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
Apr 25, 2022	2022_885601_0006	019006-21, 000217-22	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

Fenelon Court
44 Wychwood Crescent Fenelon Falls ON K0M 1N0

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

KARYN WOOD (601)

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): March 10, 11, 14, 15, 16, 17, and 18, 2022.

The following intakes were completed in this Complaint Inspection:

A log related to care concerns, continence care, housekeeping and maintenance.

A log related to concerns with visitation, resident bill of rights, plan of care, and neglect.

During the course of the inspection, the inspector(s) spoke with the interim Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Environmental Service Manager (ESM), Personal Support Workers (PSW), Housekeeping Worker (HSK), and residents.

The inspector also reviewed resident clinical health care records, relevant home policies and procedures, internal investigations, observed infection control practices in the home, the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities

During the course of this inspection, Non-Compliances were issued.

2 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	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with the resident's physician or Nurse Practitioner (NP) and each other in the assessment of resident #002 so that their assessments were integrated, consistent with and complemented each other when the resident's medication was held due to the resident experiencing a symptom that related to the resident's medical condition.

The Ministry of Long-Term Care received a complaint regarding how the resident's symptoms were managed.

The resident was prescribed a medication to manage their medical condition. The resident was experiencing a symptom related to their medical condition and their medication was held by the nurse without collaborating with the NP. The NP prescribed registered staff to assess the resident's symptom by two methods when they became aware of the resident's symptom and the resident often refused the alternative method. The resident's medical status was at risk when the resident's physician or NP was not immediately notified that the resident's medication was held by the registered staff and that the resident was refusing the alternate method for testing their symptom. There was no evidence that the nurse collaborated with the Physician or NP when they held the resident's medication. The interim Director of Care (DOC) acknowledged that registered staff should have immediately notified the physician or the NP for direction when the resident's medication was held, and when the resident refused the alternate test.

Sources: Record review of the resident's Medication Administration Record (MAR), Physician Orders, Progress Notes, interview with the interim Director of care (DOC). [s. 6. (4) (a)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with the resident's physician or Nurse Practitioner (NP) and each other in the assessment of resident #002 so that their assessments were integrated, consistent with and complemented each other when the resident's treatment cream was not applied according to the directions of the prescriber.

The resident and the Personal Support Workers (PSWs) interviewed reported the resident's skin condition was resolved and the prescribed treatment cream would be administered by the PSWs when required, upon the resident's request. The registered staff documented the PSWs were applying the treatment cream and the PSW indicated they had not applied the treatment cream as documented. The RPN and interim Director of Care (DOC) reported they were not aware the resident's skin condition was resolved and that the PSWs were not applying the treatment cream, as prescribed by the Nurse Practitioner (NP). There was no evidence that registered staff and PSWs collaborated with each other regarding the resident's skin condition or that they collaborated with the NP or physician regarding the prescribed treatment creams.

Sources: Review of the resident's Treatment Administration Record (TAR), skin assessments, and progress notes. [s. 6. (4) (a)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with the resident's physician or Nurse Practitioner (NP) and each other in the assessment of resident #003 so that their assessments were integrated, consistent with and complemented each other when the resident's treatment cream was not applied according to the directions of the prescriber.

The Personal Support Worker (PSW) reported the resident's skin condition was resolved and the prescribed treatment cream was no longer required. The registered staff documented the PSWs were applying the treatment cream and the PSW indicated they had not applied the treatment cream as documented by the registered staff. The RN documented the resident no longer required the treatment cream. The interim Director of Care (DOC) reported they were not aware the resident's skin condition was resolved and that the PSWs were not applying the treatment cream, as prescribed by the Nurse Practitioner (NP). There was no evidence that the RN collaborated with the NP or

physician regarding the prescribed treatment creams and that the resident's skin condition had resolved.

Sources: Review of the resident Treatment Administration Record (TAR), skin assessments, and progress notes, and interview with a PSW and the interim DOC. [s. 6. (4) (a)]

4. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with the resident's physician or Nurse Practitioner (NP) and each other in the assessment of resident #001 so that their assessments were integrated, consistent with and complemented each other when the resident was not receiving their medication, as prescribed.

The Ministry of Long-Term Care received a complaint regarding the resident's pain management and that the resident's medication was not being administered properly.

The Nurse Practitioner (NP) documented they denied the staff request for the resident receive their medication at a different time. The NP's rationale was related to the resident being prescribed medication that required a specific amount of time between doses to manage the resident's pain. The NP documented that if the pain medication was given at a later time, the resident could potentially experience unmanaged pain.

There were times when the registered staff held the resident's scheduled medication for a specified reason. The RN indicated that it was common practice for the registered staff to administer the resident's scheduled medication late for a specified reason. Staff reported the resident experienced pain. The resident was at risk for discomfort when the registered staff did not collaborate with the NP regarding the resident not receiving their scheduled medication, as prescribed.

Sources: Review of the resident's Medication Administration Record, Progress Notes, Plan of Care, and interviews with a PSW, an RN, and the interim Director of Care. [s. 6. (4) (a)]

5. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with the resident's physician or Nurse Practitioner (NP) and each other in the assessment of resident #001 so that their assessments were integrated, consistent with and complemented each other when the resident had a change in condition.

The Ministry of Long-Term Care received a complaint that the resident had a change in their condition and was displaying symptoms of an infection and there was a delay in testing.

RN #115 documented the resident's Substitute Decision Maker (SDM) requested a test be completed as the resident had symptoms of an infection. Several days later, the NP documented the resident had no changes in condition and that a test was ordered at the request of the resident's SDM. Several days later, RN #118 documented that the resident's test was completed. There was no evidence that the staff assessed the resident for symptoms of an infection when the resident's SDM reported concerns the resident was displaying symptoms of infection nor that the Nurse Practitioner (NP) was made aware of the concerns in a timely manner. The resident was at risk for discomfort when there was a delay in collaborating with the NP of the resident's SDMs observations with the request for a test to be completed and when there was a delay in completing the test.

Sources: Record review of the resident's progress notes, physician orders, lab results, and interviews with the RN and the interim DOC. [s. 6. (4) (a)]

6. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with the resident's physician or Nurse Practitioner (NP) and each other in the assessment of resident #001 so that their assessments were integrated, consistent with and complemented each other when the resident had symptoms and discomfort.

The Ministry of Long-Term Care received a complaint that the resident was experiencing symptoms and discomfort.

The RN did not follow the bowel protocol and there was no evidence that the RN collaborated with the NP prior to administering the bowel medication. The NP prescribed treatment based on the outcome of the bowel medication administered to the resident. The resident was symptomatic following the NP's interventions and there was no further collaboration with the NP when the registered staff held the resident's prescribed medication. The resident was at risk of discomfort when experiencing symptoms for several days and there was no evidence that staff collaborated with the NP when the bowel medication was held due to the resident's symptoms. The interim Director of Care (DOC) acknowledged that staff should have collaborated with the NP for further direction

when the resident's symptoms changed.

Sources: Record review of the resident's progress notes, physician orders, Medication Administration Record (MAR), and Point of Care (POC) documentation, and interviews with the interim DOC. [s. 6. (4) (a)]

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 the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a process to report and locate lost clothing and personal items.

A resident reported they didn't want to send clothing to the laundry due to clothing going missing. The resident indicated they had reported the missing clothing to the staff. The Laundry Aide reported there was no longer a process in place when a resident reported missing clothing. The Environmental Manager (EM) indicated staff were required to complete a form when a resident had a missing item. Staff interviewed indicated they were not aware of a form to report and locate lost clothing. The interim Director of Care (DOC) confirmed that the resident's clothing had been reported missing. The Environmental Service Manual related to missing clothing had a checklist to be completed by the employee who received the complaint of missing clothing. The EM confirmed the missing clothing checklist had not been completed for the resident and they were not aware of the resident reporting missing clothing.

Sources: Review of Client Services Response Form, Environmental Services Manual, and interviews with Laundry Aide, PSWs, RPN, EM, and the interim DOC. [s. 89. (1) (a) (iv)]

2. The licensee has failed to ensure that there was a process to report and locate lost clothing and personal items.

A resident's Substitute Decision Maker (SDM) reported the resident had a missing item. A staff documented that the laundry department was notified, and a note was placed in the communication book. The Laundry Aide reported there was no longer a process in place when a resident reported items missing. The Environmental Manager (EM) indicated staff were required to complete a form when a resident was missing an item. Staff interviewed indicated they were not aware of a form to report and locate lost items. The Environmental Service Manual related to missing clothing had a checklist to be completed by the employee who received the complaint of missing clothing. The EM confirmed the missing clothing checklist had not been completed for the resident.

Sources: Review of Client Services Response Form, Environmental Services Manual, ES D-20-20, revised December 2017, and interviews with Laundry Aide, PSW, PSW, RPN, EM, and the interim DOC. [s. 89. (1) (a) (iv)]

Issued on this 26th day of April, 2022

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

Original report signed by the inspector.