Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report (A1)

Report Issue Date: February 16, 2023

Inspection Number: 2022-1488-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: Centre d'Accueil Roger Seguin

Long Term Care Home and City: Centre d'Accueil Roger Seguin, Clarence Creek

Inspector who Amended the Report	**Inspector who Amended Digital Signature**
Joelle Taillefer (211)	Joelle Taillefer Digitally signed by Joelle Taillefer Date: 2023.02.16 11:08:08 -05'00'

AMENDED INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to reflect the change to O. Reg. 246/22, s. 55 (2) (b) in the written notification (WN) #005 related to Skin and Wound Care. The complaint inspection #2022_1488_001 was completed on January 20, 2023

INSPECTION SUMMARY

The Inspection occurred on the following date(s): November 28 - 30, 2022, December 1, 2, 6-9, 12, 13, 15, 16 and 19, 2022.

The following intake(s) were inspected:
Intakes: #00002655 and #00004565 related to unexpected death of residents
Intake: #00002781 related to staffing shortage
Intake: #00005555 related to Nursing and personal support services
Intake: #00005741 related to injury with unknown origin.
Intake: #00006395 related to multiple concerns.
Intakes: #00013649 related to abuse.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Medication Management
Falls Prevention and Management
Staffing, Training and Care Standards
Continence Care
Resident Care and Support Services

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 28 (1) 2.

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

The licensee has failed to immediately report to the Director, the suspicion of abuse of a resident.

Rationale and Summary

In 2022, a resident's Substitute Decision Maker, reported allegation of abuse toward the resident. A staff member informed the DOC who was the senior staff on call. The DOC did not inform the Director immediately using after hours pager and informed the Executive Director of Care the following day. Therefore, the incident was reported one day after the home became aware via the Critical Incident Report System.

The Critical incident System (CIS) report and the DOC interview indicated that the allegation of abuse was not reported to the Director immediately when they become aware of the incident.

As such the licensee did not inform the Director immediately as legislative requirement.

Sources: CIS report, Resident health care record. Interview with the DOC. [502]

Date Remedy Implemented: November 28, 2022

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Rationale and Summary
In 2022, a resident displayed identified bahaviours toward a co-resident. The home implemented observation of the resident's behaviours every 30 minutes and staff were to document their observation using the Behaviour Support Ontario- Dementia Observational System (BSO-DOS).

BSO-DOS record showed that BSO-DOS documentation was not completed on eight different shifts.

A staff member acknowledged that documentation was not completed consistently, as shown through their audit and ongoing education.

By staff not documenting their observation, the plan of care was at risk not to reflect the resident care need related to the observed behaviours,

Sources: BSO-DOS, CIS, Progress notes, plan of care. Interviews with staff. [502]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 107 (1) 2.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances of a sudden death.

Rationale and Summary

A resident's critical incident system report submitted in 2022, indicated that the Executive Director of Care had been informed by a staff member that additional information had been discovered regarding a resident's death four months earlier. The resident's health care records indicated that the resident had specific advance directives and no cardiopulmonary resuscitation.

Another staff member stated that the DOC had been contacted at the time of the resident's death as they were concerned about the circumstance of resident's death. The DOC had not immediately informed the Director related to the circumstances of the resident's unexpected death.

The Administrator confirmed that the resident's sudden death should have been reported to the director, due to the circumstances of the resident's death.

As such, the Director was not informed immediately related to the circumstance of the resident's death.

Sources: Resident's health care records and interviews with a Staff member, DOC and the Administrator. [211]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan related to toileting.

Rationale and Summary

On a specified date in 2022, a resident reported waiting a long time after requesting assistance. The resident stated being afraid to fall when dressing without assistance after self-toileting. The resident mentioned that they had specified hours for toileting.

The resident's current written plan of care indicated staff were to stay with the resident during the identified care, and then assist the resident with dressing.

The resident's communication and response system report for two weeks in 2022, indicated that the resident waited the following times to receive assistance: 46:54 minutes, 19:47 minutes, 37:20 minutes, 26:27 minutes, 10:41 minutes, and 1:06:52 minutes respectively.

The Executive Director of Care indicated that the resident was identified as being at risks for falls and acknowledged that the resident's waiting times for staffing response to the resident's identified care needs was too long.

As such, the resident was at risk for fall and discomfort when care was not being provided as per the plan of care.

Sources: Review of resident's health care records and interview with the Executive Director of Care. [211]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b)

The licensee has failed to ensure a resident exhibiting altered skin integrity, (i) 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, and (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Rationale and Summary
In 2022, a resident's progress notes indicated that the resident had sustained a fall and there was no injuries noted. The next day, a staff member observed a large bruise to the resident's body part, the

resident was sent to the hospital for further assessment related to the fall and returned later the same day. Five days after the fall, the Occupational Therapist (OT) documented an altered skin integrity on the resident's body part. The resident's health care records for a 10-days period after the fall, did not indicate that the resident had received a skin assessment.

Eighteen days after the fall, the resident informed the Inspector that altered skin integrity was still present to the identified body part discovered several weeks ago.

The DOC confirmed that the resident had not received a skin assessment when the resident's altered skin integrity was observed a day after the fall, and weekly thereafter by a member of the registered nursing staff, using their clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

As such, the resident's skin injury was not monitored and assessed, posing a potential risk of increased altered skin integrity.

Sources: Resident's health care records and interviews with staff and the DOC. [211]

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (2)

The licensee has failed to ensure that a resident's plan of care was based on an assessment and on the needs and preferences of that resident in regards to the use of specified devices.

Rationale and Summary

In 2021, a resident had specified devices.

The resident's plan of care did not indicate that the resident had these devices and did not indicate the resident's needs regarding the use of these devices.

A staff member stated that the resident was using the specified devices for repositioning and transfer with the staff's assistance

The Resident Assessment Instrument (RAI) Coordinator confirmed that resident's written plan of care did not indicate that the resident had these devices. The written plan of care should have set out, clear directions to staff and others who provided direct care to the resident in regard to the resident's use of those devices for their mobility.

As such, the resident's written plan of care was not based on an assessment and needs of the resident related to their use of the devices

Sources: Resident's health care records and interviews with staff. [211]