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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 30, 2014	2014_198117_0026	O-001058-14	Resident Quality Inspection

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

WOODLAND VILLA
30 Milles Roches Road, R. R. #1, Long Sault, ON, K0C-1P0

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

LYNE DUCHESNE (117), AMANDA NIXON (148), ANANDRAJ NATARAJAN (573), LINDA HARKINS (126), MEGAN MACPHAIL (551)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 7, 8, 9, 10, 14, 15, 16 and 17, 2014

Please note that two critical incident inspections, Logs # O-000607-14 and # O-001040-14, were also conducted during this Resident Quality Inspection and these inspections are incorporated within this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care, a certified physician assistant, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), the RAI Coordinator, the Registered Dietitian (RD), the Nutritional Care Manager, the Environmental Services Manager, a housekeeping staff member, the Restorative Care Coordinator, to several residents, family members, the President of the Resident Council and President of the Family Council.

During the course of the inspection, the inspector(s) reviewed several residents health care records; observed provision of resident care and services; observed and examined resident rooms, common areas, tub/shower rooms and residents personal care equipment; observed the lunch time meal services of October 7 and 16, 2014; reviewed the following programs: Medication Administration, Infection Control, Falls Prevention, Prevention of Abuse and Neglect, Skin and Wound Care, Pain Management and Continence Care; reviewed the home's registered nursing staffing schedules for the weeks of October 6 and 13 2014; reviewed the 2014 meeting minutes of the Resident Council and Family Council; reviewed the home's maintenance repair logs for 2014; reviewed two critical incident reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9. (1) 2., whereby the licensee did not ensure that all doors leading to non-residential areas that are equipped with locks are kept closed and locked when they are not being supervised by staff.

During the initial tour of the home on October 7th, 2014, Inspector #148 observed a set of double doors, located near the dining room, which were not equipped with locks that lead into a service corridor. Within the resident accessible service corridor, Inspector #148 noted doors leading to the following non-residential areas: laundry room, kitchen, mechanical room, a storage room and a staff lounge.

On October 16th, 2014, Inspector #573 observed that the door leading into the laundry room, within the resident accessible service corridor, was not fully closed and locked between 13:05pm -13:15pm. The door was being kept open by a bag on the floor, in between the door and the door frame. Inspector #573 observed that the room contained the following: – Industrial washing machine, dryer and other various laundry equipment's and products. There were no staffs in the area supervising the door. Although the laundry room door is equipped with a lock, it was not kept closed and locked in order to restrict unsupervised access to the laundry room.

On October 16th, 2014 during an interview with the Inspector #573 the Environmental Services Manager (ESM) indicated that the area beyond the double doors to be a non-residential area and the ESM confirmed the expectation is that the laundry room door to be kept closed and locked at all times when the area is not supervised by staff. [s. 9. (1) 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 all doors leading to non-residential areas are equipped with locks and that those doors leading to non-residential areas that are equipped with locks are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall.

During the initial tour in the home on October 7th, 2014, Inspector #573 observed the resident spa room at the south wing. Two resident shower rooms are located inside the spa room. Both shower rooms were equipped with one grab bar adjacent to the wall. The wall beside the faucet did not have a grab bar.

On October 15th, 2014 Inspector #573 observed a resident's shower in the spa room at the north wing which is equipped with one grab bar adjacent to the wall. The wall beside the faucet did not have a grab bar.

Inspector #573 spoke to PSW Staff's #113 and #116 indicated that the both shower rooms in the south and north wings are actively used for the residents who require showers.

On October 16, 2014, the home's Administrator and the Environmental Services Manager agreed with Inspector #573 that the shower room's identified by the Inspector do not meet the legislative requirements of s.14 related to shower grab bars. [s. 14.]

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 every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that monthly weight were taken for three identified residents.

The following 3 residents weight record and Medecare weight history were reviewed for the last 6 months (May -October 2014).

It was noted that Resident # 021's weights were done in July and October 2014, two times for that 6 months period. The plan of care was reviewed and no documentation was found related to contraindications to have the weight monitored monthly.

It was noted that resident# 022's weights were done in July, September and October 2014, three times for that 6 months period. The plan of care was reviewed and no documentation was found related to contraindications to have the weight monitored monthly.

It was noted that resident# 023's weights were done in June, July and October 2014, three times for that 6 months period. The plan of care was reviewed and no documentation was found related to contraindications to have the weight monitored monthly.

A discussion was held with the Registered Dietitian (RD) on October 15, 2014 regarding monthly weight. The RD indicated that residents monthly weights are not always taken and he had brought this to the attention of management. [s. 68. (2) (e) (i)]

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 monthly weights are taken for the following residents: Residents # 21, #22 and #23, to be implemented voluntarily.

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 failed to ensure that abuse of a resident by anyone that resulted in harm or a risk of harm is reported to the Director.

During a review of CIS # 23743-000019-14, Inspector #551 noted documentation related to a resident to resident altercation in Resident #24's health care record. The documentation indicates that on September 9, 2014, Resident #24 pushed Resident #15 causing Resident #15 fall and to sustain an injury to his/her head. It notes that nursing staff immediately assessed both residents, that the attending physician and families were notified of the incident. A review of the Ministry of Health and Long Term Care Critical Incident Reporting system was done and no information was noted to have been received related to the above incident.

On October 17, 2014, the Acting Director of Care was interviewed by Inspector #551. The Acting Director of Care stated to the Inspector that she had been notified immediately of the incident and had conducted a review of the incident. The Acting Director of Care confirmed that this incident, which resulted in harm to the Resident #15, had not been reported to the Director as per legislative requirements. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with specific weight changes are assessed.

Resident #001's weight declined 10.7% (8.7kg) from July 2014 to September 2014 (there is no documented weight for August). September weight of 72.8kg represented a loss of 14.5% (12.3kg) over a three month period (June to September, 2014) and a loss of 13.8% (11.7kg) over a six month period (April to September, 2014).

On October 17, 2014, the Registered Dietitian was interviewed by Inspector #117 and stated that documentation regarding weight changes would be in the resident's progress notes or in the Minimum Data Set (MDS) assessment that is completed quarterly.

Resident #001's health care record was reviewed, and there is no documentation to support that the weight changes as outlined above were assessed. [s. 69.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s. 229 (4), whereby the licensee did not ensure that all staff participate in the implementation of the program.

The home's policy # CS-15.2 regarding the Bedside Drainage Bags includes a detailed procedure. Under procedure 1, 3 and 6 it is indicated that "New bedside drainage bags shall be supplied for a resident requiring bedside drainage at least once weekly. – Bedside drainage bags shall be labelled with the resident's name and date - Drainage bags should be placed inconspicuously to ensure resident privacy and dignity are maintained at all times"

During RQI stage 1 resident observation on October 8th 2014 Inspector #573, observed an unclean used urinary catheter drainage bag with no name hanging in a towel stand in a room of a four resident's shared washroom. Inspector #573 spoke to PSW Staff #110 who stated that the urinary catheter drainage bag was used for Resident #2 at night times only and further the PSW staff #110 indicated that the Resident #2 did not use the bag for the last 2 days and they keep the urinary catheter bag in the washroom when not in use.

On October 14th, 2014 Inspector #573 observed the unlabelled urinary catheter drainage bag with dark yellow and orange coloured dried urine stains in a towel stand in a Resident's shared washroom.

On October 16th, 2014 Inspector #573 interviewed Registered Nursing Staff #105 who indicated that resident's personal care including the urinary catheter drainage bag must be labeled by the health care aids (PSW staffs) and they are supposed to clean them every time when they change the urinary catheter bag.

The Interim Director of Care confirmed during an interview on October 16th, 2014 that resident's urinary catheter drainage bag were to be labelled and should be kept clean for individual resident use.

Staff members were observed to not participate in the home's infection prevention and control program, specifically related to the use of urinary catheter bedside drainage bag for residents. [s. 229. (4)]

Issued on this 30th day of October, 2014

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