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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: February 13, 2024
Inspection Number: 2024-1002-0001
Inspection Type: Proactive Compliance Inspection
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
Long Term Care Home and City: Kentwood Park, Picton

Lead Inspector Carrie Deline (740788)	Inspector Digital Signature Carrie E Deline Digitally signed by Carrie E Deline Date: 2024.02.14 08:47:38 -05'00'

Additional Inspector(s) Heath Heffernan (622)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 17 - 19, 22 - 26, 2024

The following intake(s) were inspected:

- Intake: #00106335 - PCI (Proactive Compliance Inspection)

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Continence Care

Residents' and Family Councils
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC # 001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (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 nutritional care and dietary services and hydration;

The licensee has failed to ensure that the licensee's policy to record food temperatures at every meal has been implemented.

In accordance with O. Reg 246 / 22, s. 11 (1) b, the licensee is required to ensure that their written policy related to taking and recording of food temperatures is complied

with.
Specifically, staff did not comply with the licensee's policy regarding documenting food temperatures.

Rationale and Summary
Review of the food production sheet temperature documentation for a four day period indicated that there were omissions of food temperature documentation on all four dates.

During an interview with the Nutritional Care Manager (NCM) #105 they acknowledged that food temperatures were to be taken when the food comes out of the oven, while in the steam table and documented at each meal according to the licensee's policy they stated that the food temperatures were taken at each meal, however, were not always documented.

By not documenting the food temperatures at every meal, increases the risk that food safety and infection control concerns related to unsafe food temperatures may go unnoticed.

Sources: Review of licensee's policy on food temperature documentation and interview of NCM and other staff.
[622]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

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

Rationale and Summary
On a specific date the Inspector observed that a resident remained in their wheelchair in the activity lounge for a period of time of which continence care was to be performed as explained in their plan of care.

During an interview with a Personal Support Worker (PSW) they stated that the resident had not been assessed for incontinence as explained in their plan of care.

By not assessing a resident for incontinence according to their plan of care, there is risk that care will not be provided to the resident when it is required.

Sources: Review of residents plan of care, observation of resident care and interview of PSW and other staff.
[622]

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

1) The licensee has failed to ensure that the provision of care set out in a residents

continence plan of care has been documented.

Rationale and Summary
Review of a residents continence plan of care indicated that the resident was to be checked for incontinence every two hours.

Review of the point of care (POC) tasks documentation for a twelve day period, related to continence care and toileting for the resident, indicated that documentation did not reflect that the resident was being checked for incontinence every two hours.

During an interview the Personal Support Worker (PSW) stated that the resident would have been checked for incontinence every two hours however, failed to document the care.

Failing to ensure resident's continence care was documented can increase the risk of uncertainty whether the care was provided or not.

Sources: Review of the plan of care, the POC task documentation and interview with PSW and other staff.
[622]

2) The licensee has failed to ensure that the provision of care set out in three residents activity of daily living (ADL) plan of care has been documented.

Rationale and Summary
Review of the point of care (POC) tasks documentation for a period of twelve days, related to activities of daily living for three residents indicated that there were omissions in the documentation for the provision of ADL care for each resident in

the areas of dressing and personal hygiene on multiple days.

During interviews a Registered Practical Nurse (RPN) and Personal Support Workers (PSWs), stated that three residents care related to ADLs had been provided, however the documentation of the care was not always completed.

Failing to ensure that a resident's provision of ADL care such as dressing and personal hygiene has been documented, can increase the risk of uncertainty whether the care was provided.

Sources: Review of POC task documentation and interview with PSW and other staff.
[622]

3) The licensee has failed to ensure that the provision of care set out in two residents dietary plan of care has been documented.

Rationale and Summary
Review of the food intake documentation for a period of five days, indicated that residents had omissions in documentation.

During interviews the Nutritional Care Manager (NCM) and Personal Support Worker (PSW) acknowledged that staff do not always document resident food intake at meals.

Failing to ensure that a resident's food intake was documented, can increase the risk of uncertainty whether the food was provided.

Sources: Review of the food intake documentation and interview with PSW and

other staff.
[622]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246 / 22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with.

Rationale and Summary
In accordance with the Routine and Additional Precautions section 9.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee shall ensure the proper use of personal protective equipment (PPE).

On a specific date, the Inspector, observed a room posted with a contact precaution sign at the doorway which indicated that staff were to wear gloves and a gown when performing direct care with the resident. A Personal Support Worker (PSW) entered and exited the room not wearing the posted required Personal protective equipment. The PSW acknowledged that the resident was on contact precautions and they had not worn the appropriate PPE providing care.

By not wearing the appropriate personal protective equipment (PPE) as required for contact precautions increases the risk of transmission of infectious agents to staff and other residents.

Sources: Observation of resident care and services and interview with PSW and other staff.
[622]

COMPLIANCE ORDER CO #001 Skin and wound care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, 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,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1. Ensure that residents areas of altered skin integrity are reassessed weekly by a member of the registered nursing staff, if clinically indicated, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

2. Complete a weekly audit of all residents where a weekly wound assessment is clinically indicated, to ensure weekly assessments are being completed using a clinically appropriate assessment instrument. The audits are to be completed for a minimum of one month, or until all staff are compliant with the process.

3. Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings and any corrective actions taken.

4. Conduct education on the licensee's Wound Assessment and Documentation Policy and the use of a clinically appropriate assessment instrument specifically designed for skin and wound assessments, with the registered nursing staff designated to complete weekly wound assessments.

5. Maintain documentation of the education, including the names of the staff, their designation, and date training was provided.

Grounds
The licensee has failed to ensure that a resident who was exhibiting altered skin integrity, including skin breakdown was assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

The licensee's Wound assessment and documentation policy directed registered nursing staff to evaluate the wound at minimum weekly using the wound tracker software section of the electronic clinical software. The DOC confirmed in an interview that the wound tracker software referenced, in the policy, was a section in Mede care. The DOC further confirmed that the home changed from MedeCare

system to Point Click Care (PCC) system and at that time, they discontinued the use of the wound tracker software. The DOC indicated that in the current PCC system, they utilized progress notes for wound documentation.

The resident had a wound, with no documented staging, that required ongoing changes to the wound care treatment plan. The residents wound deteriorated for a period of three months with a number of treatment changes in that time period.

The residents health record was reviewed and no skin and wound assessment tool was located in either the electronic or hard copy file. In an interview with an RN, they confirmed there was no tool used to assess wounds. In an interview with the DOC they also confirmed that no assessment tool for wounds was utilized.

There was an increased risk for wound deterioration when the effectiveness of the wound care treatment was not evaluated using the clinically appropriate instrument for skin and wound.

Sources: Resident's progress notes, Prescriber's Orders, policy review and interviews with RN and DOC.
[740788]

This order must be complied with by March 27, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe Licensee has the right to request a review by the Director of this (these) Order(s) and / or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c / o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and / or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.