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
Feb 1, 2019	2019_559142_0003	025179-18	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

Garden Terrace
100 Aird Place KANATA ON K2L 4H8

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

JANET MCPARLAND (142)

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): January 23rd-25th, 2019.

Complaint Log #025179-18 (including Critical Incident Report #2882-000023-18) related to resident care and services was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with a resident, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Registered Dietitian, the Director of Care (DOC) and the Administrator.
The inspector also observed the provision of resident care and services, reviewed a resident's health care record, staff training records and specific policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 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 has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who is a member of the staff of the home.

A review of resident #001's health record indicated resident sustained altered skin integrity during an identified period of time. Resident #001's wound assessment report with an initial assessment on an identified date, noted that the resident had altered skin integrity. On an identified date, a skin assessment was completed and registered staff noted a change in resident's condition. Resident was started on a specific intervention for an identified period of time.

On an identified date, resident exhibited altered skin integrity in an identified area. On an identified date, resident was admitted to hospital for a change in condition. A skin assessment was completed upon return from hospital and resident was noted to have additional areas of altered skin integrity.

On an identified date, resident #001 was transferred to hospital due to a change in condition. On an identified date, resident returned from hospital with specific care interventions in place.

In review of resident #001's health record there was no indication that resident was assessed by the Registered Dietitian (RD) when resident was exhibiting altered skin integrity during specific period of time. During an interview with the RD, they indicated that they did not receive a referral for resident #001 related to resident's altered skin integrity. The RD further indicated that they do not always receive referrals for residents with altered skin integrity such as that exhibited by resident #001.

In an interview with RN #111, they indicated that it is the home's practice to send referrals to the RD for residents with altered skin integrity such as that exhibited by resident #001.

The Licensee failed to ensure that resident #001 was assessed by the Registered Dietitian for altered skin integrity when the resident sustained altered skin integrity during an identified period of time.[s. 50. (2) (b) (iii)]

Issued on this 1st day of February, 2019

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

Original report signed by the inspector.