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
Apr 26, 2019	2019_520622_0006	004749-19, 006257-19	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

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

HEATH HEFFERNAN (622)

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): April 10, 11, 12, 15, 16, 23, 24, 2019

The following logs were completed during this inspection:

Log #004749-19 for a complaint related to resident care and services, and alleged staff to resident abuse.
Log #006257-19/Critical Incident System report (CIS) #2743-000009-19 related to the same incident of alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Director of Operations, the Nursing Administrative Services Manager (NASM), the Skin and Wound Care Lead, the Physician, the Physician's Assistant, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

Also during the course of the inspection, the inspector reviewed hard copy and electronic health records, staff schedules, critical incident and complaint reports, applicable investigation documents, the Licensee's policies titled; Zero Tolerance of Abuse and or Neglect - Policy #AM-6.9, Reporting Incidents of Abuse – Policy #AM-6.7, Complaints Procedure – Policy #AM-6.1, Routine Skin Care and Assessment – Policy #CS-14.1, Wound Assessment and Documentation - Policy #CS-14.5, Methicillin Resistant Staphylococcus Aureus (MRSA) - Policy #IF-IC-6.2.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any, policy, the licensee is required to ensure that the policy is complied with.

O. Reg. 79/10, s. 50 (1). states that the skin and wound care program must, at a minimum, provide for the following:

1. The provision of routine skin care to maintain skin integrity and prevent wounds.

2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.

3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

4. Treatments and interventions, including physiotherapy and nutrition care.

On April 16, 2019 at 0936 hours, inspector #622 reviewed the licensee's policy/procedure titled: Wound Assessment and Documentation, Policy # CS-14.5 dated effective September 2015 which stated;

- Each wound will have the treatment plan evaluated by the Registered Nurse or her delegate at a minimum weekly in the wound tracker software section of Mede-Care.

Intake log #004749-19/ IL – 64682-OT – related to an anonymous complaint for resident #001 stated that resident #001 had specified skin wounds.

On April 16, 2019 at 1121 hours, inspector #622 reviewed the Treatment and Observation Records for resident #001 within the wound care binder dated for a three month period. The Treatment and Observation Records indicated that resident #001 had wounds, dressings were to be completed as specified. The Treatment and Observation Records were being used to document the assessment and dressing changes for resident #001's wounds.

On April 23, 2019 at 1315 hours, inspector #622 further reviewed the documentation within the wound care binder for residents #004 and #005 which stated;
Resident #004 had a wound and dressings were to be changed as specfied. The Nursing Care Plan and Treatment sheet for a stage three pressure area located in the wound care binder was being used to assess and track the pressure area on resident #004's wound.

Resident #005 had a wound with dressing changes as specified. The documentation for the assessment of resident #005's wound was being completed on the Treatment and Observation Record.

On April 23, 2019 at 0954 hours, inspector #622 reviewed the Wound Tracker section of Mede-Care which indicated that the weekly wound assessments completed by the registered staff had not been documented in the Wound Tracker section on Mede-Care for residents #001, #004 and #005.

During separate interviews with inspector #622 on April 16, 2019, the Skin and Wound Care Lead - Registered Practical Nurse (RPN) #105 and Registered Nurse (RN) #104 stated that the staff had not utilized the Wound Tracker section on Mede-Care, instead the documentation of resident #001's wound assessments were completed using the Treatment and Observation Record located within the wound care binder.

During an interview with inspector #622 on April 23, 2019 at 1330 hours, the Skin and Wound Care Lead – RPN #105 stated that:
- resident #004 had a specified wound. Resident #004's assessment documentation was

completed on the Nursing Care Plan and Treatment Sheet - Stage three pressure ulcer located in the wound care binder.
- resident #005 had a specified wound and due to the amount of documentation required for this wound, they had chosen to document resident #005's wound assessments on the Treatment and Observation record located in the wound care binder.
The Skin and Wound Care Lead - Registered Practical Nurse (RPN) #105 further stated that none of the resident's wound assessments were being documented on Wound Tracker section of Mede-Care at this time.

Therefore the licensee failed to ensure that the licensee's policy/procedure titled: Wound Assessment and Documentation, Policy # CS-14.5 was followed. [s. 8. (1) (a),s. 8. (1) (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director;
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Intake Log #006257-19/Critical Incident System report (CIS) #2743-000009-19 dated a specified date stated that an anonymous source had reported allegations of staff to resident emotional/verbal abuse, Improper/incompetent treatment of a resident that results in harm or risk of harm to a resident. The anonymous source alleged that resident #001 who passed away had been treated inappropriately, and the resident was afraid. No staff name or date was given to the home at the time related to the occurrence.

During the course of the licensee's investigation it was alleged by Personal Support Worker (PSW) #102 that resident #001 had reported to them that PSW #103 had improperly treated them. PSW #102 stated at the time, resident #001 requested they not tell anyone for fear of what PSW #103 might do.

During an interview with inspector #622 on April 11, 2019 at 1316 hours, PSW #102,

stated the same as what was noted within the licensee's investigation.

During an interview with inspector #622 on April 11, 2019 at 1249 hours, the Omni Director of Operations #111 stated they had received a telephone call on a specified date from an anonymous source related to concerns for resident #001. The anonymous source alleged that staff to resident emotional abuse of resident #001 had occurred. The OMNI Director of Operations #111 stated that they had reported the concern to the Director of Care DOC #101 by telephone on the same specified date and would have expected a CIS report to have been filed with the Ministry of Health and Long-Term Care that date.

During an interview with inspector #622 on April 11, 2019 at 1625 hours, the Director of Care (DOC) #101 stated that they could not recall the Director of Operations #111 reporting the alleged staff to resident abuse of resident #001 on the specified date.

During an interview with inspector #622 on April 12, 2019 at 1025 hours, the Administrator #100 stated that they had received the complaint related to staff to resident improper treatment for resident #001 from the Omni Director of Operations #111 on a date three days later and started interviews immediately. The Administrator stated they had they submitted the CIS report on a specified date when they were informed by PSW #102 during an investigation interview that resident #001 had reported to them that PSW #103 had treated them improperly, five days after it was reported to the licensee.

Therefore the Licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director?
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. [s. 24. (1)]

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 that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident., to be implemented voluntarily.

WN #3: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

Resident #001 had multiple diagnosis as well as specified wounds.

On April 15, 2019 inspector #622 reviewed the progress notes which indicated that Resident #001 was transferred to hospital on a specified date and was admitted with a specified diagnosis. Resident #001 returned to the home on a specified date. There was no documentation that a head to toe skin assessment was completed on resident #001 upon return from hospital on that date.

On April 16, 2019 at 1300 hours during an interview with RPN #107, the health records were reviewed for the head to toe skin assessment of resident #001 after their return from the hospital on the specified date, none were noted.

During a telephone interview with inspector #622 on April 16, 2019 at 1557 hours, Registered Nurse #104 stated a specified date they had viewed resident #001's dressings on their specified wounds when they returned from the hospital, however had not completed the head to toe skin assessment.

During an interview with inspector #622 on April 16, 2019 at 1049 hours, the Director of Care (DOC) #101 stated that a head to toe skin assessment of a resident was to be completed on return from a hospital admission. The DOC #101 and Inspector #622 reviewed resident #001's health records which did not include a head to toe assessment for resident #001 after their return from the hospital on the specified date.

Therefore, the Licensee failed to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital. [s. 50. (2) (a) (ii)]

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 that every licensee of a long-term care home shall ensure that, a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital, to be implemented voluntarily.

Issued on this 2nd day of May, 2019

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

Original report signed by the inspector.