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 4, 2019	2019_751649_0016	000721-18, 001896-18, 016747-18, 033777-18, 009204-19	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Elginwood
182 Yorkland Street RICHMOND HILL ON L4S 2M9

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

JULIEANN HING (649), ORALDEEN BROWN (698)

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 6, 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, and 23, and off-site on August 21, 26, 27, and 30, and 2019.

The following intakes were inspected:
log #000721-18 related to Residents' Bill of Rights, pain, plan of care, transferring and positioning and continence care
log #001896-18 related to transferring and positioning, falls prevention and management
log #016747-18 related to reporting and complaints and plan of care
log #033777-18 related to reporting of critical incidents, minimizing of restraints, and falls prevention and management
log #009204-19 related to plan of care.

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), assistant director of care (ADOC), physician, registered nurses (RNs & RPNs), wound care champion (WCC), registered dietitian (RD), resident services coordinator (RSC), personal support workers (PSWs), residents and family members.

Note: A compliance Order related to LTCHA, 2007, 79/10, r. 36 was identified in this inspection and has been issued in Inspection Report #2019_751649_0015, dated October 4, 2019, which was conducted concurrently with this inspection.

The inspectors reviewed residents' health records, staffing schedules, staff training records, investigation notes, conducted observations, and reviewed any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Pain
Personal Support Services
Reporting and Complaints
Responsive Behaviours
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)**

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 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with for residents #009 and #010.

In accordance with O. Reg. 79/10, s. 48. (1) 4, and in reference to O. Reg. 79/10, s. 52. (1) 4. The licensee was required to have a pain management program that provided for the monitoring of residents' responses to the effectiveness of pain management strategies.

Specifically, staff did not comply with the licensee's Pain Assessment and Management policy (policy #CARE8-O10.02, effective date of August 31, 2018), which was part of the licensee's Pain Management program that required staff to initiate monitoring when pain medication was discontinued and UCP to document observed or verbalized resident's pain and report to the nurse.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to a family member's request for an identified pain medication for resident #009 and was told by the home that they could not give the medication without a physician's order.

A review of the home's policy #CARE8-O10.02 titled Pain Assessment and Management with an effective date of August 31, 2016 directed staff to:
Initiate pain monitoring:
-Dosage increase or decrease of regular pain medication
-Pain medication is discontinued and
Documentation:
-The UCP will document pain observed or verbalized and report to the Nurse.

A review of resident #009's clinical record indicated that they had been taking an identified medication at specific intervals since their admission to the home. On an identified date, the physician wrote an order for the gradual decrease and then discontinuation of this medication.

A review of the resident's clinical records indicated that no monitoring had been initiated when the identified medication had been discontinued as was directed in the above pain policy.

Record review indicated documentation of resident #009 having pain one day after a fall to an identified body area during transfer with staff after they fell and according to the e-MAR record and progress notes no pain medication had been administered when the resident had complained of pain.

According to the point of care (POC) records for an identified period, PSW #128 had documented on the night shift that resident #009 had pain on 49 occasions.

Resident #009 was not in the home at the time of the inspection.
Interview with PSW #128 who had documented on the night shift that the resident had pain told the inspector that the resident had told them they were having pain to identified body areas. According to PSW #128 they reported the resident's pain to RN #111.

2. Resident #010 was selected for sample expansion related to non-compliance with resident #009.

According to the POC records for an identified period indicated that PSW #128 had documented on the night shift that resident #010 had pain on 37 occasions.

Resident #010 was not in the home at the time of the inspection.

Interview with PSW #128 who had documented on the night shift that the resident had pain, told the inspector the resident had pain to an identified body area and every time they moved that area they would shout out in pain. The PSW recalls reporting that the resident had pain to RN #111.

In an interview with RN #111 they denied having been told by PSW #128 that residents #009 and #010 had pain on the above occasions.

In an interview with RN #112 they acknowledged that the home's pain policy had not been followed when resident #009's identified pain medication had been discontinued and when there was documentation that residents #009 and #010 were having pain.

In an interview with DOC #109 they acknowledged that resident #009 would have required monitoring after the identified pain medication had been discontinued and further explained that the home's policy had not been followed when residents #009 and #010 had complained of pain. [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 to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

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 resident #010 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian and any changes made to their plan of care relating to nutrition and hydration were implemented.

A complaint was submitted to the MLTC related to concerns regarding resident #010's repeated altered skin integrity and the home's inability to identify their cause.

According to resident #010's progress notes they had sustained three areas of altered skin integrity.

According to the home's process, referrals are completed in point click care (PCC).

Record review indicated that referrals were completed in PCC for the RD on identified dates for the two areas of altered skin integrity, no referral was sent to the RD for the third area of altered skin integrity.

In an interview with RPN #130 who is the home's WCC, acknowledged that referrals had been sent to the RD for the first two areas of altered skin integrity and that no referral had been sent to the RD for the third area of altered skin integrity.

In an interview with RD #129, they acknowledged that they had received referrals for the first two areas of altered skin integrity but had not completed any documentation or assessed the resident. The RD further acknowledged that they had not received a referral for resident #010's third area of altered skin integrity and therefore had not assessed the resident.

In an interview with DOC #109, they were informed of the above non-compliance and responded that the resident should have been assessed by the RD. [s. 50. (2) (b) (iii)] (649)

2. The licensee has failed to ensure that residents #010 and #019 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds were reassessed at least weekly by a member of the registered nursing staff.

According to the home's process, weekly skin and wound assessments were completed

in PCC.

Record review indicated that the weekly skin and wound assessments for resident #010's area of altered skin integrity was completed on an identified date and the next assessment was completed four weeks later, another assessment was completed on another identified date and the next assessment was completed almost two weeks later. The physician had ordered a topical treatment for a specified period of time to resident #010's first area of altered skin integrity.

3. Resident #019 was selected for sample expansion related to non-compliance identified for #010.

Record review indicated that resident #019 had two areas of altered skin integrity.

According to the home's process, weekly skin and wound assessments were completed on paper on the resident's treatment administration record (TAR).

Record review indicated that the weekly skin and wound assessments for resident #019's first area of altered skin integrity was completed on an identified date and the next assessment was completed more than two weeks later, another assessment was completed on another identified date and the next assessment was completed more than two weeks later.

Further review of the TAR indicated that weekly skin and wound assessment for the resident's second area of altered skin integrity had been completed on an identified date and the next assessment was completed two weeks later, another assessment was completed on another identified dated and the next assessment was completed three weeks later. Another assessment was completed on an identified date and the next assessment was completed more than two weeks later.

In an interview with RPN #130 who is the home's WCC, acknowledged that there were gaps in the weekly skin and wound assessments for residents #010 and #019's areas of altered skin integrity during an identified period.

In an interview with DOC #109, they acknowledged that skin and wound assessments should have been completed weekly for residents #010 and #019. [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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, and changes made to the resident's plan of care relating to nutrition and hydration are implemented and is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #009 fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

A complaint was submitted to the MLTC related to resident #009 ambulating with a mobility aide when they were told by the home two weeks prior to stop using the mobility aide.

Record review indicated that resident #009 sustained two falls. Further review indicated that when the resident sustained the first fall a post fall assessment was completed four days later. The resident sustained an injury and an area of altered skin integrity to an identified body area as a result of their fall. The resident sustained a second fall and no post fall assessment was completed when the resident fell. The resident sustained an injury and an area of altered skin integrity to an identified body area as a result of the fall while they were walking with a family member using a mobility aide.

Interview with RPN #120 who was working when the resident sustained both falls acknowledged that a post fall assessment for the first fall had not been completed until four days after and told the inspector that the post fall assessment should have been completed right away. In regards, to the resident's second fall the RPN acknowledged that a post fall assessment had not been completed.

In an interview with DOC #109, they acknowledged that post fall assessments must be completed in a timely manner after every fall. [s. 49. (2)]

Issued on this 7th day of October, 2019

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

Original report signed by the inspector.