Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 30, Dec 1, 15, 19, 20, 2011	2011_034117_0038	Complaint

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

WOODLAND VILLA
30 Milles Roches Road, R. R. #1, Long Sault, ON, K0C-1P0

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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), RAI Coordinator, a Registered Nurse (RN), to several Registered Practical Nurses (RPN), to several Personal Support Workers (PSW) and to the several residents.

During the course of the inspection, the inspector(s) reviewed the health care records for the several identified residents, reviewed the home's Infection Control Daily Line Listing, and reviewed tub room skin care directives related to rashes.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

Medication

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The home's DOC stated on November 30 2011 that four identified residents have skin rashes that developed at different times in September, October and November 2011.

The DOC stated during her interview that the home's Skin and Wound Care designated lead RPN discussed with the home's Medical Director, the use and application of a cream mixture on residents skin rashes. The cream mixture is a preparation of zinc cream, calamine lotion and petroleum jelly.

No prescription for the use and application of the cream mixture was found in the health care records for the four identified residents.

The only directives found for the application and use of the cream mixture was in a tub room. A one page notice, posted on the tub room wall indicated that the cream mixture was to be applied twice daily for the identified residents.

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 related to the need to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The home's DOC stated on November 30 2011 that four identified residents have skin rashes that developed at different times in September, October and November 2011.

The DOC stated during her interview that the home's Skin and Wound Care designated lead RPN discussed with the home's Medical Director, the use and application of a cream mixture on residents skin rashes. The cream mixture is a preparation of zinc cream, calamine lotion and petroleum jelly.

The health care records of the four identified residents do not identify when the cream mixture application was initiated, the frequency of application, nor it's effectiveness on the residents' skin rashes.

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 related to the need to ensure that when a resident is taking any drug, there is monitoring and documentation of the resident's response and the effectiveness of the drug, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. Three identified residents developed skin rashes at different times in September, October and November 2011. They were individually assessed by their attending physicians and the long-term care home's Skin and Wound Care designated lead RPN, as part of the home's Skin and Wound Care Program.

1- An identified resident was noted to have a rash under his/her breasts on an identified date in September 2011. On a later date in September 2011, the resident developed other skin ailments on the other parts of the body. Prescription cream treatment was initiated. The cream medication's effectiveness on the resident's skin/rash was not consistently assessed and documented in the resident's health care record between late September and late November 2011. During this period there are only three instances of documented skin assessments and medication effectiveness.

On a specific date in November 2011, it is noted that a calamine lotion, zinc cream and petroleum jelly mixture was applied to the resident's rash with poor effect. There is no documentation in the resident's health care record as to when the above cream mixture was initiated as a skin treatment intervention, if it still ongoing nor its effectiveness on the resident's rash.

2- An identified resident was noted to have a skin rash on his/her torso on specific dates in early October 2011. There is no noted assessment of the resident's skin for a two week period in October 2011. On a specified date in late October 2011, the resident's skin rash was noted to be present on his/her torso.

On a specified date in late October 2011, the attending physician prescribed an oral antihistamine medication, on an as needed basis, to be given to the resident to relieve the skin rash. On a specified date in late October 2011, the physician changed the medication order and increased the medication dosage and frequency.

The antihistamine medication's effectiveness on the resident's skin/rash was not consistently assessed and documented in the resident's health care record between late October and late November 2011.

On a specified date in November 2011, it is noted that a rash cream was applied to the resident's rash. There is no documentation in the resident's health care record as to what type of cream was applied, when the rash cream was initiated as a skin treatment intervention, if rash cream intervention is still ongoing nor its effectiveness on the resident's rash.

3- An identified resident was noted to have a large rash on his/her back on a specific date in November 2011. Progress notes indicate that the resident rash was still present a few days later. There is no noted assessment of the resident's rash, skin status nor of interventions being done related to the rash during a one week period in November 2011, when the resident's rash was assessed by the attending physician.

On a specific date in November 2011, the RN documented in the resident's health care record that a Calamine cream mix was applied to the resident's skin in regards to excessive scratching and overall redness. There is no documentation in the resident's health care record as to when the Calamine cream mixture was initiated as a skin treatment intervention, if it was still ongoing or its effectiveness on the resident's rash.

4- Interviewed DOC and PSWs state that as of Dec 1 2011, the long-term care home staff was still applying the calamine lotion, zinc cream and petroleum jelly mixture to the three identified residents skin.

Interviewed DOC, RN, RPNs, PSWs and RAI coordinator state that the home did initiate other care interventions in relation to the resident rashes. They state that the residents' laundry was separated and washed separately and tub infection control cleaning procedures were increased. It is noted that these interventions were not documented in residents health care records and plans of care.

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 related to the home's Skin and Wound Care program needs to ensure that resident skin assessments, reassessments, interventions and the resident response to interventions are documented, to be implemented voluntarily.

Issued on this 20th day of December, 2011

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