Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Sep 10, 2020	2020_704682_0007	010072-20, 012055-20	Complaint

Licensee/Titulaire de permis

Maryban Holdings Ltd.
3700 Billings Court BURLINGTON ON L7N 3N6

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

Oakwood Park Lodge
6747 Oakwood Drive NIAGARA FALLS ON L2G 0J3

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

AILEEN GRABA (682), LISA BOS (683)

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): July 23, 24, 27, 28, 29, 30, 31, August 6, 7, 10, 11, 12, 13, 14, 18, 19, 20, 21, 2020.

PLEASE NOTE:
A Voluntary Plan of Correction (VPC) related to LTCHA s.6. (11) and a Voluntary Plan of Correction (VPC) related to LTCHA s. 5., identified in concurrent inspection #2020_704682_0008 were issued in this report.

The following intakes were completed during this complaint inspection:
010072-20
012055-20

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Director of Care (ADOC), the recreation therapy staff, the Nurse Practitioner, Registered Nurses (RN), Registered Practical Nurses (RPN), housekeeping staff, maintenance staff, Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector(s) reviewed resident clinical records, policies and procedures, investigation notes, staff education and training records, complaint log/records, staffing schedule and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

A) A review of Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued and effective on June 10, 2020, stated the following:
"Long-term care homes must conduct active screening and assessment of all residents, including temperature checks, at least twice daily (at the beginning and end of the day) to identify if any resident has fever, cough or other symptoms of COVID-19. Residents with symptoms (including mild respiratory and/or atypical symptoms) must be isolated and tested for a COVID-19.

A clinical record review included "Weights and Vital" summary that indicated a resident had changes to their vital signs for several hours. Further review included progress notes and the Registered Nurse (RN) documented that the resident had an additional decline in vital signs. Treatment was provided in response to the changes in vital signs. The resident's clinical records did not include placing the symptomatic resident in contact and droplet precautions or COVID-19 testing.

During an interview, the RN and the ADOC confirmed that the resident was not tested for COVID-19 and was not placed in isolation when they exhibited the changes in vital signs as per Directive #3. With the staff not complying with Directive #3 which included isolating and testing symptomatic residents for COVID-19, the resident and all other co-residents were at increased risk.

B) A review of Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued and effective on June 10, 2020, stated the following:
" Long-term care homes should immediately implement that all staff wear surgical/procedure masks at all times for source control for the duration of full shifts. This is required regardless of whether the home is in an outbreak or not. "

A PSW was observed by Inspector #682 to be standing in a resident area with their surgical/procedural mask dangling from their left ear, not covering their mouth or nose. Later that day, the PSW was observed by Inspector #683 in a resident area with their surgical/procedural mask under their chin. Subsequently, both Inspector #682 and Inspector #683 observed the PSW pulling up their surgical/procedural mask from under their chin in a resident area.

During an interview, the PSW confirmed that they had their surgical/procedural mask under their chin while in the resident area and not on their face over their mouth and nose. During an interview, the Administrator confirmed that they expected staff to wear their surgical/procedural masks in resident areas. Failure to follow the additional precautions/practices of staff wearing masks put all residents residing in the home at increased risk of potential exposure to COVID-19.

The home was not a safe and secure environment for its residents when staff did not follow the infection prevention and control (IPAC) measures set out in Directive #3 implemented to protect residents in long term care homes from COVID-19. [s. 5.]

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

A) A review of a progress note, indicated that the Registered Dietitian (RD) changed the resident's diet. During an interview, the RN and the Associate Director of Care (ADOC) both stated that the substitute decision maker (SDM) was to be notified of dietary changes by registered staff. The RN confirmed that registered staff were expected to inform the SDM of the diet change and document the communication in the progress notes. The ADOC acknowledged that they did not have any indication that the SDM was made aware of the dietary changes. The home failed to ensure that the resident's SDM was informed of the resident's diet change and given an opportunity to participate fully in the development and implementation of the resident's plan of care.

B) A review of the resident's medication administration record (MAR) indicated that a medication was discontinued and replaced with another medication. A progress note indicated the RPN spoke with the resident's SDM related to the dosage increase in the new medication. The RPN documented that SDM was not informed of the previous medication change and discontinuation. Further review of progress notes did not include

any documentation that the resident's SDM was contacted and informed of the medication change.

During an interview, the Director of Care (DOC) stated they expected registered staff to document any communication with families/SDM related to treatment/medication regimes and changes in the progress notes. The DOC confirmed that they did not see any documentation that the SDM was informed of the changes on the identified dates. The DOC also confirmed that the medical doctor that made the medication changes did not speak or obtain consent from the SDM. During an interview, the RPN confirmed that the resident was not capable of making a decision related to medications and the SDM was to be notified. The RPN also stated that it was expected staff notify resident/SDM and document their actions in progress notes.The RPN confirmed that the SDM stated they had not been aware of the medication change and that there was no indication in the clinical record that the SDM was notified. The home failed to ensure that the resident's SDM was informed of medication changes and given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

C) A review of a progress note indicated the RPN was made aware that the resident had an alteration in skin integrity. During an interview, the DOC confirmed that registered staff were expected to communicate with the SDM any alteration of skin integrity and changes in plan of care. The DOC also stated registered staff are expected to document the interaction with the SDM in the progress notes and confirmed that they did not see any reference in the clinical record that the SDM was informed. The DOC confirmed that the SDM was not made aware of the altered skin integrity at the time it was identified by the RPN. The home failed to ensure that the resident's SDM was informed of an alteration in skin integrity and given an opportunity to participate fully in the development and implementation of the resident’s skin and wound plan of care. [s. 6. (5)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in the plan. 2007, c. 8, s. 6 (7).

A review of the resident's clinical record included a care plan, with a focus for skin and several interventions to promote skin integrity. The resident was observed by Inspector #682 and the resident did not have a specific intervention in place as per the care plan. During an interview the PSW confirmed that they were aware that the resident was to have an intervention in place to promote skin integrity. The PSW confirmed that the intervention that was to promote skin integrity was not in place during observations.The home failed to ensure that the care set out in the plan of care was provided to the

resident as specified in the plan. [s. 6. (7)]

3. The home failed to ensure that when the resident was being reassessed and the plan of care was being revised because care set out in the plan was not effective, different approaches were considered in the revision of the plan of care related to falls.

The resident's clinical record review indicated that the resident had falls. Post fall assessments indicated that the falls occurred during a specific activity. The written plan of care was reviewed and identified that the resident was to have a fall intervention in place.

Interviews with registered staff indicated that the resident was not compliant with the intervention to prevent falls. During an interview and review of the plan of care with the ADOC, they confirmed that the resident had a particular intervention in place to prevent falls. If the resident had the intervention in place the falls could have been prevented. Furthermore, the ADOC stated they should have included other strategies.

The home failed to ensure that when the resident was being reassessed and the plan of care was being revised because care set out in the plan was not been effective, different approaches were considered in the revision of the plan of care related to falls. (561) [s. 6. (11) (b)]

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 different approaches are considered in the revision of the plan of care when a resident is reassessed and the plan of care reviewed and revised, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The home failed to ensure that equipment was kept clean and sanitary.

A) Observations were completed of all of the home's air conditioning units with the DOC. A black substance that was removed when wiped was noted on the lower grates of identified air conditioning units. The DOC and maintenance staff confirmed the black substance was present. In an interview with the maintenance staff, they indicated that they thought the black substance was caused from condensation. The home did not ensure that the identified air conditioning units were kept clean.

B) Inspectors #682 and #683 observed the privacy curtains in specific rooms that included what looked like stains and spills. A tour was completed of specific rooms with the DOC and they acknowledged that there were unclean privacy curtains in all identified rooms. The home did not ensure that the privacy curtains were kept clean in the identified rooms.

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 equipment is kept clean and sanitary, to be implemented voluntarily.

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Issued on this 11th day of September, 2020

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

Original report signed by the inspector.