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: March 28, 2024 | |
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| Inspection Number: 2024-1002-0002 | |
| Inspection Type:<br>Complaint | |
| 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<br>Stephanie Fitzgerald (741726) | Inspector Digital Signature |
| Additional Inspector(s) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 27-29, 2024 and March 4-6, 2024 The following intake(s) were inspected:

- Intake: #00109021 - IL-0123056- Complaint regarding wound care and responsive behaviours.

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Staff and others to be kept aware

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the residents' plan of care and have convenient and immediate access to it.

Rationale and Summary
In July of 2023, the LTCH transitioned to a new electronic documentation system.

During an interview with a Personal Support Worker (PSW), it was identified that PSWs do not have access to any resident's plan of care.

Inspector completed an observation of the Point of Care (POC) documentation system and the PSW was unable to view a plan of care.

Subsequent interviews with multiple staff, indicated that the PSW staff did not know how to access a resident's plan of care. During the interviews, it was identified that there is no communication system to report changes in residents plan of care, with the exception of shift

report which does not get updated into the written plan of care. During the interviews with PSWs, it was identified that the written plan of care would be located in a resident's physical chart, however in subsequent interviews with RN/RAI it was indicated this was not the current process.

During an interview with RN/RAI it was confirmed that the process for staff to access the plan of care for any resident within the LTCH would be through the POC documentation system, on the PSW staffs tablet. It was confirmed that there is no paper copy of the written plan of care in the physical charts.

During interviews with RN/RAI, and Director Of Care (DOC), it was confirmed that staff do not have convenient and immediate access to residents' plan of care.

By not ensuring staff have convenient and immediate access to the resident's plan of care, staff may not be kept aware of its contents. There is a risk that the plan of care will not be complied with. This could place the comfort and safety of the resident at risk.

Sources: Observation of POC Documentation System, Interviews with PSWs, RN/RAI, and DOC.
[741726]

## WRITTEN NOTIFICATION: Required programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to ensure that their written skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions, was complied with, for a resident of the Long-Term Care Home (LTCH).

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their written skin and wound care program for the resident is complied with. Specifically, staff did not comply with the licensee's Healthy Living, Healthy Skin program Policies:

1. Preventative Skin Care Policy #OTP-HLHS-3.4:
Each resident shall have a preventative skin care plan, as per the Healthy Living, Healthy Skin Program.

2. Wound Assessment And Documentation Policy #OTP-HLHS-3.7:
Treatment of a wound shall be recorded on the electronic Treatment Administration Record (TAR). Each wound will have the treatment plan evaluated by the registered nurse or her delegate at a minimum weekly in the TRC Skin Documentation Tool section of the electronic clinical software. In the event treatment is not required, any follow up assessment or observation shall be documented in the electronic Treatment Administration Record and TRC Skin Documentation Tool.

Rationale and Summary
A Resident was admitted to the LTCH on a day in October, 2023.

According to the resident's progress notes, on specific days in October, 2023, and January, 2024, they were identified, as having a wound.

Inspector completed an observation of the resident on and noted the resident to have altered

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skin integrity.

During a review of the resident's written plan of care, there was no identified focus for preventative skin care. This was confirmed during separate interviews with multiple staff.

The DOC confirmed the Preventative Skin Care Policy #OTP-HLHS-3.4 was not complied with for the resident.

During a review of the resident's TAR, there were no orders for Treatment Administration listed for October-December, 2023, and January-February, 2024. Inspector could not locate a weekly TRC Skin Documentation Tool, or weekly assessment progress notes.

During separate interviews with RN/RAI and DOC, it was confirmed the process for a resident with impaired skin integrity, would be to add an observation in the TAR to monitor the area. If an open area was identified, staff are to complete a TRC Documentation Tool weekly, and include the following items within a progress note: Location of wound, size in centimeters and millimeters, depth, colour of involved tissue, drainage; amount, colour, odour, subjective symptoms; pain, itching, weekly photo.

RN/RAI and DOC confirmed the Wound Assessment And Documentation Policy #OTP-HLHS-3.7 was not complied with for the resident.

By not ensuring the written protocol related to Skin and Wound Care Management was complied with, the resident was at an increased risk of wound deterioration.

Sources: Resident's electronic health record, Progress Notes, assessment history, TAR; Preventative Skin Care Policy #OTP-HLHS-3.4; Wound Assessment And Documentation Policy #OTP-HLHS-3.7: Interviews with PSW, RN/RAI, and DOC. [741726]

## 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) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure that resident #001 was assessed by a registered dietitian who is a member of the staff of the home, when exhibiting a skin condition that was likely to require or respond to nutrition intervention.

Rationale and Summary.
A Resident was admitted to the LTCH on a day in October, 2023.

According to the resident's progress notes, on specific days in October, 2023, and January, 2024, they were identified, as having a wound.

Inspector completed an observation of the resident on and noted the resident to have altered skin integrity.

During a review of the resident's electronic and physical health records, a referral to the dietitian could not be located.

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During separate interviews with an RN and DOC, it was confirmed the process is to have the dietitian assess each resident, for every new wound, using Point Click Care (PCC). The RN and DOC confirmed there was no record of a dietitian referral being completed, when the resident exhibited a wound.

By not ensuring the resident was assessed by a registered dietitian who is a member of the staff of the home, when exhibiting a skin condition that was likely to require or respond to nutrition intervention, they were at risk for further wound deterioration

Sources: Resident's electronic health record, Progress Notes, and assessment history; Interviews with RN and DOC. [741726]

## COMPLIANCE ORDER CO #001 Responsive behaviours

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:
(1) Develop and implement written strategies, including techniques and interventions, to prevent, minimize or respond to the resident's responsive behaviours. These strategies must be added to the resident's written plan of care.
(2) Conduct education on the written strategies developed in (1) to all direct care staff, involved in the care of the resident.
(3) Develop and complete a weekly audit tool, to determine if the strategies and interventions

from (1) are effective. This tool shall include actions taken if an intervention is noted to be ineffective. The audits should be completed for a minimum of one month.
(4) Maintain a written record of the requirements under (2) and (3). Documentation of education shall include the names of the staff, their designation, and date training was provided.

Grounds
The licensee has failed to ensure that strategies were developed and implemented to respond to a resident's responsive behaviours.

Rationale and Summary
A resident was admitted to the LTCH on a day in October, 2023. During a review of the resident's progress notes, it was indicated that care was not being provided as specified in the plan of care, due to responsive behaviours.

During a review of the resident's current plan of care, it was noted that the resident has responsive behaviours. There were no listed approaches to care, or strategies to mitigate the behaviour identified. There was a listed focus of behaviours in relation to specific diagnoses, the last revision was during the initial care planning, during October, 2023.

Interviews held with multiple staff, indicate there are no interventions or approaches listed in the plan of care, on how to mitigate responsive behaviours for the resident.

During an interview with Social Service Worker (SSW), it was stated that education had been provided to staff, from a third party organization, in relation to approaches to care for the resident.

A review of the contents discussed in the education, showed strategies and approaches to care, to mitigate responsive behaviours. These strategies could not be identified within the resident's written plan of care.

During interviews with RN/RAI and DOC it was confirmed that the the plan of care for the resident did not include written strategies, including techniques and interventions, to prevent, minimize or respond to the specific responsive behaviour.

When there are no written strategies, including techniques and interventions, to prevent, minimize or respond to the resident's refusal of care; there was a risk to the resident's comfort, well being, and skin integrity.

Sources: Resident's care plan and progress notes; third party organization educational content; interviews with PSW's, SSW, RN/RAI, and DOC. [741726]

This order must be complied with by May 10, 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.