Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Sep 3, 2019	2019_684604_0018	012628-19	Complaint

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

The Willows Estate Nursing Home
13837 Yonge Street AURORA ON L4G 3G8

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

SHIHANA RUMZI (604)

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 26, and 29, 2019.

During the inspection complaint intake related to Critical Incident System (CIS) report, was inspected related to an injury of unknown cause.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW),and Substitute Decision Maker (SDM).

During the course of the inspection, the inspector conducted observations of staff to resident interactions, provisions of care, conducted reviews of health records, staff training records, review of the home's Critical Incident System (CIS) binder, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 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).

Findings/Faits saillants :

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.

The Ministry of Long-Term Care (MLTC) ACTIONline received a complaint on an identified date. The complainant indicated during a visit they noted resident #001 had an identified injury and requested an identified care to be carried out and was upset they were not informed of the resident's injury.

The home submitted a Critical Incident System (CIS) report, on an identified date to the MLTC Director, indicating alleged abuse had occurred. The CIS report further stated the home was informed by the family and reported to the home's Registered Practical Nurse (RPN) #104, that resident #001 had sustained an injury to an identified location of there body. The family reported to the RPN that the resident indicated they where grabbed but was unable to recall the details of the time, date, location or names of the staff involved. The CIS report indicated on an identified date the home' physician had ordered identified care to be provided to the resident. The resident was diagnosed to have an identified injury.

An interview was carried out with complainant #100 who stated they found resident #001 pointing to an identified location of there body and the complainant noticed an injury. The resident had stated to the complainant that they where held down.

A review of resident #001's plan of care was carried out for two identified review periods. Under the problem statements it provided staff with identified care needs by the resident including the number of staff needed to provide the identified care.

An interview was conducted with PSW #109, who stated when they arrived for their identified shift resident #001 was provided care and the PSW provided the care independently with no second staff present on an identified date. The PSW acknowledged that they are to have two staff for an identified care as the resident presented with identified responsive behaviors during care.

An interview was conducted with the Acting DOC #103, who reviewed the above plan of care with the inspector and indicated resident #001 was to have an identified amount of staff for identified care needs and the PSW did not follow the set plan of care.

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 was provided to the resident 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. 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 :

The licensee has failed to ensure that any person who had reasonable grounds to suspect that abuse of a resident by anyone, the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

The home submitted a Critical Incident System (CIS) report, on an identified date to the MLTC Director, indicating alleged abuse had occurred. The CIS report further stated the home was informed by the family and reported to the home's Registered Practical Nurse (RPN) #104, that resident #001 had sustained an injury to an identified location of there body. The family reported to the RPN that the resident indicated they where grabbed but

was unable to recall the details of the time, date, location or names of the staff involved. The CIS report indicated on an identified date the home' physician had ordered identified care to be provided to the resident. The resident was diagnosed to have an identified injury.

An interview was carried out with complainant #100 who stated they found resident #001 pointing to an identified location of there body and the complainant noticed an injury. The resident had stated to the complainant that they where held down.

A review of resident #001's documentation was carried out for an identified time period. On an identified date documentation was carried out by RPN #104 indicating they identified an injury on an identified location of the resident's body and the DOC was informed.

An interview was conducted with RPN #104, who indicated they observed resident #001 to have an identified injury on an identified location of the resident's body and the they had checked the notes and indicated there was no report related to the resident sustaining any injuries. The RPN indicated the resident stated they where grabbed but was unable to recall the date, time, or who the two staff where. The RPN further stated they sent an email at the end of there shift to the Acting DOC #103 regarding the allegation of abuse.

An interview was conducted with the Acting DOC #103, who indicated they received an email from RPN #104 on an identified date, and time. The ADOC stated the email indicated resident #001 had an identified injury and the resident had stated they were grabbed but did not remember details. The Acting DOC stated they saw the email and identified resident #001's statement to be an allegation of abuse which should have been report immediately to the Director.

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 person who had reasonable grounds to suspect that abuse of a resident by anyone, the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that there was in place a written policy to promote zero tolerance of abuse of residents, and the licensee shall ensure that the policy was complied with.

Home's policy "Zero Tolerance of Abuse and Neglect of Resident", policy #AM-6.9, with an effective date of June 2015, states under policy number three which directs staff to immediately contact the manager on call for the home and the Operations Personnel on-call for the Home Office related to allegations of abuse.

An interview was carried out with complainant #100 who stated they found resident #001 pointing to an identified location of there body and the complainant noticed an injury. The resident had stated to the complainant that they where held down.

An interview was conducted with RPN #104, who indicated they observed resident #001 to have an identified injury on an identified location of the resident's body and the they had checked the notes and indicated there was no report related to the resident sustaining any injuries. The RPN indicated the resident stated they where grabbed but was unable to recall the date, time, or who the two staff where. The RPN further stated they sent an email at the end of there shift to the Acting DOC #103 regarding the allegation of abuse.

An interview was conducted with the Acting DOC #103, who indicated they received an email from RPN #104 on an identified date, and time. The ADOC stated the email indicated resident #001 had an identified injury and the resident had stated they where grabbed but did not remember details. The Acting DOC stated they saw the email and identified resident #001's statement to be an allegation of abuse. The Acting DOC stated the RPN should have called the manager on call who was the Administrator and informed them immediately of the resident's statement, and the manager on-call would have given further directions. The Acting DOC acknowledged the home's "Zero Tolerance of Abuse and Neglect of Resident" policy was not followed by the RPN.

WN #4: 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 :

The licensee has failed to ensure that when the resident exhibited an alteration in skin integrity the resident 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.

An interview was carried out with complainant #100 who stated they found resident #001 pointing to an identified location of there body and the complainant noticed an injury.

The home's policy "Wound Assessment and Documentation" policy HLHC-TP-4.7 with an effective date of April 2017, under procedure indicates upon admission and quarterly thereafter a Minimum Data Set (MDS) assessment shall be completed in combination with "Skin Condition" assessment. A wound acquired between assessments periods shall be documented in the Wound Tracker software section of Medecare or PCC by the registered nurse or their delegate.

A review of resident #001's MED-ecare e-Notes was carried out for an identified time period was carried out by RPN #104. The note indicated resident #001 had an identified injury to an identified location of their body.

A review of resident #001 e-Assessment was carried out for an identified period of time and the Inspector was unable to find evidence resident #001 received an identified assessment was carried out using a clinically appropriate assessment instrument.

An interview was conducted with RPN #104, who indicated an identified assessment was to be carried out when an injury was noted on a resident as per home's policy. The RPN stated they worked an identified date and time and provided nursing care to resident #001. The RPN stated when they started medication administration and got to the resident they observed an identified injury on an identified location of the residents body. The RPN acknowledged that they did no carry out an identified assessment for the resident as required.

An interview was conducted with the Acting DOC #103, who stated an identified assessment was to be completed when a resident was noted to have an injury. The Acting DOC reviewed the above CIS report and reviewed resident #001's MED e-care e-Assessment and acknowledged that a identified assessment for an identified injury was not carried out as required for resident #001.

Issued on this 3rd day of September, 2019

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

Original report signed by the inspector.