Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
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Original Public Report

Report Issue Date: November 17, 2023
Inspection Number: 2023-1178-0006
Inspection Type: Complaint Critical Incident Follow up
Licensee: Omni Healthcare (Lambton) Limited Partnership, by its general partner, Omni Healthcare (Lambton) GP Ltd.
Long Term Care Home and City: Bear Creek Terrace, Petrolia

Lead Inspector	**Inspector Digital Signature**
Terri Daly (115)	Terri Daly Digitally signed by Terri Daly Date: 2023.12.11 13:55:27 -05'00'

Additional Inspector(s)
Cassandra Taylor (725)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 8, 9, 10, 14 and 15, 2023.

The following intake(s) were inspected:
• Intake: #00093622 - CI #2673-000051-23 related to reporting.
• Intake: #00094727 - CI #2673-000054-23 related to a resident fall with injury.
• Intake: #00095442 - related to a care and services complaint.
• Intake: #00094280 - Follow-up Compliance Order FLTCA, 2021 - s. 107 (1) related to unlicensed beds.

The following intakes were completed in this inspection: Intake: #00099952 – CI #2673-000063-23 and Intake: #00095238 – CI #2673-000055-23 related to falls.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1178-0005 related to FLTCA, 2021, s. 107 (1) inspected by Terri Daly (115)

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management
Resident Charges and Trust Accounts

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (9) 1.

The licensee failed to ensure the provisions of care a resident were documented in the plan of care.

The resident was identified as a risk for a specific incident. During an observation of the resident, they were observed with a device to limit that risk.

During an interview with Registered Practical Nurse (RPN) #104 they indicated that this resident had a device as a intervention for this risk.

During an interview with the Falls Program Lead #105 they indicated that the resident had a specific device that was initiated post previous incident and that it had been missed when updating the care plan.

Date Remedied - November 10, 2023.
[725]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to immediately report an allegation of neglect for a resident to the Director.

Rationale and Summary
The home received an e-mail complaint, alleging neglect of a resident. The home responded to the complainant and completed the complaint process.

During an interview with the Director of Care (DOC) #101 they confirmed they did not complete a Critical Incident (CI) report for this incident immediately upon receiving the complaint of neglect and should have.

Not immediately reporting allegations of neglect to the Director placed the resident at risk.

Sources: CI report, the homes e-mail communication and interview with the DOC. [725]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee failed to ensure that a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment was being used.

Rationale and Summary
During a record review of a resident's clinical record the home was using an assessment tool for a weekly wound and skin assessment titled Head to Toe Assessment in Point Click Care (PCC) with notes to support the assessment in PCC progress notes.

It was noted that this tool was lacking information related to the skin and wound assessment including factors, current treatment, date of initial alteration, where and how the altered skin integrity was acquired, exudate, odour, and pain, on a consistent basis.

A check box on the Head to Toe Assessment for weekly skin assessment initiated was not complete during assessments on two specific dates despite that staff documenting that the resident had alteration in skin integrity during this time period.

At the time of this inspection the home could not provide a skin and wound care policy to support the use of a clinically appropriate assessment instrument.

Review of OMNI policy titled Wound Assessment and Documentation Policy #: OTP-HLHS-3.7. The policy indicates that the assessment should include the following observations: location, size of area in centimeters and millimeters, depth, colour of involved tissue, drainage; amount, colour, odour and subjective symptoms; pain, itching.

During an interview with Director of Care #101 they indicated that the Head to Toe Assessment did not qualify as a clinically appropriate assessment instrument for skin and wound assessment, and that the home's tool was lacking specific information important for skin and wounds that should be assessed.

There was minimal risk to the resident at this time as their altered skin integrity had improved.

Sources: Clinical records for the resident, interviews and the home's policy.
[115]

WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The Licensee failed to ensure that the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010, was provided to the complainant.

Rationale and Summary
A complaint was submitted to the home on a specific date. The home had completed their follow up with the complainant. On review of the documentation the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman had not been provided.

Review of the home's complaint procedure did not include direction to provide complainants with the contact information.

The DOC #101 indicated the contact information was not included and that the policy did not provide direction to provide the contact information as required.

Not providing the contact information for the Ministry or patient ombudsman could potentially limit access to external sources if the complainant remains unsatisfied.

Sources: The complaint, the home's policy and interview with the DOC.
[725]

WRITTEN NOTIFICATION: Resident records

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)

The licensee failed to ensure the written record for a resident was kept up to date at all times.

Rationale and Summary
The resident had an incident on a specific date, the incident was unwitnessed, and a specific monitoring tool was initiated. The resident exhibited a change in status which resulted in the resident being transferred to the hospital.

Review of the progress notes indicated that on the date of the incident there was no documentation to indicate it had occurred. A late entry progress note was later written three days after the incident outlining the details of the incident.

Review of the specific monitoring tool indicated an incomplete entry four hours prior to the resident being transferred to the hospital.

Review of the electronic Risk Management assessment for this resident's incident that had occurred on a specific date had not been completed until three days after the incident. Review of the post incident assessment on paper did not have a date, time or signature of the person who had completed the assessment. The assessment was uploaded to the residents' miscellaneous section of the electronic file.

The home's policy related to this type of incident stated in part that the post incident assessment shall be initiated in the electronic clinical software as soon as possible after the resident has been assessed and is safe and comfortable.

During an interview with the Director of Care (DOC) #101 they had confirmed that the documentation should have been completed as soon as possible after the incident.

Not ensuring resident records are kept up to date at all times placed the resident at risk for potential missed assessments resulting in a potential undetected decline in condition.

Sources: The resident's records, the home's policy and staff interview with the DOC. [725]