Ontario

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 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
Jun 7, 2019	2019_618211_0012	010176-19	Critical Incident System

Licensee/Titulaire de permis

Centre d'Accueil Roger Seguin
435 Lemay Street Clarence Creek ON K0A 1N0

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

Centre d'Accueil Roger Seguin
435 Lemay Street Clarence Creek ON K0A 1N0

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

JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 22, 23, 27, 2019.

The Intake Log #010176-19 was related to alleged abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC) , Assistant Director of Care (ADOC), Registered Nurses (RNs), Resident Assessment Instrument Minimum Data Set Coordinator (RAI-MDS Coordinator), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), resident #001 and the resident's family member.

In addition, Inspector #211 reviewed residents' health care records, Policy and Procedures related to: Prevention of Abuse and Neglect, Skin and Wound Management and Responsive Behaviours Management. Inspector #211 observed resident interactions with staff.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
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. 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 the written policy to promote zero tolerance of abuse and neglect was complied with.

Inspector #211 reviewed the licensee's policy #ADM DG 1217, titled Prevention of abuse, improper treatment and/or neglect (Prevention des Abus, Mauvais Traitements et/ou Negligence), dated August 20, 2018. The policy indicated the following:
All employees, volunteers, contractors, contractual partner and/or visitor have the legal obligation to:
-Immediately report any suspected or actual abuse or neglect to the responsible manager or the on-call manager as soon as they became aware of the incident.
-Report immediately and directly to the Ministry of Health and Long-Term Care any incident of alleged, suspected or witnessed abuse or neglect.
A report shall be made to the MOHLTC Director with the results of each investigation conducted and any actions taken by the licensee in response to any incident of abuse or negligence of residents.

On an identified date, the Ministry of Health and Long-Term Care (MOHLTC) Info line-LTC after hours was contacted by the licensee to report an incident of alleged physical abuse. Resident #001's family member alleged that an individual caused injuries to the resident's identified body area.

On an identified date, a CIR was submitted to the MOHLTC that resident #001 had responsive behaviors on an identified date. Police officer #1 responded to the call and attended to the LTC home. The CIR indicated that on the same day, the Administrator, police officer #1, the family member and a visitor were in the room with resident #001. At the time, the resident's family member commented that the altered skin integrity on the resident's identified body area appeared as if someone had grabbed the resident by the identified body area and left marks. The CIR indicated that the Administrator and police officer #1 informed the family member that the angle of the marks were not consistent with the suspect origin of the wounds. The following day, the DOC was informed by RN #113 that resident #001's family member had posted pictures of the resident's altered skin integrity with comments suggesting that the resident had been abused by an individual in the home. Police officer #2 came to the home on that day and informed the Administrator that the resident's family member wanted to press charge for abuse.

The progress notes written by RPN #104 dated on an identified date, indicated that resident #001's family member showed a picture asking if the marks on the resident's body area were created by the identified source.

During an interview on an identified date, the Administrator explained that on an identified date, a discussion with the resident's family member, including police officer #1 occurred related to the resident's body area injury and concluded that the marks didn't appeared to be created by the identified source. Police officer #1 agreed with the Administrator and the family member appeared to be satisfied with the information. The Administrator stated being contacted by a staff member the next day, stating that the resident's family member posted a picture of resident's altered skin integrity with comments suggesting that the injury was from the identified source . On the same day, police officer #2 came to the home and declared that the resident's family member pressed charges for abuse.

The licensee has failed to ensure that the licensee's written policy to promote zero tolerance of abuse and neglect was complied with. The licensee did not follow their policy has indicated:
-Employees have the legal obligation to immediately report any alleged, suspected or actual abuse or neglect. The responsible manager or the on-call manager need to be contacted as soon as the employee become aware of the incident.
-The Ministry of Health and Long-Term Care shall be immediately contacted of any incident of alleged, suspected or witnessed abuse or neglect. [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 to ensure that the written policy to promote zero tolerance of abuse and neglect was complied with, to be implemented voluntarily.

WN #2: 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 when a person who has reasonable grounds to suspect that 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 a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director of Ministry of Health and Long-Term Care (MOHLTC).

Review of the resident #001's health care record for an identified date on a specific shift, indicated that PSW #101 took pictures of resident #001 altered skin integrity and showed the pictures immediately to RN #103.

Resident #001's progress notes written by the administrator on an identified date, indicated the resident's family member expressed their worry six days later, related to the resident's injury stating that the area appeared to be an identified source that entered into the resident's skin.

On the identified date, resident #001's progress notes documented by RPN #104 indicated that the resident's family member showed pictures, asked if the injury appeared as the identified source, then stated that two other individuals confirmed that the wounds were created by the identified source.

The next day, the Ministry of Health and Long-Term Care (MOHLTH) Infoline-LTC Homes After Hours, received a call from the licensee indicating that resident #001's family member made allegation of abuse related to resident #001's injury that was created by an identified source.

The day after, the Ministry of Health and Long-Term Care (MOHLTH) received a Critical Incident Report (CIS) from the licensee. According to the CIS, resident #001 sustained a injury to the identified body area eight days earlier. On the identified date, PSW #101 took pictures of the resident's injuries. The CIS indicated that resident #001's family member commented that the resident's injury appeared as if an identified source left marks.

The licensee has failed to ensure when the Administrator and RPN #104 who had reasonable grounds to suspect that alleged abuse was expressed by resident #001's family member that resulted in harm to the resident has occurred, immediately reports the suspicion and the information upon which it is based to the Director. [s. 24. (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 when a person who has reasonable grounds to suspect that 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 a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director of Ministry of Health and Long-Term Care MOHLTC, 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 when a resident exhibiting altered skin integrity, including skin breakdown, skin tears, or wounds, the resident 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.

On an identified date, the Ministry of Health and Long-Term Care (MOHLTH) received a Critical Incident Report (CIS) from the licensee. According to the CIS, resident #001 sustained an injury to the identified body area eight days earlier. On the day of the injury, PSW #101 took pictures of the resident's injuries since resident #001 was refusing that the staff touched the identified body area. The CIS indicated that resident #001's family member commented that the resident's injury appeared as if an identified origin left marks.

The home's policy #6090, titled Skin Integrity, Care and Management of skin injury and pressure sore, mouth care, foot and hands nails care (Intégrité de la peau Soins/gestions des blessures et plaies de pression, soins de la bouche et des dents, soins des ongles des mains et des pieds), dated Mai 2018, indicated that the nurse responsible of the Skin Integrity Program must be consulted for any new wound by emails. Furthermore, the integrity of the skin for each resident will be evaluated during each bath by the personnel support workers (PSWs) and the skin condition will be reported to the Registered Nurse (RN)/ Registered Practical Nurse (RPN) or documented in the Skin Integrity's record. The Skin Integrity's record will be completed and inserted in the treatments' book.

Resident's care plan under skin integrity section, for two specific dates, indicated to identify and to report any signs of altered skin integrity exhibiting redness, swelling, discoloration and eruptions for resident #001.

Review of resident #001's progress notes for an identified date, indicated that a specific injury was observed to the resident's body area.

The resident #001's progress notes written by the Administrator on an identified date as a late entry, described the altered skin integrity's color, the measurement and the appearance of the injuries. The notes indicated that all the injuries were covered with a dry scab.

Review of the resident #001's progress noted documented by RN #109 on an identified date as a late entry, indicated that a visual evaluation of the resident's body area was completed eight days earlier. The identified injury with specific altered skin integrity was present to the resident's body area. RN #109 wrote that the assessment indicated that there was no signs of infection or drainage and to let the area open to air.

RN #109 wrote in the resident's progress notes on an identified date that an assessment was completed for resident's identified body area with the attendance of the DOC and

ADOC. The color of the injury was less dark measuring at a certain amount in centimeters and the injury had an extension measuring at an identified cm. The notes indicated small areas of dry altered skin integrity were observed and well adhered together measuring each a certain centimeters. The altered skin's integrity are healing well and no dressing was required. Keep the area opened to air.

On an identified date, inspector #211 received from the home's administrator, five copies of resident #001's identified body area taken on the day of the injury and from the next consecutive two days. The injury pictures taken on the day of the altered skin integrity and from the next day of the injury showed an identified numbers of altered skin integrity areas that appeared elevated and surrounded with an identified color. The wound picture taken three days after the altered skin integrity's injury showed dark areas surrounded with an identified color.

Review of the resident's health care records by inspector #211 revealed that a picture was taken nine days after the injury of the resident's identified body area. The picture demonstrated dark areas positioned in a middle of a circle. Some of the dark areas has a specific appearance.

In an interview with PSW #107 on an identified date, indicated when a resident is receiving a bath, it is the responsibility of the PSW to evaluate the resident's skin condition and to document under the flow sheet into the electronic medical record. PSW #107 indicated that PSWs need to document under one of the three sections if the resident's skin was intact or if resident's skin appeared red. Furthermore, the PSW need to document if a member of the nursing staff was informed related to the resident's altered skin integrity. PSW #107 stated that resident #001's bath was given seven days after the injury and the documentation indicated that the resident's skin was intact. PSW #107 stated that this documentation was incorrect.

In an interview with the DOC on an identified date, stated that when PSW #101 took and showed the pictures of resident #001's body area injury to RN #103 on the day of the injury, an skin and wound evaluation should have been completed with the measurement on that shift.

In an interview with ADOC on an identified date, stated that the clinically appropriate assessment instrument that was specifically used for skin and wound was not completed until nine days later. Furthermore, after a review of the flow sheet under the section skin evaluation from the day of the injury to 12 days later, the ADOC stated that the PSWs

documented incorrectly that the resident's skin was intact. The ADOC revealed that resident #001's altered skin integrity area should have been assessed and documented using the clinically appropriate assessment instrument that is specifically designed for skin and wound on the day of the injury. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure when a resident exhibited altered skin integrity, including skin breakdown, skin tears or wounds, the resident received immediate treatment and interventions to reduce or relieve pain,

The resident #001's progress notes written by the Administrator on an identified date as a late entry, indicated that the Administrator observed a altered skin integrity with the presence of a family member and a visitor. The notes described the colors of the altered skin integrity. The size of the altered skin integrity was measuring a certain amount in circumference. There was injuries in the middle of the altered skin integrity that was in a specific position. Another injury was also discovered in the area. The notes indicated that all the altered skin area were covered with a dry scab.

Review of the resident #001's progress noted documented by RN #109 on an identified date as a late entry, indicated that a visual evaluation of the resident's identified body area was completed the next day of the altered skin integrity's injury. A specific appearance of the altered skin integrity was present to the resident's body area. RN #109 wrote that the assessment indicated that there was no signs of infection or drainage and to let the area open to air. Additionally, RN#109 wrote that an assessment was completed for resident's identified body area nine days after the injury. The color of the altered skin area was less dark measuring a certain amount in centimeters and the area had an extension measuring another certain amount in cm. There was areas of dry injuries well adhered together measuring different size centimeters. The injury was healing well and no dressing was required. Keep the area opened to air.

Review of the resident #001's health care record by Inspector #211 observed that there was no information indicating that resident #001 received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required on the identified shift.

In an interview with PSW #101 on an identified date, revealed that resident #001 refused RN #103 or PSW #116 to touch the identified body area.

In an interview with RN #103 on an identified date, stated that an identified skin altered

skin integrity on resident #001's specific body area was observed on an identified date. RN #103 revealed that one identified altered skin integrity area was observed on the day of the injury. The resident refused to have a compress applied on the area.

In an interview with RPN #106 responsible for the "Resident Assessment Instrument-Minimum Data Set (RAI-MDS) on an identified date, stated that resident #001 did not received a pain evaluation from the day of the injury. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure when a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident 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.

Resident #001's health care records indicated that the resident sustained an injury to the specific body area on a identified date.

In an interview with RPN #106 responsible for the RAI-MDS Assessment on an identified date, confirmed that resident #001 was not referred to a registered dietician since the day of the resident's altered skin injury. [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 when a resident exhibiting altered skin integrity, including skin breakdown, skin tears, or wounds, the resident receives the following:
(i) 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,
(ii) immediate treatment and interventions to reduce or relieve pain, and
(iii) an 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, to be implemented voluntarily.

Issued on this 20th day of June, 2019

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

Original report signed by the inspector.