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
Apr 21, 2021	2021_569508_0006	017704-20, 020377-20, 025512-20, 025584-20	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

ROSEANNE WESTERN (508), GILLIAN HUNTER (130)

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): February 17, 23, March 1, 2, 12 and 17, 2021 (on-site), February 22, 24, 25, 26, March 3, 4, 5, 8, 10, 11, 15, 16, 18, 19, 22, 23, 24, 25 and 26, 2021 (off-site).

During the course of the inspection, the inspector(s) toured the facility, observed residents and resident care, reviewed relevant resident clinical records, investigation notes, critical incident reports, infection prevention and control (IPAC) records, staff education reports, complaint log, relevant policies and procedures.

This inspection was conducted related to the following intakes:

- Log #:017704-20 related to skin and wound and nutrition concerns;
- Log # 020377-20 related to personal support services, skin and wound, pest control and communication concerns;
- Log # 025512-20 related to Infection Prevention and Control (IPAC) concerns and visitation policies;
- Log # 025584-20 related to staffing, IPAC concerns and alleged neglect of residents;

This Complaint inspection was conducted concurrently with the following Critical Incident inspection #2021_820130_0003.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC/ IPAC Coordinator/Wound Care Coordinator), Medical Director, Outbreak Team Leader-Pandemic Response Division Niagara Region Public Health, registered staff, personal support workers, Food Services Manager (FSS), Registered Dietitian, recreation staff, universal workers, residents and families.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Skin and Wound Care

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

- **2 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. (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).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Substitute Decision Maker (SDM) of resident #201 was provided the opportunity to participate fully in the development and implementation of the plan of care.

a) Complaints were submitted to the Director related to the SDM not being notified when there was a change in the resident's condition and when changes were made to their plan of care.

Resident #201 started exhibiting symptoms in September 2020. Later that afternoon, the resident was reassessed and the physician came in to conduct an assessment.

Five days later, orders were received for further investigative tests due to the resident's condition.

Review of the documentation in the resident's clinical record indicated that the resident's SDM had not been notified of the resident's change in condition until six days after the resident's change in condition.

Sources: resident clinical record and interviews with the resident's SDM and Administrator.

b) Review of resident #201's clinical record indicated that the Registered Dietitian (RD) changed the resident's diet texture which was documented in a quarterly assessment.

The SDM indicated they had not been made aware of this change or had a discussion with the RD when the resident's diet texture was changed.

The Administrator reviewed the clinical record and confirmed that the resident's SDM was not notified when the RD changed the resident's diet texture.

Sources: resident clinical record and interviews with the resident's SDM and Administrator. [s. 6. (5)]

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

a) A complaint was received regarding care not being provided as specified in a resident's treatment plan.

A resident had a procedure in 2020 and returned back to the home two weeks later with a treatment plan.

A document was reviewed over an identified period of time. The Skin and Wound Lead indicated that this was the form staff were using to document the treatments provided. The review confirmed that staff did not provide this treatment as ordered on identified dates.

Sources: resident clinical record and interview with Skin and Wound Coordinator.

b) A Critical Incident (CI) Report was submitted to the Ministry of Long Term Care (MLTC) in December 2020 related to an unexpected death of a resident.

The resident was cognitively impaired and unable to make decisions for themselves. The resident's Advanced Health Care Directive (AHCD) indicated that the resident was to be transferred to hospital with Cardiopulmonary Resuscitation (CPR) if and when required.

AHCD is a document developed to ensure that resident's wishes are respected in important decisions made for a resident when they are no longer able to make decisions for themselves.

The resident started exhibiting symptoms and tested positive for COVID-19 during the home's COVID-19 outbreak. The resident required interventions over this identified period.

Interview with RN #116 indicated that during the COVID-19 outbreak, staff would review the resident's AHCD when residents had a change in condition to ensure their wishes were respected. Over an identified period, the resident exhibited symptoms up to the time of their death.

The clinical record was reviewed with RN #116 and they confirmed that the resident's AHCD were not reviewed during this time and the resident's AHCD were not followed.

Sources: interview with RN and resident clinical record. [s. 6. (7)]

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 Substitute Decision Make (SDM) is provided the opportunity to participate fully in the development and the implementation of the plan of care and that care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 residents who exhibited altered skin integrity, including skin tears or pressure areas 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) It was identified by staff that resident #201 had an alteration in skin integrity. The physician assessed the resident the following day, confirmed this and documented the area was to be monitored for infection.

Review of the resident's clinical record indicated that the resident's open area had been assessed and documented in the progress notes; however, staff did not conduct a skin assessment using a clinically appropriate assessment instrument specifically designed for this purpose when it was required.

Sources: resident clinical record and interview with the RN.

b) According to the clinical record, a resident had an identified health condition and multiple areas of impaired skin that were not reassessed at least weekly using a clinically appropriate assessment instrument.

These areas were identified, numbered and documented in the resident's clinical record. These areas were not reassessed weekly using a clinically appropriate assessment instrument, as confirmed by the ADOC.

Sources: review of skin and wound assessments, progress notes, care plan and resident and staff interviews. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident was assessed by a RD when there was a new area of altered skin integrity.

A resident was identified as a high nutritional risk due to their diagnosis. The resident had a procedure in hospital and was readmitted back to the home with a new alteration in skin integrity.

Review of the resident's clinical records indicated that when the resident was readmitted back to the home with an alteration in skin integrity, no referral was completed for the RD for reassessment.

Interview with the RD and record reviews confirmed that the RD did not receive a referral for reassessment of the resident's new area of altered skin integrity.

Sources: resident clinical records, interview with the RD. [s. 50. (2) (b) (iii)]

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 receives a skin assessment using a clinically appropriate instrument specifically designed for skin and wound and that residents are assessed when required by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

Issued on this 27th day of April, 2021

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

Original report signed by the inspector.