Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 6, 2020	2020_836766_0002	000043-20, 000364-20	Complaint

Licensee/Titulaire de permis

CVH (No. 8) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Errinrung Long Term Care Home
67 Bruce Street P.O. Box 69 THORNBURY ON N0H 2P0

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

KATY HARRISON (766), KIM BYBERG (729)

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): January 9, 10, 16, 20, 21, 22 and 23, 2020.

The following intakes were completed in this Complaint inspection:

Log #000043-20, Critical Incident (CI) #2513-000001-20 related to prevention of abuse;

Log #000364-20, related to concerns regarding personal support services.

During the course of the inspection, the inspector(s) spoke with Regional Director, Resident Services Manager (RSM), Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Program Manager, Food Service Manager (FSM), Registered Nurse (RN), Registered Practical Nurse (RPN), RAI/Restorative Care (RCC), Business Office Manager, Personal Support Workers (PSW), Agency staff, residents and family members.

The inspectors also toured resident home areas, observed resident care provision, meal service, resident staff interaction; reviewed relevant clinical records, relevant policies, procedures and staff training records pertaining to the inspection.

This complaint inspection was completed in conjunction with the follow up inspection #2020_836766_0001.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
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. 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

The Ministry of Long-Term Care (MLTC) received a complaint on a specified date, related to nutrition and hydration, specifically, resident #001 not receiving the correct diet texture as ordered by the dietician.

Resident #001's plan of care stated that the resident was to be provided a specified diet and fluids.

Resident #001's progress notes in point click care (PCC) stated that the dietitian reassessed resident #001 on a specified date, and changed their fluid consistency. The resident's progress notes stated that fluids that were the wrong consistency were provided to resident #001.

On a specified date a memo was sent to dietary and PSW serving staff from the home's FSM, stating that there was an issue with providing the wrong diet texture to residents.

During the inspection an observation was completed by inspector 729 during meal service, and a document titled "Master Diet List" with a specified date on it was located on the black serving cart in the dining room. It stated that resident #001 was to receive a particular type of diet and fluids. A second document titled "Master Diet List" updated four months later was found in the dining room servery in a binder, which stated resident #001 was to receive a different diet texture.

PSW #105 shared that they used the master diet list located on the black serving cart when they provided drinks at meal service.

FSM #120 shared that staff would look in the dietary binders, and on the carts to find diet interventions for residents. FSM #120 stated that on a specified date there was a miscommunication amongst staff, and resident #001 did not get the correct fluid consistency. FSM #120 shared that the master diet list on the black serving cart was not current.

The licensee failed to provide the correct fluid consistency to resident #001 as specified in the plan of care. [s. 6. (7)]

2. The licensee failed to ensure that resident #001’s plan of care was revised when their care needs changed, and when the plan was no longer necessary.

The MLTC received a complaint related to care concerns for resident #001.

On a specified date the progress notes located in PCC, for resident #001 stated that when a PSW was completing nail care, they accidentally injured the resident. The RPN reminded the PSW not to cut resident #001's finger nails as per a recent change in direction and they would send out another memo to all staff as a reminder.

Resident #001’s plan of care located in point click care (PCC) stated that nail care was to be provided, to trim fingernails and toenails on each bath day. The plan of care task was initiated on a specified date and revised on five months later.

PSW #112 and #118, stated that they reviewed all residents' plans of care located in PCC for care interventions. They stated that when providing bathing care for resident #001, they would clean and trim their fingernails.

DOC #106 stated that it was the home's practice to communicate changes in a resident's condition by putting out memos to all staff. The registered staff and RAI-Coordinator were responsible for completing updates in the resident’s plan of care. They acknowledged that resident #001’s plan of care was not up to date to reflect the change in direction for nail care.

The licensee failed to ensure that resident #001’s plan of care was revised when their

care needs changed related to providing nail care. [s. 6. (10) (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 related to ensuring that the care set out in the plan of care is provided to the resident as specified in the plan
and the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe lift and transferring devices when assisting resident #001.

During inspector #729's observations of resident #001, on a specified date, PSW #112, #113, and RPN #114 were transferring the resident with a lift, using a specified sling size. During the transfer from bed to chair, resident #001 slid down in the sling and was not able to be positioned in the wheel chair safely. PSW #112, #113 and RPN #114 took several attempts to get the resident into their chair.

ED #115 was notified by inspector #729 of the transfer and the use of a transfer sling that did not appear to fit resident #001. ED #115 and RPN #114 used a measuring tape and measured resident #001 from their coccyx to their head to determine the appropriate sling size. ED #115 compared the measurement to the manufacture's guidelines titled "ArjoHuntleigh Getinge Group Passive Clip Slings" dated October 2014. According to the manufacturers guideline resident #001 should use a different size sling.

Review of resident #001's Lift and Transfer assessments in PCC identified that they had

a lift and transfer assessment completed on a specified date. The assessment identified that resident #001 was to be transferred using a lift. The assessment did not include an assessment of the sling type or size.

Review of resident #001's plan of care located in PCC stated the resident required total assistance with the use of a lift and a specified sling size. The care plan entry was initiated on a specified date and revised six months later.

The home's policy titled "Sling Algorithm", policy #LP-01-01-03 A3, appendix three stated that staff were to size all slings according to manufacturer's guidelines.

The manufacture's guidelines titled "ArjoHuntleigh Getinge Group Passive Clip Slings" dated October 2014 stated there were two ways to determine the size of the sling, using the ArjoHuntleigh measuring tape, and measuring over the resident's coccyx to the top of the head. The color on the measuring tape indicated the required sling size. If the sling size fell in between two sizes, it was recommended to select the smaller size. The second method was to place the sling over the resident's back and make sure the sling covered the resident from the top of their head to their coccyx.

RCC #107 said they were responsible to complete all resident lift and transfer assessments that included sling size and selection. They would either use a measuring tape and measure the residents, or bring two different slings and determine what fit the resident the best. They were not sure who assessed resident #001 for the sling size.

The licensee failed to ensure that staff used safe lift and transferring devices when assisting resident #001. [s. 36.]

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 related to ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, 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 failed to ensure that resident #001 received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments, if clinically indicated.

The MLTC received a complaint on a specified date, related to skin and wound care.

During the inspection, inspector 729 observed areas of altered skin integrity on resident #001.

Resident #001's assessment titled "Skin - Head to Toe skin assessment V4" was completed on a specified date and stated that resident #001 had an area of altered skin integrity. The assessment did not include measurements, drainage, odor, cause, wound bed description or treatment plan.

On a specified date a "Skin - Head to Toe assessment" was completed that showed resident #001 had an area of altered skin integrity. The assessment did not include any

other pertinent documentation related to the area of altered skin integrity.

On a specified date a "Skin - Head to Toe assessment" identified that resident #001 had an area of altered skin integrity. The assessment did not include any other pertinent documentation related to the area of altered skin integrity.

On a specified date a “Skin - Head to Toe assessment” identified that resident #001 had multiple ares an area of altered skin integrity. The assessment did not include the nature of the skin impairment, nor did it include a treatment plan.

DOC #106 confirmed that resident #001 did not have a skin and wound assessment using a clinically appropriate assessment tool using the home’s weekly impaired skin assessment for all areas of impairment.

The licensee failed to ensure that resident #001 received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that when resident #001 exhibited altered skin integrity, they were reassessed at least weekly by a member of the registered nursing staff.

The assessments “Skin – Head to Toe skin assessment V4” that were completed on specified dates, for resident #001's initial nine areas of skin impairment were reviewed. There were no weekly skin assessments found for these areas of altered skin integrity.

RPN #111, #119 and DOC #106 shared that residents with impaired skin integrity received weekly assessments until the area was healed. They stated that resident #001 had head to toe assessments completed, but they did not have weekly assessments completed for their areas of altered skin integrity identified on a specified date.

The licensee failed to ensure that when resident #001 exhibited altered skin integrity that they were 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 to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

Issued on this 7th day of February, 2020

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

Original report signed by the inspector.