Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Jul 10, 2019	2019_740621_0018	008144-19	Complaint

Licensee/Titulaire de permis

CVH (No. 2) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Birchwood Terrace
237 Lakeview Drive, R.R. #1 KENORA ON P9N 4J7

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

JULIE KUORIKOSKI (621), MELISSA HAMILTON (693)

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): June 17 - 20, 2019.

The following intake was inspected during this Complaint Inspection:
- One intake related to skin and wound care, falls prevention, and staff to resident neglect.

Additionally, Follow Up Inspection #2019_740621_0017, and Critical Incident System (CIS) Inspection #2019_740621_0019, were conducted concurrently with this Complaint Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Nurse Practitioner (NP), the Registered Dietitian (RD), the Resident Assessment Instrument (RAI) Coordinator, a Registered Nurse (RN), a Registered Practice Nurse (RPN), and a Personal Support Worker (PSW).

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, and reviewed the home's documentation, including relevant resident health care records, staff training, and specific licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others who provided direct care to resident #002 were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

A complaint was received by the Director, on a day in April 2019, related to concerns regarding altered skin integrity for resident #002.

Inspector #693 reviewed all completed assessments for resident #002, and identified a Weekly Impaired Skin Integrity Assessment, for a new area of altered skin integrity, on a particular area of the body, was completed by RPN #109 on a specific date in March 2019.

Inspector #693 reviewed the physician's orders for resident #002, for a specific duration between March and June 2019. The orders that were composed by NP #112 on certain dates during this time period, identified a particular care activity was to be completed at specified time intervals, using an identified methodology.

Inspector #693 reviewed care plans that were in place for resident #002 during April and May, 2019, and identified that a particular care activity was added by the Resident Assessment Instrument (RAI) Coordinator, on a specific date in May 2019, which identified the use of a specific methodology, and was to be completed over specified time intervals. It was identified by the Inspector that previous care plans did not have any interventions relating to this particular care activity for the resident.

During an interview with PSW #108, they stated that PSW staff were aware of the care a

resident required, as per the resident's plan of care, from reading the care plans on their Point of Care (POC) tablets. PSW #108 stated that they did not have access to physician orders on their tablets, but that any care they were required to provide and document for a resident, was on their POC task list.

During an interview with the RAI Coordinator, they stated that the identified care activity had been added to resident #002's care plan on a specific date in May 2019, and that for the period of time between this date and when the intervention had been ordered, the PSW staff would not have seen specifics related to what care activity was required for this resident on their POC task list, or the care plan they had access to on their tablets. The RAI Coordinator reviewed all processed orders on the electronic medical record (EMR) for resident #002 and stated that, although the specific care activity was ordered by NP #112 on a particular date in April 2019, the order was not properly processed, and was never added to the EMR or the PSWs' POC task list.

Inspector #693 reviewed the home's policy, titled, "Physician/ Nurse Practitioner Orders, RC-16-01-14", last updated in February, 2017. The policy indicated that the Nurse and Interdisciplinary Team were responsible for updating the plan of care when there were new orders, and for transcribing the orders electronically.

During an interview with RN #104, they stated that the PSWs had access to the plan of care for each resident in POC, on their tablets. The RN reviewed resident #002's care plans and the orders that were processed in the EMR from specific date between April and May 2019, and stated that the nurses who signed off on the April 2019, order for a specific care activity to be completed, were responsible for transcribing this into the EMR, so that PSWs were aware and could access this information. They also stated that the care activity interventions in question, should have then been placed on resident #002's care plan for all staff to access. [s. 6. (8)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented, related to repositioning of resident #002.

A complaint was received by the Director, on a day in April 2019, related to concerns regarding altered skin integrity for resident #002.

Inspector #693 reviewed all completed assessments for resident #002, and identified a Weekly Impaired Skin Integrity Assessment for a new area of altered skin integrity, was completed by RPN #109, on a specific date in March 2019.

Inspector #693 reviewed the physician's orders for resident #002, for a specific duration between March and June 2019. The orders that were composed by NP #112 on certain dates during this time period, identified a particular care activity was to be completed at specified time intervals, using an identified methodology.

During an interview with PSW #108, they stated that resident #002 required a particular care activity to be completed at specified time intervals, using an identified methodology for altered skin integrity. They stated that the resident had specific information located in a certain area of the home, which informed PSW staff of the specified care activity that was required. The PSW stated that the specified care activity that was provided by PSW staff, was normally documented in POC, but there was no documentation completed to show that resident #002 had this care activity completed.

During an interview with the RAI Coordinator, they stated that if a physician ordered a specific care activity to be completed for a resident, it was to be included as a task in POC for PSWs to complete, and was to be documented on the resident's flowsheet.

Inspector #693 reviewed the POC flowsheet documentation, as provided by the RAI Coordinator, for resident #002, for April and May, 2019. The Inspector identified that there was no documentation completed on the flowsheets, as required.

During an interview with RN #104, they reviewed the physician's orders for resident #002, and stated that there were orders from a specific number of dates in April and May 2019, for a particular care activity to be completed, at specified time intervals, using an identified methodology, for altered skin intergrity. RN #104 stated that completion of the care activity, as identified in the orders, was to be documented by the PSWs in POC. RN #104 reviewed the POC documentation for April and May, 2019, for resident #002, and confirmed that there was no intervention specific to the order listed on the flowsheets, and therefore, no documentation that the resident had the care activity provided to them, as outlined in the physician's orders.

Inspector #693 reviewed the home's policy, titled, "Interdisciplinary Wound Care Team Roles, Appendix 1, RC-23-01-01 AI", last updated in February 2017. The policy identified that care staff were responsible for [providing a specific care activity to] the resident, as per the plan of care, and documenting, as required.

During an interview with the DOC, they stated that PSW staff documented the provision

of care, set out in the plan of care, in POC on their tablets. The DOC stated that the specified care activity for resident #002 was to be documented by the PSWs in POC. The DOC confirmed that there were physician's orders for resident #002 from specific dates in April and May 2019, for the completion of a specified care activity. The DOC reviewed the POC flowsheet documentation for April and May, 2019, for the resident, and confirmed that there was no documentation completed for the required care activity. [s. 6. (9) 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 to ensure that the staff and others who provide direct care to resident #002 are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (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. O. Reg. 79/10, s. 48 (1).
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. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary 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 was developed and implemented in the home.

A complaint was received by the Director on a day in April 2019, related to concerns regarding altered skin integrity, for resident #002.

Inspector #693 reviewed all completed assessments for resident #002, and identified a Weekly Impaired Skin Integrity Assessment for a new area of altered skin integrity, that was completed by RPN #109, on a specific day in March 2019.

Inspector #693 reviewed the physician's orders for resident #002, for a specific duration between March and June 2019. The orders that were composed by NP #112 on certain dates during this time period, identified a particular care activity was to be completed at specified time intervals, using an identified methodology.

During an interview with PSW #108, they stated that resident #002 required a certain care activity completed, as a treatment for altered skin integrity. The PSW stated that the specific care activity was not documented. Additionally, the PSW identified that all PSW staff were required to complete care activity, and that specific information pertaining to the care activity was located in a certain area of the home, to inform PSW staff when and how to complete the required care.

Inspector #693 reviewed the home's policy, titled, "Turning Clock Guidelines, RC-23-01-10 A3", last updated in February 2017. The policy indicated that nursing management should be educated on how to audit the "Turning Clock" for repositioning, and that the "Turning Clock" should be audited once per shift.

Separate interviews were conducted with RPN #109, the RAI Coordinator, RN #104, and the DOC. The interviewed staff members stated that the home utilized "Turning Clock" repositioning as part of their Skin and Wound Care Program, for residents who had altered skin integrity. They stated that "Turning Clock" repositioning was not audited at anytime, for any resident in the home. The DOC reviewed the Skin and Wound Management Program with Inspector #693 and confirmed that audits included in this program, in relation to "Turning Clock" repositioning were not completed. [s. 48. (1) 2.]

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 an interdisciplinary 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 is developed and implemented in the home, 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,
(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 resident #002, who exhibited altered skin intergrity, was assessed by a registered dietician who was a member of the staff of the home.

A complaint was received by the Director on April 16, 2019, related to concerns regarding altered skin integrity, for resident #002.

Inspector #693 reviewed all completed assessments for resident #002, and identified a Weekly Impaired Skin Integrity Assessment for a new area of altered skin integrity was completed by RPN #109, on a specific date in March 2019. The assessment contained a referral section, which indicated that a referral had been made to the physician. Additionally, the Inspector identified further Weekly Skin Assessments completed on a date in April and May 2019, which indicated that, on these dates, a referral was made to the home's Registered Dietitian (RD).

During an interview with RPN #109, they stated that when a resident had a new area of altered skin intergrity, the nurse who identified it, should have made a referral to the RD on Point Click Care (PCC). Together with the Inspector, RPN #109 reviewed the referrals made in PCC, for resident #002, and identified that a referral to the home's RD was only made in May 2019.

Inspector #693 reviewed the home's policy, titled, "Skin and Wound Program: Wound Care Management, RC-23-01-02", last updated in February, 2017. The policy indicated that a resident who exhibited any form of altered skin integrity, including pressure ulcers was to be assessed by an RD.

During an interview with RD #111, they stated that each day they worked in the home, they checked on PCC for any referrals, and then assessed the referred residents. RD #111 stated that staff were to send referrals in PCC to them as soon as an area of altered skin integrity was identified. The RD stated that they first received a referral for resident #002's altered skin integrity on a specific date in May 2019. The RD further stated that they received no referrals for resident #002, on specific dates in March or April 2019, or on any other date prior to the first referral received in May 2019. [s. 50. (2) (b) (iii)]

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 resident #002, who exhibits a pressure ulcer on their coccyx, is assessed by a registered dietician who is a member of the staff of the home, to be implemented voluntarily.

Issued on this 11th day of July, 2019

[redacted]

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

Original report signed by the inspector.