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
Dec 24, 2018	2018_674610_0025	016225-18, 029338-18	Complaint

Licensee/Titulaire de permis

ATK Care Inc.
1386 Indian Grove MISSISSAUGA ON L5H 2S6

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

Exeter Villa
155 John Street East EXETER ON N0M 1S1

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

NATALIE MORONEY (610)

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): December 14, 17, 2018

The following complaint inspections were completed concurrently in the home:

Log #016225-18, IL-57743-LO, IL-57881-LO, IL-57881-LO, IL-57936-Lo, related to care concerns.
Log #029338-18, IL-61434-LO related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Registered Nurse (s), and Personal Support Workers.

Inspector (s) also reviewed record documentation, policy and procedures, observed resident home area's and observed resident care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

The Ministry of Health and Long Term Care received a complaint for an identified resident regarding altered skin integrity and pain that was allegedly not being assessed while the identified resident was in the home.

A record review of documentation for the identified resident showed that the resident had been admitted to the home with two areas of altered skin integrity.

The home's policy "Skin and Wound Management Program" stated in part resident would "receive immediate treatment and interventions to reduce or relieve pain, promote wound healing and prevent infections as required".

The "Physician Medical Directives" for the identified resident showed that treatments were to be written in the physician orders and physician notified if wound deteriorates.

Record documentation review of the Electronic Medication Administration System

(eMAR) showed that there was no treatment order documented for the wound care for two altered skin integrity areas for the identified resident.

The home obtained a treatment order for one of the two altered skin integrity areas.

The home’s policy “Pain Management” RCSM stated in part that a "comprehensive pain assessment Form 1" will be done every admission and readmission and quarterly as part of the quarterly assessment of resident care needs". If question 1 a) of the pain assessment is entered as Yes the comprehensive pain assessment will be completed. A summary of the pain assessments is documented in the multidisciplinary notes following each assessment.

Further record review documentation showed that the identified resident did not have an initial pain assessment when they were admitted to the home.

The nurse acknowledge that the home had not completed a pain assessment when the identified resident was admitted to the home, and that the treatment order's were not obtained by the physician.

The DOC stated that the expectation was that a written order would be obtained for skin and wound treatments immediately, and that a pain assessment should have been completed for the identified resident on admission.

The licensee has failed to ensure that the identified resident that was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, and promote healing, as required.

Issued on this 14th day of January, 2019

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

Original report signed by the inspector.