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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 9, 2019 | 2019_665551_0017 | 012276-19, 012535-19 | Complaint |

## Licensee/Titulaire de permis

The Glebe Centre Incorporated
950 Bank Street OTTAWA ON K1S 5G6

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

Glebe Centre
950 Bank Street OTTAWA ON K1S 5G6

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

MEGAN MACPHAIL (551)

## 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): August 14, 15, 16 and 19, 2019.**

**The following logs were inspected:**
**012535-19 related to concerns about the care of a resident and an allegation of staff to resident abuse.**
**012276-19 / Critical Incident Report 2811-000011-19 related to an allegation of staff to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Nursing Staff, the Physiotherapist, the Coordinator of Nursing Programs, the PSW Supervisor, the Environmental Services Supervisor, the Director of Care (DOC) and the Executive Director.**

**During the course of the inspection, the inspector(s) reviewed health care records and a Skin and Wound policy, and made observations relating to a resident and staff to resident interactions.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Laundry**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Prevention of Abuse, Neglect and Retaliation**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **5 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #001 was provided the opportunity to participate fully in the development and implementation of the plan of care.

Resident #001 is toileted using a mechanical lift. Since admission, the resident has received peri-care is a specific way, as per their preference.

On a specified date, PSWs #102 and #107 assisted resident #001 to the toilet. Upon completion, resident #001 was informed by the PSWs that peri-care would not be performed as per the usual way, and would be done in a different way. The resident stated that the different way was against their wishes.

In an interview with RPN #103, they stated that at shift change on a specified date, they instructed PSWs #102 and #107 not to do resident #001's peri-care as per the usual way, and instructed them on how it would be done instead. The RPN stated that they had not consulted with resident #001 prior to the change being implemented. [s. 6. (5)]

***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 #001 is provided the opportunity to participate fully in the development and implementation of their plan of care, to be implemented voluntarily.***

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**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 residents #001, #002 and #003 who were exhibiting altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

Resident #001 was admitted to the home on a specified date. In a Head to Toe Skin Assessment completed on the day of admission, and in the Minimim Data Set (MDS) admission assessment, and in the two subsequent assessments, resident #001 was coded as having altered skin integrity.

On a specified date, a skin treatment plan was set-up by the Skin Care Coordinator/Coordinator of Nursing Programs, and on a specified date, an initial assessment was completed by an Enterostomal Therapist (ET), and follow-up assessments were completed due to the presence of altered skin integrity.

A review of resident #001's health care record indicated that resident #001 consistently had altered skin integrity, and in nine (9) months, a Wound/Pressure Ulcer Assessment was completed on three (3) occasions, and not weekly as required. [s. 50. (2) (b) (iv)]

2. A review of resident's #002's eTAR for a five (5) month period, noted that the resident required on-going treatments due to altered skin integrity.

A review of resident #002's health care record indicated that during this 5 month period, a Wound/Pressure Ulcer Assessment was completed 9 times. A Wound/Pressure Ulcer Assessments was not not completed for:

- a four (4) week period between specified dates.

- a seven (7) week period between specified dates.

- a 3 week period between specified dates. [s. 50. (2) (b) (iv)]

3. Resident #003 was admitted to the home on a specified date. A Wound/Pressure Ulcer Assessment was completed on the day of admission due to the presence of altered skin integrity.

A review of resident's #003's eTAR for a six month period noted that resident #003 required on-going treatments due to altered skin integrity.

Following the assessment on the day of admission, a Wound/Pressure Ulcer Assessment was not completed for a 7 week period.

A Wound/Pressure Ulcer Assessment was not completed for skin impairment to a specified body part for:

- a 9 day period between specified dates.

- 8 day periods on 3 occasions.

- a 9 day period between specified dates when a deterioration of the wound was noted.

A Wound/Pressure Ulcer Assessment was completed on a specified date due to the presence of altered skin integrity to a different body part. A weekly Wound/Pressure Ulcer Assessment was not completed after the initial one despite the on-going presence of altered skin integrity that required treatment.

According to the progress notes and eTAR, there were 3 other areas of skin impairment, that required treatment, for which a Wound/Pressure Ulcer Assessment was never completed.

In interviews with the Skin Care Cordinator/ Coordinator of Nursing Programs and the DOC, they both stated that it was expected that registered staff complete a Wound/Pressure Ulcer Assessment on a weekly basis. The Skin Care Coordinator/Coordinator of Nursing Programs stated that they do not advise the registered nursing staff when to complete the Wound/Pressure Ulcer Assessment because it was a policy.

According to the Guiding Principles of Wound/Pressure Ulcer Assessment Record (RS 11.03.01): 3. All wounds shall be fully reassessed weekly to determine wound status and treatment effectiveness. The Procedures directs staff to: 1. Initiate a Wound Assessment Record when a wound requires treatment. 2. Wound/Pressure Ulcer assessment to be entered into the ETAR to communicate to all nurses working on the floor when it is due. [s. 50. (2) (b) (iv)]

***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 all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

**Specifically failed to comply with the following:**

**s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the results of the abuse investigation were reported to the Director.

A Critical Incident report (CIR) was submitted to the Director under LTCHA, 2007, s. 24 (1) on a specified date to report an allegation of staff to resident abuse. According to the CIR, resident #001 alleged that during the provision of care, a PSW hurt them.

According to the CIR, the action taken as a result of the incident was to check resident #001 for signs of bruising, and there was no visible bruising.

The CIR was not amended to notify the Director of the results of the licensee's investigation into the allegation of abuse. [s. 23. (2)]

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**WN #4: 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 suspected abuse of resident #001 was immediately reported to the Director.

A CIR was submitted to the Director on a specified date to report an allegation of staff to resident abuse. The CIR was submitted one day after the allegation was made.

In an interview with RPN #103, they stated that on a specified date, during the provision of care by PSWs #102 and #107, resident #001 accused PSW #107 of injuring them.

The Director was not immediately informed of the allegation of abuse that occurred on a specified date during the provision of care. [s. 24. (1)]

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

**Specifically failed to comply with the following:**

**s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #001 was notified of the results of the alleged abuse investigation immediately upon completion.

A CIR was submitted to the Director on a specified date to report an allegation of staff to resident abuse.

According to resident #001, they were not interviewed by anyone from the management with regards to the allegation and are not aware what the outcome of the investigation was.

According to the DOC, registered nursing staff assessed the resident after the allegation was made, and there was no sign of injury so the allegation was not pursued further. [s. 97. (2)]

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**Issued on this 18th day of September, 2019**

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

**Original report signed by the inspector.**