Ontario

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

London District
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Original Public Report

Report Issue Date: May 31, 2024	
Inspection Number: 2024-1178-0002	
Inspection Type: Critical Incident	
Licensee: Omni Healthcare (Lambton) Limited Partnership, by its general partner, Omni Healthcare (Lambton) GP Ltd.	
Long Term Care Home and City: Bear Creek Terrace, Petrolia	
Lead Inspector Adriana Tarte (000751)	**Inspector Digital Signature**
Additional Inspector(s) Terri Daly (115)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 30, 2024 and May 1-3, 2024.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake #00102785 related to an unexpected death
- Intake #00104143 related to fall prevention and management; and
- Intake #00108779 related to prevention of alleged abuse and neglect.

The following intake was completed in this inspection:

- Intake #00104626 related to fall prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
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 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

Rationale and Summary
A review of a resident's care plan indicated fall interventions in place. A progress note confirmed that three of the fall interventions had been removed per the

resident's request. The care plan indicated conflicting information for assistance required under mobility.

A staff member acknowledged that the fall interventions in question were discontinued per the resident's request. They stated they will review the most current mobility assessment to confirm mobility status.

An updated review of the care plan confirmed that the fall interventions and mobility had been revised based on the assessment of the resident and on the needs and preferences of that resident.

Sources: Resident plan of care and interview with staff.

[000751]

Date Remedy Implemented: May 1, 2024

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
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,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that a resident was reassessed at least weekly when they were exhibiting altered skin integrity.

Rationale and Summary
A review of an incident report confirmed that a resident had altered skin integrity after a fall. A review of a head to toe assessment showed that the altered skin integrity required skin and wound care. This assessment did not meet the definition of a clinically appropriate assessment instrument specifically designed for skin and wound assessment. There were no weekly skin and wound assessments for the wound in the resident's health records.

A registered staff confirmed that weekly skin and wound assessments should have been completed. The Administrator confirmed that the skin concern met the altered skin integrity definition and that the head to toe assessment used at the time of the incident was not a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

When the home did not complete weekly assessments of the impaired skin integrity, the risk of complications related to the impaired skin integrity may not have been identified and treatment may not have been initiated immediately.

Sources: Resident's health records, head to toe assessment, incident report; and interviews with staff.

[000751]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (b)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(b) the identification of any risks related to nutritional care and dietary services and hydration;

The licensee failed to ensure the identification of a risk related to nutritional care and dietary services and hydration.

RATIONALE AND SUMMARY:
A review of a resident's care plan, physician's orders and Registered Dietitian assessment indicated a specific diet type. The report sent to the Ministry of Long-Term Care indicated that the resident aspirated while being fed a specific food item.

A registered staff indicated that the food item was not an appropriate consistency for the resident to safely tolerate. They indicated that they had provided information to the Nutrition Manager and had placed signage at the desk indicating that the food item in question was not safe for any resident on that specific diet type. The signage was observed by the inspector.

A staff member acknowledged that they had provided the food item to the resident and they were not aware that it was not acceptable for a resident with that specific diet type.

The Administrator and the Nutrition Care Manager acknowledged that at the time of this incident that the home's nutrition program should have identified the risk relate to the food item and that staff should be aware of what is safe and tolerable for residents on specific diet types.

Not providing residents with appropriate foods for their diet type presented a choking risk.

SOURCES: interview, record review, observations.

[115]