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

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Original Public Report

Report Issue Date: December 6, 2023

Inspection Number: 2023-1319-0004

Inspection Type:
Critical Incident

Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

Long Term Care Home and City: Forest Hill, Kanata

Lead Inspector	**Inspector Digital Signature**
Lisa Kluke (000725)	Lisa Kluke Digitally signed by Lisa Kluke Date: 2024.01.25 14:08:51 -05'00'

Additional Inspector(s)
Maryse Lapensee (000727)
Laurie Marshall (742466)
Shevon Thompson (000731)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 1 to 3 and November 6 to 9, 2023
The following intakes were completed during this Critical Incident (CI) inspection:
Intakes #00091629, #00098564, and #00094079 were related to incidents of hospitalization of residents with significant changes in their health conditions.
Intake #00096311 was related to an incident of alleged staff to resident neglect.
Intake #00096702 was related to a written complaint to the home regarding alleged resident to resident abuse.
Intake #00099330 was related to resident to resident abuse.
Intakes #00099590, #00100215 and #00100286 were related to falls resulting in a significant change in condition for these residents.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that the written plan of care for a resident set out the planned care for the resident's fall prevention interventions including the use of specified equipment.

Rationale and Summary:
In a progress note dated four weeks prior, a physiotherapist, documented that this

resident had been explained the use of the specified equipment and they had been provided to the resident. Inspector reviewed the resident's current care plan, with effective date of 11 weeks earlier. No information was noted in the written plan of care for this equipment for the resident. In an interview with an RN, they stated that using this equipment was one of the main fall prevention and management strategies in place for this resident. The RN affirmed that the use of this equipment was not included in the resident's plan of care.

On a specified date during this inspection, a PSW confirmed that this resident was using this equipment. In an interview with a Physiotherapist, they stated that the fall prevention and management interventions for this resident, included the use of this specified equipment.

The next day, the Administrator provided an updated record to the Inspector. The updated written plan of care for this resident, was reviewed by the inspector and information for this equipment was present.

Sources: a resident's progress notes and written plan of care, interview with a PSW, an RN and a Physiotherapist. [000731]

Date Remedy Implemented: November 9, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer

necessary.

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed and this resident required the use of a mobility device.

Rationale and Summary:
This resident's care plan document stated the resident was not needing an assistive device for mobility in their room and the hallway.
The Inspector observed this resident using a specific mobility device.
Two Personal Support Workers (PSWs) confirmed that this resident used a specific mobility device and should be in resident's care plan document.
A Registered Practical Nurse (RPN) confirmed that this resident was using this specified mobility device and their care plan document was not reflecting this at this time.

This resident's care plan document was updated on a specified date during this inspection, to reflect that the resident required to use this mobility device.

Source: Observation, the resident 's health records, interviews with two PSWs and an RPN. [000727]

Date Remedy Implemented: November 3, 2023

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident.

The licensee has failed to ensure that the written plan of care for a resident, set out the planned care for the resident's specialty clothing, transfer needs and skin and wound interventions.

Rationale and Summary:
During this inspection, the Inspector reviewed this resident's electronic health care records regarding a recent hospitalization with significant change in condition and noted discrepancies in the resident's current plan of care.

A-The resident's current care plan document indicated staff needed to apply and remove the specialty clothing to the resident daily. The resident's Treatment Administration Record (TAR) indicated the resident's specialty clothing have been on hold for the last 10 months.

B-The resident's current care plan document indicated for transfer needs, that the resident required specific equipment and assistance to help them get up from sitting position. The physiotherapist indicated during an interview that the resident required a different type of equipment and assistance for all transfers after a reassessment was completed eight months prior due to a specified complex skin condition. The Physiotherapist indicated that this was not updated in the current plan of care. The physiotherapist indicated nursing staff update the resident's care plan and kardex documents.

C-The resident's current care plan document indicated the resident required wound

care on specified days each week and as required (PRN). The treatment intervention for this skin condition required specified medical wound supplies. The resident's TAR did not contain these wound interventions as required in the plan of care for documentation of this skin wound since the open area began over a year ago. The Inspector reviewed documented orders from the resident's return from an external assessment location recently for this skin wound. This documentation indicated that the resident would require new treatment intervention using specified wound supplies and frequency. This information was in the TAR however not updated in the resident's care plan document.

A Registered Practical Nurse (RPN) indicated during an interview that the resident's care plan and kardex documents would need to be updated with: A- placing the specialty clothing on hold. B- transfers with the current evaluated equipment and assistance for the resident. C- wound care to be updated with the new orders for wound treatment. This RPN further indicated the resident's open wound should have been added to the TAR over a year ago, however this part of the plan of care was missed by the initiating nurse and then never added as required until 10 months later.

Failure to have the planned care for this resident's needs related to use of specialty clothing, transfers equipment and assistance and skin and wound interventions identified in the written plan of care, increased the risk of deterioration of this wound and resident injury.

Sources: Resident health care records and interviews with an RPN and a physiotherapist. [000725]

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that the written plan of care for a resident sets out clear directions on transferring the resident, to staff and others who provide direct care to the resident.

Rationale and Summary:
The Inspector observed a sign above this resident's bed which indicated that the resident was independent for transfer needs. In a review of this resident's current care plan document, the intervention for transferring the resident indicated assistance required for transfers.

During an interview, three days after this observation, a PSW affirmed that this resident required specified assistance and transfer methods.

An RN reviewed the resident's current care plan document. The RN verified that the intervention for transferring listed in the care plan document was not the same as the sign in the resident's room above the bed.

A Physiotherapist confirmed the transfers the resident needed was with the specified assistance and specified method of transfer as well as the use of specified equipment when the resident was weak.

Failure to ensure that the written plan of care for this resident sets out clear

directions, on transferring the resident, places the resident at increased risk for unsafe transferring.

Source: Observation of this resident's room, review of the resident's written plan of care, interview with a PSW, an RN and a Physiotherapist. [000731]

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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 the plan of care was provided to a resident as specified in their plan related to skin and wound pressure relief interventions.

Rationale and Summary:
The resident's current plan of care for skin integrity indicated the resident is to be applied specialty equipment devices at all times for required pressure relief for skin breakdown by RN/RPN/PSW.

On a specified date, the Inspector observed the resident seated at their bedside and their specialty equipment devices were not applied. The next day, the Inspector observed the resident seated at their bedside and their specialty equipment devices were not applied.

The Inspector asked the resident to move their body however the resident indicated

they could not as it hurt too much.

A Personal Support Worker (PSW) caring for the resident that day indicated to the Inspector that they applied the pillow behind the resident to prevent the resident from rubbing their body on the frame of their seating device. This PSW further indicated they applied a towel to keep the resident warm. This PSW proceeded to lift the resident and the resident indicated that they were in pain when the PSW removed the towel from behind them. This PSW indicated they were not aware of any specialty equipment devices the resident needed to wear.

A Registered Practical Nurse (RPN) indicated the resident was not wearing the specialty equipment device as it caused heat and swelling, and they did not know if they needed to use the specialty equipment device for the other area. This RPN indicated they should have the physiotherapist reassess the resident for need for these specialty equipment devices.

The physiotherapist indicated the resident required to wear the specialty equipment devices for offloading and pain prevention needs for skin integrity and this intervention continues to be required.

As such, not following the interventions in the plan of care related to the application of the specialty equipment devices, posed increased risk of damage and pain to the resident.

Sources: Resident health care records and interviews with the resident, a PSW, a RPN, and a Physiotherapist. [000725]

WRITTEN NOTIFICATION: Required programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
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:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the home's policy for the fall prevention and management program was complied with. In accordance with O. Reg 246/22 s. 11 (1) (b), 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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with.

Rationale and Summary:
A review of the fall prevention and management program, Section ,7 Policy #OTP-FP-7.3 outlined the following procedures:
Procedure 2. All residents will be assessed for falls risk using the Morse Falls Risk assessment tool at the time of admission, with any significant change of status and post fall.
Procedure 8. The registered staff shall communicate the outcome of each assessment to nursing and personal care staff in the home and again at the next shift to shift report with the use of a Falls Huddle. The registered staff will utilize a Falls Huddle Script to ensure all key points are captured during a Falls Huddle or

shift Report.
Procedure 9. All residents deemed to be at risk for falls will have a pictograph represented within their personal room or on their assistive device as cueing for all staff that the resident is at risk for falls. For example, the pictograph could be a falling star strategically placed on a walker or wheelchair.

In a review of the Falls Risk Assessment history, for a specific resident, the Inspector noted there had been no documented fall risk assessment completed for resident's fall on a specified date.

A Personal Support Worker (PSW) confirmed that they did not know of a pictograph or picture that was used to indicate that a resident was at high risk for falls.

A Physiotherapist affirmed that the home did not use any kind of pictograph to indicate residents at high risk for falls.

During an interview with the Director of Care (DOC) and Administrator, they validated that the pictograph mentioned in the falls policy was not being utilized to identify the residents that are at risk for falls and there was no other intervention in place for this. During the same interview, the DOC confirmed that there was no documentation of a completed Falls Risk Assessment for this resident's fall on that specified date. They also verified that there was no Falls Huddle taking place and there was no formal huddle script being used.

Failure to ensure that the fall prevention and management program is complied with places the residents at an increased risk for falls and injury.

Source: Falls prevention and management program - Policy #OTP-7.3, a resident's Falls Risk Assessment history, interviews with a PSW, a Physiotherapist, the DOC

and the Administrator. [000731]

WRITTEN NOTIFICATION: Required programs

NC #007 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 ulcers, and provide effective skin and wound care interventions.

The licensee has failed to ensure that their written policy related to the skin and wound program was complied with, for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their written policy related to the skin and wound program for a specified resident was complied with. Specifically, registered nursing staff did not comply with the licensee's current policy titled "Wound Assessment and Documentation" dated March 29, 2022, which was included in the licensee's skin and wound care program. This policy indicated on page 1 of 2 that treatment of a wound shall be recorded on the electronic Treatment Administration Record (TAR).

Rationale and Summary:
On specified date approximately a year ago, a resident developed alterated skin integrity to an area on their body which was identified by registered nursing staff that required wound care and assessment. This treatment was not added to the resident's Medication Administration Record (MAR) or Treatment Assessment Record (TAR) as required. This alteration in skin integrity site deteriorated as

identified in an external assessment approximately 11 months later to have significantly deteriorated.

A Registered Practical Nurse (RPN) indicated residents that require wound care are identified in the home's electronic MAR or TAR. This RPN was not able to locate this resident's specified altered skin integrity area for the month prior to this external assessment in the MAR or TAR in their electronic system.

The Inspector reviewed the home's electronic MAR/TAR for this resident which did not indicate any wound care treatment to this altered skin integrity site over this 10 month period.

As such, this resident did not receive regular wound treatment and assessments to this skin site which significantly deteriorated. This resident required a lengthy external assessment period for treatment and review of interventions for proper healing.

Sources: Review of this resident's health record and external assessment records, and interviews with an RPN. [000725]

WRITTEN NOTIFICATION: Skin and wound care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that for a resident exhibiting an alteration in skin integrity, received 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.

Rationale and Summary:
On a specified date approximately one year ago, in the resident's progress notes and skin tracker indicated this resident developed a specified alteration of skin integrity to an area on their body and required wound care and treatment. The home uses "wound tracker" as their clinical assessment instrument for skin and wound assessments. In a review of the resident's wound tracker for this specified skin site, it was noted that 32 assessments in a 45 week period were completed. This resident went to an external assessment location for assessment and treatment for significant deterioration to this altered skin integrity site.

A Registered Practical Nurse (RPN) indicated they are required to complete a skin assessment on a specified day of the week for this resident after the skin care is completed for each skin site in the "wound tracker" section in the home's electronic health records.

The Director of Care (DOC) indicated during an interview that there were a number of skin assessments missing for this altered skin integrity site based on review of the resident's electronic health records.

By not using the "wound tracker" staff were not tracking the increasing severity of this alteration of skin site before it became severely deteriorated requiring the

resident to go to an external assessment location for 13 days of treatment.

Source: Record review of this resident's health records, and interviews with an RPN, and the DOC. [000725]

WRITTEN NOTIFICATION: Skin and wound care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
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,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that a resident exhibiting an alteration of skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary:
A resident had an altered skin integrity site first identified approximately one year ago.

Inspector reviewed this resident's wound trackers and progress notes for a two month period in the home's electronic health records. It was noted that weekly skin assessments of this pressure ulcer were not completed weekly on two specified weeks. It was further noted on the next wound assessment, that the resident's altered skin integrity site had deteriorated and later required prescribed medications for infection treatment. The resident was then sent for an external assessment due

to significant deterioration in this altered skin integrity site.

The Director of Care (DOC) indicated they could not locate the weekly wound care assessments for this altered skin integrity site on these specified dates.

As such, the resident was placed at risk of worsened altered skin integrity by not completing weekly assessments from registered nursing staff of their specific skin site as required.

Source: Review of a resident's health records and interview with the DOC. [000725]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee has failed to ensure that written approaches for a specified resident including assessment, reassessment, and identification of behavioral triggers were documented.

Rationale and Summary:
An external assessment report dated prior to this resident's admission identified that this resident had specific behaviours which they described and stated these behaviours often escalated in the evening and nighttime. The report summarized

that these behaviours had become an issue prior to admission.

Review of this resident's detailed individual report on incidents and progress notes identified that upon admission and review of resident's admission documentation by a registered staff, it was identified that they had a previous history of specific behaviours that could affect other residents.

The admission care plan indicated that this resident had other types of specified behaviours. The care plan indicated that this resident had a history of a number of specified behaviours with detailed interventions in place.

This resident's progress notes indicated they were involved in three different resident to resident altercations occurring over a 13 day period approximately six weeks after admission.

Behavioral Support Ontario (BSO) data collection sheet, Dementia Observation System (DOS) mapping was implemented at time of admission approximately six weeks before these altercations for a four day period. There were no documented (DOS) mapping entries on the first two days of this observation and monitoring period and only partial entries for the last two days of this assessment period. DOS mapping started again during a specified week approximately one month later, relating to medication adjustment needs for a specific behaviour. In review of this second DOS mapping assessment, the resident had two documented incidents of responsive behaviours however the data entry or identification of triggers was inconsistent. In review of the unit security check binder for this period, that there were no documented entries for the reported incidents that occurred as specified in the resident's progress notes.

Interview with a BSO staff, they reported that DOS mapping could not identify if they

had behaviours because it was not documented long enough to assess. BSO also confirmed that they were responsible to ensure that DOS documentation was completed by staff.

Interview with an RPN reported that this resident had medications to manage behaviours, but it was too soon to determine if new medical interventions were yet effective. Another RPN reported that registered staff are to inform PSW staff when a resident is on safety checks every 15 minutes and PSW staff are required to document in the security check binder. Interview with a third RPN reported that this resident had another incident when they were admitted on another floor that was not related to these current behaviours. They reported that this resident did not demonstrate these behaviours during their observations.

The Director of Care (DOC) reported that prior to admission it was identified that this resident had specific triggers related to their personal environment as well as behaviours towards nursing care staff. The Administrator and DOC confirmed that they were not told of these triggers/behaviours and felt that their behaviours were under control at time of admission acceptance to the home. Both confirmed that staff were required to complete DOS mapping over the required period.

Failure to provide written approaches to care, behavioral assessments and reassessments of behavioral triggers resulted in actual risk towards co-residents.

Sources: External organization assessments, detailed incident report notes, resident's progress notes, admission care plan, current care plan, DOS mapping, security checks, interviews with three RPN's, a BSO staff member, the DOC and the Administrator. [742466]

WRITTEN NOTIFICATION: Responsive behaviours

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to take actions to respond to a resident's responsive behaviours by ensuring that the resident's responses to interventions and reassessments were documented.

Rationale and Summary:
Behavioral Support Ontario (BSO) data collection sheet, Dementia Observation System (DOS) mapping was implemented for a four day period of time at the resident's admission. There were no documented (DOS) mapping entries on the first two days and only entries for evening and nights on the last two days of this collection of information period. DOS mapping was initiated approximately a month later relating to a medication adjustment for a specified behaviour at night.

DOS mapping documentation during this second assessment period indicated that the resident was involved in a resident to resident altercation incident on a specified day. DOS mapping documentation continued for the evening and into the early hours of the night shift however nursing staff did not resume this mapping documentation until the evening two days later. DOS mapping did not identify altercations between co-residents that occurred in this assessment period. Security checks for every 15- minutes lacked documentation for the month after their admission and showed that there were no documented entries of every 15-minute

security checks at the time of the reported incidents that occurred on two separate occasions during this assessment period.

A PSW reported that registered staff communicate at the start of their shift which residents require safety checks and confirmed that they did not document safety checks in the security binder.

Two RPN's reported that registered staff are to inform PSW staff when a resident is on safety checks and PSW staff are required to document in the security check binder. Both RPN's confirmed that this resident should be monitored for safety checks every 15 minutes.

The Director of Care (DOC) and the Administrator confirmed that PSW's are supposed to be documenting in the security check binder for residents who require security checks every 15 minutes and that DOS mapping was to be documented for the week it was ordered.

Failure to complete the DOS and documenting the residents' responsive behaviours led to an increased risk of not taking actions to respond to the needs of the resident, including assessments, reassessments, and interventions. This posed an increased risk to other residents' due to altercations that occurred.

Sources: External organization assessments, DOS mapping, care plans, this resident's progress notes, security checks, Policy (#S.M. 1.6, May 29, 2023) for Supporting a Resident with Responsive Behaviours; Interviews with a PSW, two RPN's, the DOC and the Administrator. [742466]