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 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 8, 2016	2016_289550_0034	012189-16	Complaint

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE LAURIER MANOR
1715 MONTREAL ROAD GLOUCESTER ON K1J 6N4

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

JOANNE HENRIE (550)

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): September 21, 22, 23, 26, 29, 30, October 3, 4 and 5, 2016

This Complaint Inspection is related to a complaint regarding falls and wound care.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), several Registered Nurses (RN), a Registered Practical Nurse (RPN), several Personal Support Workers (PSW), an Activity Aide, several residents and a family member.

In addition, the inspectors reviewed resident health care records and critical incident reports. Inspectors also observed resident care and services, staff and resident interaction.

The following Inspection Protocols were used during this inspection:
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Legendé 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds:
(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.

Resident #001 was admitted to the home with multiple medical conditions. He/she later passed away in hospital.

On a specific date the resident was assessed by the home's nurse practitioner and treated for an infection of a specific wound. He/she was later assessed by the Enterostomal Therapy Nurse (ET nurse) and was diagnosed with a change in wound status. On that same day, the Registered Nurse sent a consult to the home's Registered Dietician requesting a protein supplement for the resident for the management of his/her wound.

Inspector #550 reviewed the resident's health care records and observed there was no documentation to support that the resident was assessed by the home's Registered Dietician with nutritional interventions implemented for the management of wounds.

The inspector with the home's Registered Dietician (RD) reviewed the progress notes for a specific period of time and observed there were no notes documented by the Registered Dietician. In the assessment tab in Point Click Care, there was a referral sent to the R.D. by the Registered Nurse on a specific date requesting a protein supplement for wound management. The RD documented on the referral that the resident was not assessed as he/she had been transferred to the hospital and that she would reassess the resident upon readmission.

The dietary assessments in PCC are documented as follows for four specific months:
On a specific date: Altered skin integrity was checked, note indicating the resident was still in hospital.
No assessment completed for the following month.
On a specific date: nothing checked on the assessment except high risk and a note indicating readmission with a specific treatment is documented.
On a specific date: no assessment completed except high risk checked and a note indicating re-weight for a specific month was not completed is documented.
On a specific date: no assessment completed except high risk checked and a note indicating readmission is documented.
On a specific date: no assessment completed except high risk checked and a note indicating sent back to hospital, not responding to a specific treatment and currently advance 3 is documented.

The inspector and the Registered Dietician reviewed the resident's plan of care and observed there was no indication that the resident was receiving a protein supplement for the management of wounds. The dietician indicated to the Inspector that she obviously forgot to assess this resident. She indicated she remembered this resident was very particular with food and she possibly had thought that he/she would not want the high protein diet and forgot to document this.

As evidenced above, resident #001 who had wounds, was not assessed by the home's Registered Dietician. [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 that all residents exhibiting skin 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 any changes made to the resident's plan of care relating to nutrition and hydration are implemented,, to be implemented voluntarily.

Issued on this 10th day of November, 2016

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

Original report signed by the inspector.