Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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 26, 2019	2019_543561_0018	006544-19	Complaint

Licensee/Titulaire de permis

Maryban Holdings Ltd.
3700 Billings Court BURLINGTON ON L7N 3N6

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

Oakwood Park Lodge
6747 Oakwood Drive NIAGARA FALLS ON L2G 0J3

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

DARIA TRZOS (561)

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 9, 10, 12, 15, 16, 18, 19, 2019.

The complaint inspection log #006544-19 was completed related to multiple care concerns.

The following Critical Incident System (CIS) inspections were completed concurrently with this inspection:
2661-000011-19, log #012252-19 - related to resident to resident alleged abuse,
2661-000010-19. log #011505-19 - related to resident to resident alleged abuse,
2661-000012-19, log #013401-19 - related to resident to resident alleged abuse.

PLEASE NOTE: Non-compliance related to O. Reg 79/10 s. 30(2), example (D) was identified during CIS inspection report #2019_803748_0004 and is issued in this report.

Inspector Emmy Hartmann (#748) was also present during this Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, and residents.

During the course of the inspection, the inspector(s): toured the home, observed provision of care, reviewed clinical records, policies and procedures, complaints log, training records and annual evaluation of the program.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Medication
Nutrition and Hydration
Skin and Wound Care

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

4 WN(s)
3 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A complaint was logged with the Ministry of Long Term Care (MOLTC) indicating that resident #003 had an altered skin integrity that was observed by a Personal Support Worker (PSW) on an identified date in 2018, which was missed by the home.

Clinical records were reviewed and indicated that in 2018, registered staff documented in progress notes that the resident had an area of altered skin integrity and the RN was notified. The physician assessed the resident; however, there was no collaboration between the physician and the registered staff, there was no follow up to the area of concern and no action was taken. Clinical records indicated that on an identified date in 2019, the physician assessed the resident once again, as the area of concern continued to be present, ~~and the resident was referred to the specialist for further assessments.~~

The interview with the Director of Care (DOC) indicated that when the physician visited on their round days, they do them with the RN on the unit and they would go over the

assessments together.The DOC confirmed that there was no collaboration in the assessment of the resident's altered skin integrity and the need for the referral to the specialist.

The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident #003's altered skin integrity. [s. 6. (4) (a)]

2. The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident/SDM had been given an opportunity to participate fully in the development and implementation of the plan of care.

A complaint was logged with the MOLTC, indicating that resident #003 had an altered skin integrity observed by a PSW on an identified date in 2018 and there was no follow up.

Clinical records were reviewed and indicated that in 2018, registered staff documented in progress notes that the resident had an area of altered skin integrity and the RN was notified. There was no documentation indicating that the family was notified of the altered skin integrity.

RPN #104 who made the progress note in 2018, was interviewed and they stated that it was an expectation that they documented if the SDM was being notified of any changes in the health condition; however, they could not recall if they had notified the SDM at that time of the altered skin integrity. RN #105 was interviewed and stated that it was an expectation to notify the SDM of the altered skin integrity and they were not aware if resident #003's SDM was notified at the time.

The DOC was interviewed and acknowledge that there was no evidence that the SDM was notified of the altered skin integrity in 2018.

The home failed to ensure that the SDM had been given an opportunity to participate fully in the development and implementation of the resident #003's plan of care. [s. 6. (5)]

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other; and to ensure that the resident, the SDM, if any, and the designate of the resident/SDM has been given an opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) A complaint was logged with the MOLTC, indicating that resident#003 had an altered skin integrity which was observed by a PSW on an identified date in 2018.

During this inspection it was identified that PSW used flow sheets to document care provided and one of them was skin observations. PSWs were expected to check if a resident had their skin intact or if they had an altered skin integrity. Clinical records were reviewed and identified that PSWs were not always documenting skin observations for resident #003.

Flow sheets were reviewed for three months. During those months there was no skin observation documented on 34 days on day shifts, 57 days on evening shifts and 12 days on day shifts.

i) Resident #001's flow sheets were reviewed for one of the identified months in 2019 and on the following days the skin observations were not documented by PSWs on five days on day shifts.

ii) Resident #006's flow sheets were reviewed for an identified month in 2019 and PSWs failed to document skin observation on four days on the day shift and six days on the evening shift.

PSWs #114 and #118 were interviewed and stated that they always do skin observation while providing care and it was expected the they documented if the skin was intact or if a resident was observed to have an altered skin integrity. Then, they were expected to report the altered skin integrity to registered staff.

RPN #104 was interviewed and stated that the PSWs were expected to assess resident's skin while they provided care and document whether the skin was intact or had any alteration on flow sheets and then report any issues to registered staff.

The DOC was interviewed and confirmed that PSWs failed to document skin observation for the three residents on the dates identified by MOLTC Inspector.

D) Critical Incident System (CIS) report submitted to the director on an identified date in 2019, described an incident between resident #001 and resident #002.

The CIS indicated that there was possible minor injury on resident #002's skin.

During a review of the home's investigation notes, a written account of the incident submitted by PSW #107, mentioned that they witnessed the incident between resident #001 and resident #002.

During an interview with PSW #107, they identified that the resident had an area of altered skin integrity as a result.

During an interview with the DOC, it was identified that they saw resident #002, the day after the incident, and that the resident had an area of altered skin integrity.

During an interview with resident #002, they identified that they sustained an area of altered skin integrity as a result of the incident.

During an interview with RN #106, they confirmed that they were the charge nurse on duty when the incident between resident #001 and resident #002 took place. They indicated that they had assessed both residents, and all the documentation related to their response was documented in the progress notes.

A review of resident #002's clinical records, including their progress notes and assessments, identified that there was no assessment documented, following the incident. (748)

The licensee failed to ensure that assessment for resident #002 was documented. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A complaint was logged with the MOLTC indicating that resident #003 had an area of altered skin integrity which was observed by a PSW on an identified date in 2018 and the home failed to assess it.

Clinical records of resident #003 were reviewed and identified that a progress note made on an identified date in 2018, which stated that the resident had an area of altered skin integrity. The clinical records did not include the skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when the altered skin integrity was observed.

Interview with RPN #104 and RN #105 indicated that it was an expectation that a skin assessment called Wound Assessment Tool (WAT) was to be completed for any altered skin integrity. They both confirmed that it was not done for this resident.

The DOC confirmed that registered staff did not completed the skin assessment using

their skin assessment tool called WAT for resident #003.

The licensee failed to ensure that a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when resident #003 had an area of altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A complaint was logged with the MOLTC indicating that resident #003 had an area of altered skin integrity which was observed by a PSW on an identified date in 2018 and the home was not assessing the altered skin integrity.

Clinical records were reviewed for resident #003 and identified that the resident had an altered skin integrity that started on an identified date in 2018. On an identified date in 2019, the clinical records stated that the issue was still present ~~and the physician had ordered a referral for further tests~~. ~~The results of the test identified a diagnosis related to the altered skin integrity. Between the time when it was first identified, the resident's altered skin integrity was assessed only four times. Resident~~ #003's altered skin integrity was not reassessed weekly by registered staff as clinically indicated.

Interview with RPN #104 indicated that any altered skin integrity should have been reassessed weekly using an assessment tool called WAT, under the assessment tab in PCC.
RN #105 was interviewed and stated that it was an expectation that any altered skin integrity was reassessed on weekly basis and documented in WAT in PCC.

The home's Skin Care and Wound Program, dated November 2015, stated that the procedure for altered skin integrity included at minimum weekly assessments to detail the progress of the wound.

The DOC confirmed that the weekly assessments were not completed for this resident's altered skin integrity as clinically indicated.

The home failed to ensure that resident #003 exhibiting altered skin integrity, was assessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; and to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

A) Observations of home areas and residents' rooms were completed by Inspectors #561 and #748 throughout the inspection. MOLTC Inspectors identified that 11 resident rooms were observed to have stained privacy curtains.

B) The following were also observed by MOLTC Inspectors throughout the inspection,:
- three home areas had dirty floors and baseboards,
- one home area had dusty window ledges in residents' rooms,
- one home area had dirty baseboards.

The housekeeping staff #124 was interviewed and indicated that dusting and cleaning the floors including baseboards was part of daily routine cleaning. If the housekeeping staff observed a privacy curtain that needed to be washed it was an expectation that they put it in the maintenance log book. The maintenance person would then take it down and wash it.

The maintenance and housekeeping log books were reviewed by Inspector #561 and none of the identified curtains were being logged, except for room 501-1 which was logged on June 25, 2019; however, there was no signature or date of whether it was changed or washed.

The Administrator was interviewed and stated that they did have the deep cleaning schedules in place and they complete audits for preventative maintenance, which were provided to Inspector #561. The Administrator indicated that it was an expectation of all staff to add any repairs or issues with housekeeping to the maintenance and housekeeping logs so that the issues could be addressed.

The home failed to ensure the home, furnishings and equipment were kept clean and sanitary. [s. 15. (2) (a)]

Issued on this 7th day of August, 2019

[redacted]

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

Original report signed by the inspector.