff on maple unit regarding routine hand hygiene practices, including practices specific to resident mealtimes hand hygiene.
2) Provide education for registered staff on Willow unit regarding Isolation precaution procedure.
3) Conduct an audit daily for 2 weeks on mealtime hand hygiene. Document the date, who completed the audit, non-compliances and corrective action taken. Audit records must be kept and be readily available for inspector to review.
4) Document and retain records of the above education including the date and who provided the education.

Grounds
A) The licensee has failed to ensure that residents were supported with performing hand hygiene before meals by providing appropriate hand hygiene agents.

Specifically, in accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022, Additional Precautions requirement 10.2, the licensee failed to ensure that appropriate hand hygiene agents as described in the hand hygiene program were provided to the residents to perform hand hygiene prior to receiving meals.

Rationale and Summary

An observation of a dining room was made where a staff member supported residents in the dining room with hand hygiene prior to meal service using separate

wet hand towels placed in a basin.

The staff member reported that the handwash basin had hand towels soaked in warm water with no soap.

IPAC lead acknowledged that staff are required to use soap and water or hand sanitizer when assisting residents with hand hygiene before meals.

A review of the long-term care home's Hand Hygiene Policy indicated that staff will remind and/or assist resident to complete hand hygiene with soap and water when visibly soiled or with an alcohol-based hand sanitizer before and after each meal and snack offering.

Failing to provide appropriate hand hygiene agents to residents to effectively perform hand hygiene before meals may increase the risk of infection transmission.

Sources: Hand hygiene policy, observation, interview with staff.

B) The licensee has failed to implement, the standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary

During an observation, an isolation cart was noted in front of a resident’s door with no signage.

Staff acknowledged that the resident was on isolation and the isolation signage should have been placed on the door immediately with the isolation cart.

Failure to put safety precautions in place other residents at risk for infection.

Sources: Progress notes, assessments, plan of care, interview with staff.

This order must be complied with by January 21, 2025

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;
(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

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.