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

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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
Jul 22, 2021	2021_745690_0017	005779-21	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Owen Hill Care Community
130 Owen Street Barrie ON L4M 3H7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

TRACY MUCHMAKER (690)

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): July 5-9, 2021

The following intake was inspected upon during this Complaint inspection:
-One log, which was the result of a complaint that had been submitted to the Director regarding the care of several residents.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Interim Director of Care (IDOC), Assistant Director of Care (ADOC), Infection Prevention and Control (IPAC) Lead, Director of Environmental Services, Registered Dietitian (RD), Housekeeper(s), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), students and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, observed infection control practices, cooling requirements, reviewed relevant health care records, internal documents, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **0 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

A complaint was submitted to the Director related to Personal Support Staff (PSW) staff not providing care as per resident's plan of care for several residents. The complaint included information that staff were not providing assistance with an activity of daily living (ADL) for a resident.

During a review of the resident's health records, the inspector viewed a document that indicated that staff were to apply a treatment at specified times. The Inspector noted that on the electronic treatment administration record (eTar), registered staff indicated that the treatment was applied to the resident by PSW staff.

According to the home’s policy titled “Skin and Wound Care Management Protocol”, PSW staff were follow the residents’ specified plan of care regarding any individualized skin management interventions.

In an interview with the PSW, they disclosed to the inspector they had not applied the treatment on the resident as per the support action on the days that they had signed for it, and were not sure if other staff had. In interviews with the Interim Director of Care (IDOC), they identified that staff were to complete care as per the care plan and that if a staff member documented that care was completed, then they would expect that the staff had completed the care.

Sources: A resident's health records, the home’s policy titled “Skin and Wound Care Management Protocol-VII-G-10.90”, last revised November 2020, interviews with PSW

staff, and the IDOC. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented for a resident.

During a review of the resident's health records, the inspector identified that the resident had an area of altered skin integrity. The inspector could not locate any assessments related to the altered skin integrity.

A review of the home’s policy titled “Skin and Wound Management Protocol”, indicated that the Nurse would complete an electronic Head to Toe assessment weekly until healed for any resident experiencing intact skin alterations such as excoriation and rashes.

In interviews with a PSW, and an Registered Practical Nurse (RPN), they indicated that the resident had an area of altered skin integrity. The RPN indicated that based on the type of altered skin integrity, they were to complete a head to toe assessment on the resident. The Inspector and RPN reviewed electronic health records for resident and they verified that there was no documented assessments related to the altered skin integrity. The RPN indicated to the inspector that they had assessed the resident’s skin but that they must have missed the documentation. In an interview with the IDOC, they verified that staff should have completed a head to toe assessment on the resident, and documented the assessment on PCC.

Sources:A resident's assessments and progress notes, the home’s policy titled “Skin and Wound Management Protocol-VII-G-10.90”, last revised November 2020, interviews with PSW #113, RPN #116, and the IDOC. [s. 6. (9) 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 care set out in the plan of care is provided as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. A complaint was submitted to the Director related to PSW staff not providing care as per the plan of care for several residents.

During a review of a staff personnel file, the inspector identified that further concerns related to the PSW, were submitted three months after the initial concerns were forwarded. The document alleged improper care of residents, and violation of the resident's rights by the PSW. The investigation notes included notes from other staff members reporting the concerns. There were no documents to indicate that the two staff members that brought the concerns forward were interviewed.

A review of the home's policy titled "Prevention of Abuse and Neglect of a Resident-VII-10.00", indicated that the Executive Director (ED) or designate would initiate an investigation by requesting that anyone aware of or involved in the situation, write, sign and date a statement accurately. The policy further indicated that the ED or designate would interview any person (s) who completed written and signed statements.

In an interview with the ED, they indicated that the PSW involved had been interviewed, but that they could not recall if the two staff members that submitted the notes were interviewed for further information and that they could not locate any notes to indicate that the interviews had occurred. The ED verified that according to the home's Prevention of Abuse and Neglect of a Resident policy, there should have been interviews with the staff members that brought the allegations forward and a record kept in the investigation file.

Sources: Staff personnel file, the home's policy titled "Prevention of Abuse and Neglect of a Resident-VII-10.00", last revised April 2021, interviews with the PSW, and the ED. [s. 20. (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 the home's Prevention of Abuse and Neglect policy is complied with, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the home was a safe and secure environment for its residents.

Covid-19 Directive #3, directed that all staff and essential visitors were required to wear appropriate eye protection (e.g., googles or face shield) when they were within two metres of a resident(s) as part of provision of direct care and/or when they interacted with a resident(s) in an indoor area.

Furthermore, the home's policy titled "Novel-Coronavirus-COVID-19 Prevention and Management", indicated that as per provincial health authority directives, the minimum requirement for Personal Protective Equipment (PPE) during the COVID-19 pandemic in long term care communities was: Universal surgical mask and eye protection within two metres of a resident when providing direct care and/or interacting with a resident in an indoor area.

On the second day of the inspection, the inspector observed a PSW, and a contracted worker in the dining room with residents, neither were wearing any eye protection. The Inspector also observed a student feeding a resident in the dining room with their eye protection on top of their head.

In separate interviews with the two staff, the student, and the ED, they all verified that they were to be to be wearing the eye protection when within two metres of a resident, including in the dining room.

Sources: Observations of staff, and a student, Covid-19 Directive #3, effective date June 9, 2021, the home's policy titled, "Novel Coronavirus-Covid-19 Prevention and Management, June 2021, interviews with staff and the ED. [s. 5.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any allegation of Abuse or neglect of a resident, or improper or incompetent treatment or care of a resident that resulted in harm or risk of harm was immediately reported to the Director.

A complaint was submitted to the Director related to a PSW not providing care as per the plan of care for several residents.

The home's policy titled "MOHLTC Duty to Report" indicated that anyone who had reasonable grounds to suspect that any incident of alleged, suspected, or witnessed abuse, or improper or incompetent care of a resident that resulted in harm or risk of harm to a resident immediately reported the suspicion to the MOHLTC Director.

During a review of investigation notes, the inspector identified that further concerns related to the PSW, were submitted three months after the initial concerns were forwarded. The document alleged improper care of residents, and violation of the resident's rights by the PSW.

In an interview with the ED, they verified that they had received the allegatations, and had completed an investigation but that they did not notify the Director and that they should have.

Sources: Staff personnel file, the home's policy titled "MOHLTC-Duty to Report-XXII-D-10.20", last revised June 2019, interview with the PSW, and the ED. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (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 to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a complaint was received concerning the care of a resident or operation of the home, the complaint was investigated and resolved where possible, and that the investigation was commenced immediately.

A complaint was submitted to the Director related to a PSW not providing care as per the plan of care for several residents.

In a interview with the ED, they verified that an email had been sent by a staff member to the previous Director of Care (DOC), the Assistant Director of Care (ADOC), and themselves related to care plan discrepancies and the care provided by a PSW. The ADOC and ED verified that a care plan review was completed for the residents, and there had been a response to the complainant, however; they were unsure if there was any investigation done related to the complaint about the care provided by the PSW, and that they could not locate any investigation or interview notes.

Sources: Investigation notes, interviews with the complainant, ADOC, and the ED. [s. 101. (1) 1.]

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Issued on this 27th day of July, 2021

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

Original report signed by the inspector.