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

London District
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Original Public Report

Report Issue Date: September 27, 2023	
Inspection Number: 2023-1357-0006	
Inspection Type: Critical Incident	
Licensee: S & R Nursing Homes Ltd.	
Long Term Care Home and City: Afton Park Place Long Term Care Community, Sarnia	
Lead Inspector Julie Lampman (522)	**Inspector Digital Signature** Julie Lampman Digitally signed by Julie Lampman Date: 2023.09.28 10:41:02 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 13, 14, 15, 18, 19, 2023.
The inspection occurred offsite on the following date(s): September 21, 2023.

The following intake(s) were inspected:

- Intake: #00094505/Critical Incident System (CIS) related to resident to resident abuse;
- Intake: #00094866/CIS related to falls prevention and management.

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

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a resident received a twice weekly treatment.

Rationale and Summary
A resident's electronic Treatment Administration Record indicated that the resident had altered skin integrity which required a treatment twice a week. There was no documentation to support that this had been completed, as scheduled, on a specific date.

The Manager of Resident Care (MRC) stated Registered Nurse (RN) # 109 had not completed the treatment as scheduled.

There was low risk to the resident by not completing the twice weekly treatment.

Sources:
Review of the resident's clinical records and an interview with the MRC. [522]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

1. The licensee has failed to ensure that care provided to a resident was documented.

Rationale and Summary
A resident had an initial skin and wound assessment for an area of altered skin integrity. There was no skin and wound assessment documented the following week.

The Manager of Resident Care (MRC) stated Registered Practical Nurse (RPN) #119 completed the dressing change and assessment of the area of altered skin integrity, but forgot to document the skin and wound assessment.

There was low risk to the resident by not documenting the weekly skin and wound assessment.

Sources:
Review of the resident's clinical records, the home's "Skin and Wound Program" policy #RCM10-06-01 revised May 20, 2022; and an interview with the MRC and other staff. [522]

2. The licensee has failed to ensure that safety checks for a resident were documented.

Rationale and Summary
A resident's care plan stated that the resident was to have safety checks completed.

The resident's Point of Care Documentation Survey report noted there were no documented safety checks for three specific shifts.

The Manager of Resident Care (MRC) reviewed the documentation and confirmed the safety checks had not been documented and should have been.

There was low risk by staff not documenting the safety checks for the resident.

Sources:
Review of a Critical Incident System report, the resident's clinical records and an interview with the MRC. [522]

WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect a resident from abuse by another resident.

O. Reg 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

Rationale and Summary
An incident of resident to resident abuse occurred, and one of the residents sustained injuries. The abuse was witnessed by a staff member.

The staff member stated they heard one of the residents scream, and when they entered the room they witnessed the incident of abuse. The staff member stated they did not ring the call bell as they thought

that it was better to go get the registered staff member at the nurses' station as it was not too far away.

The registered staff member stated the staff member should have pulled the emergency call bell and not have left the residents alone.

While speaking with Inspector #522, the resident vividly recounted the incident. Staff of the home stated that the resident was visibly upset after the incident.

There was moderate impact to the resident as they had sustained injuries and were scared and frightened after the incident. There was moderate risk to the resident, as they were left alone when the staff member went to get a registered staff member.

Sources:
Review of a Critical Incident System report, residents' clinical records, the home's "Resident Abuse and Neglect" policy Admin 08-05 revised April 2022, email correspondence, investigative notes; and interviews with the resident, the MRC and other staff. [522]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident who exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A resident had an initial skin and wound assessment for an area of altered skin integrity. There was no skin and wound assessment documented two weeks later.

The Manager of Resident Care (MRC) stated Registered Nurse (RN) #109 had not completed the resident's skin and wound assessment as the weekly assessment had not been added to the resident's electronic Treatment Administration Record to prompt the RN to complete the assessment.

There was low risk to the resident as staff observed the wound twice weekly during a treatment.

Sources:
Review of the resident's clinical record, the home's "Skin and Wound Program" policy #RCM10-06-01

revised May 20, 2022; and interviews with RN #109 and the MRC. [522]

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (a)

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between a resident and other residents, including, identifying factors, based on information provided through observation, that could potentially trigger such altercations.

Rationale and Summary
Specific charting was initiated for a resident after an incident of resident to resident abuse involving the resident.

Review of the resident's charting noted there was no documentation on three shifts after the incident occurred.

Behavioural Supports Ontario (BSO) – Personal Support Worker (PSW) #115 acknowledged there was missing documentation on the resident. BSO-PSW #115 stated the PSWs on the floor were responsible to complete the charting every half hour. BSO-PSW #115 stated if they reviewed the charting they would send the form back and ask for a new one to be completed as there were too many gaps in the documentation.

There was moderate risk by not completing the charting on the resident, as staff had the potential to miss identifying factors that could trigger the resident's responsive behavior.

Sources:
Review of a Critical Incident System (CIS) report, the home's "Responsive Behavior" Policy RCM 10-05-00 revised May 20, 2022; and interviews with BSO-PSW #115 and other staff. [522]