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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 29, 2018	2018_591623_0008	008720-18	Resident Quality Inspection

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care on McLaughlin Road
114 McLaughlin Road LINDSAY ON K9V 6L1

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

SARAH GILLIS (623), CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 7, 8, 9, 10, 11, 14 and 15, 2018

The following intake was inspected concurrently during the RQI inspection:
Log #020855-17 - Critical Incident Report related to allegation of improper care of a resident
Log #022836-17 - Critical Incident Report related to resident to resident
Log #028140-17 - Critical Incident Report related to a missing resident
Log #000527-18 - Critical Incident Report related to fall with injury
Log #003591-18 - Critical Incident Report related to allegation of improper care of a resident
Log #006798-18 - Complaint related to allegation of improper care of a resident
Log #007768-18 - Complaint related to laundry services and allegation of improper care of a resident

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Nursing (DON), Environmental Services Manager (ESM), Activation Manager, Food and Nutrition Manager, Resident Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Behavioural Support Staff, Personal Support Workers (PSW), Laundry Aides, representatives of the residents council and the family council, residents and family member's.

In addition, during the course of the inspection, the inspectors toured the home, observed staff to resident and resident to resident interactions, resident social programs, medication administration and infection control practices. The inspectors reviewed clinical health records, Resident Council and Family Council meeting minutes, medication incident reports, medication management meeting minutes, the licensee's internal investigation records and policies related to laundry services, falls prevention, skin and wound care and resident safety - zero tolerance of abuse and neglect.

Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
9 WN(s)
6 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #027 related to a specific identified responsive behaviour was provided to the resident as specified in the plan.

Review of the plan of care for resident #027 in effect on a specified date was completed, interventions in the plan of care related to a specific responsive behaviour, that were not provided for resident #027 on two identified dates were;

-Requires monitoring when interacting with identified residents-resident is not to be left unsupervised with identified residents at any time. Episodes have been noted of resident #027 displaying this identified responsive behaviour towards other residents

-Staff to provide increased monitoring during acute episodes.

The progress notes for resident #027 indicated;

-on a specific date, after supper resident #027 was directed to an identified resident area and T.V. was turned on. Resident#027 was found in a different identified area at a specified time with co-resident #029. Resident #027 was noted to be displaying identified responsive behavoiurs towards resident #029. Resident #027 was reminded that to stay in an identified resident area after supper. Resident #027 assisted back to this identified area, where the television remained on.

-on a specific date, resident #027 was witnessed by PSW staff, displaying an identified responsive behavoiur towards resident #028 in a resident area. Resident #027 was observed displaying an identified responsive behavoiur towards #028, Residents #027 and #028 were removed from the area.

-on a specified date, Resident #027 was noted to be sitting in a resident area with two specific residents, one being resident #027. RPN #125 documented that resident #027 was displaying identified responsive behaviours toward resident #028.

Review of Dementia Observation System (DOS) monitoring for resident #027 in effect for the period of seven specific days, identified a number of incomplete areas on the form. On the DOS form for the second day of DOS monitoring, indicated that the required hourly checks were not completed on the DOS form for three consecutive hours and then for one hour later that same day. PSW/BSO #123 indicated that audits of the DOS forms were completed daily with reminders given to staff and information forwarded to DOC and RCC.

During an interview with inspector #194, PSW/BSO # 123 indicated that the identified

interventions were in place for resident #027 on an identified date and had been communicated to all staff, entered into the plan of care and Kardex. PSW #123 indicated that a BAT tool was also completed with interventions related to identified responsive behaviour.

During interview with inspector #194 on a specific date, the DOC indicated that the specific interventions for resident #027 related to identified responsive behaviour on an identified date, had been in place and communicated to staff.

During interview with inspector #194 conducted on a specific date, PSW #119 indicated that there was no need to supervise resident #027 when alone with identified residents.

The licensee failed to set out the care in the plan of care for resident #027 related to identified responsive behaviours when resident #027 was left unattended in a resident area with identified residents on two specific dates. The increased monitoring for resident #027 on an identified date, was not documented in the DOS forms. [s. 6. (7)]

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 by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:
b) complied with

Related to log #006798-18

The licensee has failed to comply with their policy Caressant Care Nursing & Retirement Homes - Wound Assessment (last review date October 2017) - O.Reg. 79/10, s. 30. (1) Every licensee of a long-term home shall ensure that the following is complied with in respect of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs under section 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.

The licensee's policy states:

All residents with skin and wound issues shall have these appropriately treated and assessed by the Registered Staff in conjunction with the Wound Care Champion and Managers in the home. Registered staff shall utilize the E-TAR (Electronic Treatment Administration Record) on Point Click Care wound assessment program to document and assess wound treatments and wound progress.

All residents with skin and wound issues shall have these areas assessed by registered staff every 7 days.

The Home shall keep the physician and family informed of all wounds issues.

Procedure:

When a resident presents with a skin or wound issue, Registered Staff shall assess the area shall assess the area and appropriately document using the Point Click Care Skin and Wound Care module. This assessment shall include at a minimum the following:
- location of skin/wound issue
- Type of wound/skin issue (stage of wound, rash, skin tear etc.)
- Wound size: length, width and depth
- Presence of drainage including amount, colour, odour

- Description of wound bed and surrounding area
- Presence of undermining and/or tunneling
- Pain expressed of resident

Registered staff shall enter the skin/wound treatment on the E-TAR indicating the specific treatment, frequency of the dressing change/application, 3M products to be used etc.

An additional entry on the E-TAR shall be made to indicate the weekly assessments of the area.

Registered staff shall sign off all treatments provided on the eTAR as scheduled after completion of the skin/wound treatment.

Weekly the registered staff shall re-assess the skin/wound area and document this in PCC skin and wound module.

A referral to the dietitian shall be made on PCC for all residents with skin and wound issues.

During an interview with Inspector #623, the SDM for resident #009 indicated that they were not informed that the resident had an open wound, they observed the wound when they took resident #009 for a scheduled test on a specific date.

Review of the clinical records for resident #009 indicated the following:

The wound on resident #009's specified area was first identified on a specific date, in a progress note written by RPN #100. An initial wound assessment was not documented in PCC until four weeks later, by RPN #101. There is no documented evidence that the SDM was notified of the identified wound. The referral to the dietitian was not initiated until four weeks later, by RPN #101. The nursing measure - treatment and dressing application was not initiated on the E-TAR until four weeks after the wound was first identified. The weekly assessment of the right breast wound was not entered on the E-TAR for three consecutive months, for registered staff to sign as completed.

During an interview RPN #101 indicated that they did not initiate a weekly wound assessment, an E-TAR for dressing application and sign-off of weekly wound assessment, for resident #009, despite being aware of the wound on a specific date, as indicated in a progress note. Weekly skin assessments were initiated in PCC four weeks

later and the nursing measure dressing application was also entered into the E-TAR on the same date. RPN #101 indicated a weekly wound assessment sign off was not initiated in the E-TAR.

During an interview with Inspector #623, the DON indicated that there was no documented evidence that the SDM for resident #009 was informed of the wound on the resident's right breast, that was initially documented on a specified date. The DON indicated that the licensee's policy indicates that the home shall keep the family informed of all wound issues and this was not done. The DON also indicated that the licensee's policy titled Wound Assessment, was not followed for resident #009.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with related to the skin and wound care program. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the licensee's policy, related to the management of head injury routine post fall, specifically for resident #018 is complied with.

Related to log #007768-18

On a specific date, the Director received a complaint submitted by resident #018's POA.

The complainant indicated in a specified month, resident #018, had returned from the hospital for an unrelated illness with an antibiotic treatment. The complainant indicated, shortly after the resident's return to the home, resident #018 sustained a fall and within 14 hours, the resident died.

Review of clinical documentation and interview with the Director of Nursing and RPN #144, indicated, resident #018 had a history of non-compliance with self transferring.

Review of the resident's plan of care related to transferring was completed, (current at the time of the fall).

Clinical documentation indicated on a specific date, resident #018 was observed attempting to self transfer and again the following day, documentation indicated:
On a specific date resident #018 was trying to transfer self to a mobility device and slid to the floor. "I know I did wrong, I should have rang the bell." Code care was called. Vitals taken, ROM done. SDM notified of fall. Did not hit head so Head Injury Routine was not

initiated. Post fall investigation done. Fall assessment done.

Review of the licensee's Resident Safety Plan policy, which included a Fall Risk Screening and Post Fall Management section indicated:
Upon discovery of a fall, Code Care is called. The interdisciplinary team will;

a) Initiate Head Injury routine and assess resident's level of consciousness and any potential injury associated with the fall as required.
g)Monitor the resident for 48 hours after a fall if the resident is taking anticoagulants.

On a specific date, at the time of the incident, resident #018 had been prescribed and had been receiving, a specific anticoagulant medication, daily for eleven months.

Review of the licensee's policy related to Head Injury Routine indicated:

1.Immediately after a resident sustains a trauma to the head or an unwitnessed fall, the Registered Nurse in charge is to assess the resident using the Glasgow Coma Scale and to do a complete set of vital signs.
6.Using the Glasgow Coma Scale as a documentation tool and vital signs, assess the resident for 72 hours with following frequency:
-Every half hour for the first 2 hours following the injury
-Every hour for the next 4 hours
-Every 4 hours for the next 8 hours
Every shift for the remainder of the 72 hour monitoring.

Review of clinical documentation and separate interviews conducted with the Director of Nursing and with RPN#114, did not provide any evidence that the monitoring of resident #018 post fall was conducted as per the licensee's policy related to use of the Glasgow Scale. Resident #018 was taking anticoagulant medication and the fall on a specified date, was presumed unwitnessed . [s. 8. (1) (a),s. 8. (1) (b)]

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 by ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(b) is complied with related to skin and wound care, and falls prevention, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that furnishings and equipment are maintained in a safe condition and in a good state of repair.

During a tour of the building conducted by inspector #194 on a specific date, the following was observed:

- A specific shower room had a three foot slit in the flooring at the base of the shower area, which had peeled back with under-flooring exposed. The gap in the flooring would be a potential infection control concern related to the inability of the floor to be properly disinfected and cleaned.

- A second specific shower room had a two foot slit in the flooring, when inspector #194 stepped on the surrounding flooring water gushed out of the gap unto the flooring in the shower room. The gap in the flooring would be a potential infection control concern related to the build up of water under the flooring in this area. A two inch hole in the upper wall behind the door, caused by the door stop was noted.
- In a specific tub room, the flooring along one complete wall was coming away from the wall with a gap inches between flooring and wall. Repairs had been attempted by placing screws through flooring to secure to the wall and were now pulled away from the wall with screw remaining in the flooring. The space between the wall and flooring is a potential infection control concern, cleaning and disinfecting of the area would not be possible. Flooring damage in center of room, near the floor drain, posed a potential tripping hazard.

The licensee has failed to ensure that equipment in the tub/shower rooms were maintained in a safe condition and in a good state of repair. [s. 15. (2) (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 by ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, (d) is available at each bed, toilet, bath and shower location used by residents.

During a tour of the building by inspector #194, it was identified that the following resident areas did not have functioning resident-staff communication and response system:

-a specific shower room had a resident-staff communication and response system on the wall near the toilet. Inspector #194 pulled the resident-staff communication and response system and it was not functioning. The resident-staff communication and response system near the tub in the room was functioning.

-a specific tub room had a two resident-staff communication and response systems on the wall on either side of the tub. Inspector #194 pulled the resident-staff communication and response system and they were not functioning. The resident-staff communication and response system near the toilet in the room was functioning.

Administrator and ESM were informed of the malfunctioning resident-staff communication and response system in the tub/shower rooms in the home and stated they were unaware that the system was not functioning.

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available at each bed, toilet, bath and shower location used by residents. [s. 17. (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 by ensuring that the home is equipped with a resident-staff communication and response system that
(d) is available at each bed, toilet, bath and shower location used by residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Review of the policy "Abuse & Neglect -Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to staff" was completed by inspector #194, and indicated;

Resident-Resident Abuse;

-The Caressant Care Internal Incident report form will be completed by the DOC or Delegate. The completed form will be forwarded to the Multidisciplinary Resident Care Team and Multidisciplinary Team Conference for review, and evaluated for implementation of future preventative measures.

During interview with inspector #194, the DOC indicated that they had not completed the Caressant Care Internal Incident report form as directed in the abuse policy, for the incident related to a CIR for an allegation of resident abuse involving resident #027 and #028 on a specific date. The DOC also confirmed that no other staff had completed the Internal Incident Report form for the identified incident.

The licensee has failed to comply with it's policy on abuse related to the incident of resident abuse on a specific date. [s. 20. (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 by ensuring that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #6: 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 is specifically designed for skin and wound assessment.

Related to log#006798-18

A complaint was received by the Director which indicated that resident #009 had a

wound that was worsening and was not being treated.

Review of the clinical records for resident #009 indicated that an open area was identified on a specific date, by the PSW and reported to RPN #100. RPN #100 documented in the progress notes a description of the open area and a dry dressing was applied. After reviewing the clinical records, Inspector #623 was unable to find documented evidence that a skin assessment was completed in Point Click Care, when the open area was first identified on a specific date.

During an interview with Inspector #623, RPN #101 indicated that a skin assessment in Point Click Care was not initiated until four weeks later, for resident #009.

During an interview with Inspector #623, the DON indicated that it is the expectation of the licensee, that when a resident is identified to have a skin or wound issue, the registered staff will complete a skin assessment in Point Click Care.

The licensee 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 is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds: been assessed by a registered dietitian who is a member of the staff of the home.

Related to log #006798-18

A complaint was received by the Director which indicated that resident #009 had a wound that was worsening and was not being treated.

Review of the documentation for resident #009 indicated that on a specific date, PSW staff identified to RPN #100 that the resident was exhibiting an alteration in skin integrity on the right breast. The documentation indicated that an open area was identified and a dry dressing was applied to the area.

A referral to the Dietitian was initiated four weeks after the wound was initially identified, by RPN #101 and was not completed for four more weeks, by the Registered Dietitian, when recommendations were made to promote wound healing.

The Dietitian was not available for interview during the inspection.

During an interview with Inspector #623, the DON indicated that the expectation of the licensee is that a referral to the dietitian is to be completed for all resident's with identified skin and wound issues.

The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wound has been assessed by a registered dietitian who is a member of the staff of the home. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Related to Log#006798-18

A complaint was received by the Director which indicated that resident #009 had a wound that was worsening and was not being treated.

Review of the clinical records for resident #009 indicated the following:
On a specific date, RPN #100 documented that they were notified by the PSW that resident #009 had an unusual rash on an identified area. RPN #100 documented that an assessment was completed and an open area was identified in a specific area. RPN documented that the area was cleansed and a dry dressing was applied.

Two days later, RN #122 documented that a new dressing was applied to a specific open area on resident #009.

The following day, RPN #101 documented a follow-up for a reported wound on resident #009. An open area in a specific location assessed and wound care was completed. Will reassess resident weekly.

Four weeks later, RPN #100 documented that resident #009 had drainage from the specified open area, and the area had increased in size. On the same day, RPN #101 completed a wound assessment in point click care which included measurements and a description of the wound, and weekly assessments began.

Review of the electronic treatment administration records (eTAR) for a specific month, indicated that there were no nursing measures, wound dressing or weekly wound assessment identified on the eTAR during this month.

During an interview with Inspector #623, RPN #101 indicated being the wound care champion for the home. RPN #101 indicated that an initial assessment was completed for resident #009's identified wound on a specific date, by RPN #101, and the note indicated that weekly follow up would be initiated. The RPN confirmed that a follow up assessment was not completed for resident #009 until a second referral was received four weeks later. RPN #101 indicated that the expectation of the licensee is that when a wound is identified, an assessment will be completed weekly by an RN or RPN.

During an interview with Inspector #623, the Director of Nursing (DON) indicated that the expectation of the licensee is that when a skin or wound issue is identified, registered staff will assess the area and appropriate documentation will be completed in PCC. All residents with identified skin or wound issues will have the area assessed by registered staff every seven days.

The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff. [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 by ensuring that 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, (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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident the home are immediately forwarded to the Director.

Related to log #020855-17

On a specific date, a letter of complaint was received by the Executive Director of the home, The complaint, from the resident #008's family member was related to the care and assessment of resident #008.
On the same, the Executive Director of the home responded to the complainant in writing and advised the concerns brought forward would be investigated and the family member would be contacted with the results of the investigation.
Eight days later, the home completed the internal investigation.
Three days after the internal investigation was completed, the Executive Director responded in writing to the family member with the results of the licensee's internal investigation.
There is no evidence, that the complainant, responded to the licensee's written letter related to the results of the investigation.

Review of the licensee's policy-Complaint Process, indicated:
1.When a complaint is received from a resident, family member, visitor, physician, or any member of the public, the Executive Director will report to the appropriate authority, i.e.Ministry of Health and Long Term Care, CIATT Division immediately. The only exception to immediate reporting is a verbal complaint which is resolved within 24 hours.
2. If the complaint is received in writing, it must be forwarded to the MOH CIATT Division along with a copy of the written response to the complainant.

Review of the licensee's complaint log for a specific year, indicated the complaint from

resident #008's family member on a specific date, was logged, response regarding the receipt of the complaint, investigation, and response to family related to results of investigation was made. The complaint was also logged for Continuous Quality Improvement (CQI) analysis.

Interview with the Executive Director and review of the licensee's 2017 complaint binder did not provide evidence that the Director had received a copy of the written complaint or a written report documenting the response made to the complainant.

The licensee has failed to immediately forward a written complaint concerning the care of a resident of the long-term care home to the Director. 2007, c. 8, s. 22 (1). [s. 22. (1)]

WN #8: 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 or neglect investigation reported in a CIS were reported to the Director.

During interview with inspector #194, the DOC confirmed that the Director was not notified of the results of the abuse identified in the specific CIS. On an identified date, resident #027 was witnessed by PSW staff, displaying an identified responsive behaviour towards resident #028 in a resident area.

The licensee failed to immediately report the outcome of the abuse investigation reported in the CIS to the Director. [s. 23. (2)]

WN #9: 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's SDM were notified of the results of the alleged abuse or neglect investigation reported in a specific CIS, immediately upon the completion.

During interview with inspector #194, the DOC confirmed that the POA's of resident #027 and #028 were not notified of the results of the abuse investigation identified in a specific CIS. On a specific date, resident #027 was witnessed by PSW staff, being displaying an identified responsive behaviour towards resident #028 in a resident area.

The licensee failed to ensure that the resident’s SDM were immediately notified upon completion of the abuse investigation reported in the specific CIS. [s. 97. (2)]

Issued on this 20th day of July, 2018

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

Original report signed by the inspector.