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
Oct 28, 2019	2019_767643_0029	011396-19	Follow up

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

Carefree Lodge
306 Finch Avenue East NORTH YORK ON M2N 4S5

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

ADAM DICKEY (643)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 21 - 24, 2019.

The following compliance order follow-up intake was inspected during this inspection:
Log #011396-19 - related to the home's skin and wound care program.

During the course of the inspection, the inspector(s) spoke with the Administrator, Interim Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection the inspector(s) conducted observations of staff to resident interactions and the provision of care, review of resident health records and relevant policies and procedures.

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)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 48. (1)	CO #001	2019_740621_0015	643

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. (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 written plan of care for resident #002 set out clear directions to staff and others who provided direct care to the resident in relation to a treatment in place for an area of altered skin integrity.

As part of follow-up inspection into compliance order (CO) #001 under inspection report #2019_740621_0015, resident #002's treatment orders and treatment administration record (TAR) were reviewed. Review of resident #002's Digital Prescriber's Orders showed an entry from an identified date, which indicated to discontinue treatment to a specified area of altered skin integrity. A new treatment order was initiated, which indicated a specified antiseptic treatment for the area of altered skin integrity. Review of resident #002's TAR for an identified month, showed a treatment for the specified area of altered skin integrity with the above antiseptic treatment intervention. No further instruction for this treatment was identified in the Digital Prescriber's orders nor the TAR.

Observation by the inspector, showed RN #104 removed the dressing from resident #002's specified area of impaired skin integrity which consisted of an identified absorbent material, identified dressing tape and the above identified antiseptic treatment intervention. RN #104 cleansed the area, and carried out the above identified antiseptic treatment intervention. RN #104 then covered the area with an identified absorbent material and identified dressing tape. When asked how the RN knew what to dress the area with after carrying out the antiseptic treatment intervention, they indicated that the previous order had indicated to use the identified absorbent material and dressing tape. The RN indicated that the current treatment order did not provide clear direction for the specified area of altered skin integrity.

In an interview, interim DOC #100 indicated that treatment orders were received from the physician and transcribed into the TAR by the registered staff. The DOC indicated that it was the expectation for treatment orders to be complete instruction for registered staff to perform dressing changes for residents with altered skin integrity. The DOC acknowledged that the above treatment order for resident #002's specified area of altered skin integrity did not provide staff with clear direction on which type of dressing to apply. [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 the written plan of care for each resident 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 LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.

On May 24, 2019, the following compliance order (CO #001) from inspection #2019_740621_0015; made under O. Reg. 79/10, s. 48. (1) was issued:
The licensee must be compliant with s. 48(1)2 of Ontario Regulation 79/10.
Specifically, the licensee must ensure that direct care staff follow the home's policy titled "Skin Care and Wound Prevention and Management - RC-0518-02", published January 1, 2019, with respect to resident #002 in the following areas:
a) Ensure utilization of clinical best practice during dressing changes, in accordance with infection prevention and control practices; and as identified in the home's policy;
b) Ensure that provision of care as set out in the plan of care with respect to weekly wound assessments, turning and repositioning schedules, and administration/provision of treatments, is documented;
c) Ensure that maintenance of an individualized plan of care is both current and accurate;

d) Ensure all wounds are assessed/reassessed using the Ulcer/Wound Assessment Record weekly, or more frequently as indicated;
e) Ensure that Physician's orders for the resident's skin and wound care are followed as directed;
f) Ensure that use of normal saline during wound care is consistent with the home's policy, and best practice; and
g) Ensure that monitoring of healed/resolved wounds is completed and documented in the resident's progress notes.

The compliance date was July 26, 2019.

The licensee completed steps a, c, d, e, f and g.
The licensee failed to complete step b.

a. As part of the follow-up for CO #001, resident #002's care plan was reviewed which instructed staff to carry out an identified care intervention every two hours and as needed (PRN) according to the diagram in the resident's room.

In interviews, PSWs #103, #105 and #106 indicated that prior to the launch of the new electronic documentation system in the home, residents who required the above care intervention had the provision of this care documented every two hours on a PSW worksheet which was kept in the Nursing and Personal Care Record (NPCR) binders on the unit. The PSWs indicated that they now would document on the provision of care in point-of-care (POC) tablets when care was provided.

Resident #002's PSW worksheets and documentation survey reports from the electronic documentation system were reviewed. Review of the worksheet from an identified two week period showed incomplete documentation from 12 identified dates.

b. As a result of identified noncompliance for resident #002, the sample of residents reviewed was expanded to include resident #004.

Review of resident #004's care plan showed staff were instructed to carry out an identified care intervention every two hours when in bed or wheelchair. Review of tasks in the electronic documentation system did not show a task for staff to document the above identified care intervention for resident #004.

In an interview, PSW #103 indicated that they had been aware of the care plan direction to provide the above identified care intervention every two hours and had been providing the care as per the plan. PSW #103 indicated that there was no task assigned in the POC system to document the provision of this care intervention.

Review of documentation survey reports from the electronic documentation system did not show documentation of the above identified care intervention being provided by staff for two identified months.

c. As a result of identified noncompliance for resident #002 the sample of residents reviewed was expanded to include resident #005.

Resident #005's PSW worksheets and documentation survey reports from the electronic documentation system were reviewed. The PSW worksheets showed the documentation of the provision of care was incomplete for 13 identified dates of the 34-day period reviewed.

In an interview, interim DOC #100 indicated that it was the expectation of the home for the PSW worksheets to be completed fully with documentation of the care provided every two hours. The DOC acknowledged that the documentation was not complete for the identified care intervention being provided to residents #002, #004 and #005 and had not complied with step b) of CO #001 under inspection #2019_740621_0015. [s. 101. (3)]

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 order made under this Act is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was maintained for each resident of the home.

As part of follow-up inspection into CO #001 under inspection report #2019_740625_0015, resident #002's health records were reviewed. Step b) of the compliance order instructed the licensee to:
b) Ensure that provision of care as set out in the plan of care with respect to weekly wound assessments, turning and repositioning schedules, and administration/provision of treatments, is documented.

A record of the provision of care documentation for an identified care intervention for resident #002 for a specified three month period was requested by the inspector. Original paper copies of resident #002's PSW worksheets for an identified care intervention were provided to the inspector which included a specified two week period. No record of resident #002's PSW worksheets were produced by the home for a specified one month period, nor for a specified four day period.

In an interview, the home's Administrator #101 indicated that the records of provision of the above identified care intervention as set out in the residents' care plans was documented on paper records prior to the launch of the electronic documentation system in the home. The Administrator indicated that it was the expectation of the home for these records to be maintained on-site as part of the resident health record for residents still residing in the home. The Administrator acknowledged that the record of the PSW worksheets for the identified care intervention for resident #002 was not maintained. [s. 231. (a)]

Issued on this 30th day of October, 2019

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

Original report signed by the inspector.