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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 25, 2016	2016_276537_0007	002272-16	Resident Quality Inspection

Licensee/Titulaire de permis

S & R NURSING HOMES LTD.
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

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

AFTON PARK PLACE LONG TERM CARE COMMUNITY
1200 AFTON DRIVE SARNIA ON N7S 6L6

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

NANCY SINCLAIR (537), ALICIA MARLATT (590), CAROLEE MILLINER (144)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 1, 2, 3, 4, 5, 8 and 9, 2016

The following Critical Incidents and Complaint inspections were conducted concurrently during this inspection:
Log # 031531-15/CI 2872-000021-15 related to allegations of abuse to a resident.
Log # 000715-16/IL-42381-LO related to allegations of abuse to a resident.
Log #034357-15/IL-41867-LO/IL-42378-LO related to allegations of neglect of resident needs.
Log #028612-15/CI 2872-000020-15 and corresponding Log #033575-15/IL-41658-LO related to allegations of neglect of resident needs.
Log #032161-15/IL-41616-LO related to related to allegations of neglect of resident needs.

During the course of the inspection, the inspector(s) spoke with the Vice President of Long Term Care, Administrator, Manager Resident Care, Assistant Manager Resident Care, RAI Coordinator, Environmental Service Manager, Dietitian, one Food Service Worker, one Registered Nurse (RN), five Registered Practical Nurses (RPN), 17 Personal Support Workers (PSW), Residents' Council Representative, Residents and Families.

The inspector(s) also conducted a tour of all resident areas and common areas, observed residents and care provided to them, meal service, medication passes, medication storage areas, reviewed health care records and plans of care for identified resident, policies and procedures, meeting minutes and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **5 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	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

An identified resident had falls. The post fall note provided specific directions for staff as a result of the falls. At the time of inspection, review of the most recently revised plan of care did not include direction to nursing personnel consistent with the directions following the post fall note.

Interview of Personal Support Worker(PSW) #117 confirmed the care provided to the resident was actually as directed from the post fall note. Registered Practical Nurse (RPN) #120 confirmed the resident's plan of care was not revised to include the post fall directive and did not provide clear directions to staff.

The Manager of Resident Care #100 also confirmed the resident's plan of care did not provide clear directions to staff and should have been revised to include the post fall directive. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, 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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

An identified resident was observed to have an extensive area of altered skin integrity.

Review of the resident's clinical record since their admission revealed no indication that the staff were aware of the extensive area of altered skin integrity.

Interview with Personal Support Worker(PSW) #126 revealed that PSW #126 was aware of this resident's altered skin integrity and indicated that this resident always had similar areas of altered skin integrity present. PSW #126 confirmed that PSW's were to document all areas of new skin integrity impairment in the Point of Care(POC) system and were also expected to report them to the registered staff for assessment.

Interview with Registered Nurse(RN) #119 revealed that RN #119 was aware of the area of altered skin integrity. RN #119 confirmed the PSW's were expected to document and report areas of impaired skin integrity to the registered staff. RN #119 explained the registered staff were to document in risk management, an incident report indicating the

location, size and cause of the altered skin integrity if known and that a progress note and corresponding skin assessment should also be completed and documented in the Point Click Care(PCC) system. RN #119 shared that the area of skin integrity impairment should also be added to the Treatment Assessment Record(TAR) to ensure the area was monitored on an ongoing basis until resolved. Review of the progress notes, risk management reports and skin assessments confirmed that none of these had been completed for the areas of altered skin integrity for this resident. RN #119 confirmed that the identified area of altered skin integrity of this resident was currently not being monitored as required as no assessments were done and it was not added to the TAR for continuous monitoring.

An interview with the Assistant Manager Resident Care(AMRC) #127 confirmed that staff were expected to monitor altered skin integrity progression until it was resolved. She confirmed that PSW's were expected to document in POC, areas of altered skin integrity and to report them to the registered staff. She confirmed the registered staff were expected to complete and document a risk management report, progress note and skin assessment and that areas of impaired skin integrity should be added to the TAR to ensure continuous monitoring of the altered skin integrity until resolved. She confirmed that the staff were not following the home's process for skin and wound care monitoring. [s. 50. (2) (b) (i)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that documentation of the use of a physical device for restraining included all assessment, reassessment and monitoring, including the resident's response.

Interview with Registered Practical Nurse (RPN) #113 revealed resident #041 had a physician order and Substitute Decision Maker consent for the use of a physical device specifically for the purpose of restraining. RPN #113 indicated that, with the use of this method of restraining, the expectation of the registered staff was to ensure that the device was being used properly, the device was in good working order, and that the registered staff did an evaluation of the need for the ongoing use and appropriateness of the device every shift, which was to be captured in the electronic Medication Administration Record (eMAR) or the electronic Treatment Administration Record (eTAR). RPN #113 confirmed that the required documentation for the use of the restraint was not present in the eMAR or eTAR and was not being completed.

The identified resident was observed using the identified device for restraining. Interview with Personal Support Workers(PSWs) #112, 114 and 115 revealed that the identified device was used for the purpose of restraining the resident, as other interventions tried had been ineffective. PSW #115 indicated that, when this method of restraining was used, the expectation for documentation included hourly monitoring of the resident for safety, comfort and positioning and this documentation was to be completed within the Point of Care (POC) system. PSW #115 verified that the required documentation was not being completed as this task was not present in the POC system for the PSW to document.

The home's policy titled "Minimizing Restraining of Residents - RCM 10-008-01" last revised February 11, 2014, indicated the following:

"Documentation
1. Hourly - Personal support workers (PSWs) will monitor and document each resident with restraints to ensure that the resident is safe, comfortable and is properly positioned on the Restraint/PASD Application Form or within the POC software.
3. Every 8 Hours - The Registered Team Member (RTM) will assess and document each shift on the Restraining Application Form or within the software, the continued need for the restraining and the Residents response to the restraint."

The Manager Resident Care #100 confirmed that with the use of a restraint, the expectation was that the assessment, reassessment and monitoring, including the resident's response to the use of the restraint was to be documented by all staff. [s. 110. (7) 6.]

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 every use of a physical device to restrain a resident includes documentation of all assessment, reassessment and monitoring, including the resident's response, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was dressed appropriately, suitable to the time of day and in accordance with their preferences, in their own clean clothing and appropriate clean footwear.

An identified resident was observed to be dressed inappropriately in an item that required replacement/repair. During an interview, the resident was unable to tell the inspector why they were dressed inappropriately. On another occasion, the resident was observed to be dressed appropriately in a similar item that did not require replacement/repair.

An interview with Personal Support Worker(PSW) #126 revealed that PSW #126 recalled seeing the resident dressed inappropriately. PSW #126 shared that the PSW's were expected to report to the registered staff, items of residents that needed to be repaired/replaced. PSW #126 was unable to recall if PSW #126 had reported to the registered staff.

Interview with PSW #116 revealed the resident was transferred to the home area where PSW #116 worked and was received in previously identified inappropriate item, and confirmed that it had been reported to the registered staff and had kept her eye out for the family to speak with them if they came in, however they did not.

An interview with Registered Nurse(RN) #119 confirmed that PSW's were to report resident items that needed to be repaired/replaced to the registered staff. RN #119 explained that the registered staff are responsible for contacting the family and entering a progress note to inform other staff that repairs/replacements have been requested from the family. Whether the family replaces or repairs the required items is up to them. RN #119 confirmed that the resident should not be wearing items that needed repair. She confirmed that there was no progress note related to the mentioned item requiring repair in PCC and removed the item as the resident had alternate appropriate items for use.

An interview with the Assistant Manager Resident Care #127 confirmed that the staff were to notify families of items that needed to be replaced or repaired and were not an appropriate for resident use. [s. 40.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

The drug supply room was observed and was found to contain government stock medications. The Assistant Manager Resident Care #127 confirmed there were no controlled substances located in the drug supply room.

An interview with the Environmental Services Manager #132 confirmed that he had keys to the drug supply room and they were given to him approximately one month ago. The purpose of having the drug supply room keys was so he could put the government stock medications away when they were delivered to the home. He shared that the home's staff had removed the high risk medications from the room so he would be able to go in and put drug deliveries away.

An interview with the Assistant Manager Resident Care #127 verified that the Environmental Services Manager #132 had a key to the drug supply room.

The Administrator #101 confirmed that the Environmental Service Manager #132 should not have a key for the medication storage area. [s. 130. 2.]

Issued on this 29th day of February, 2016

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

Original report signed by the inspector.