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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 17, 2018	2018_575214_0007	005747-18	Resident Quality Inspection

Licensee/Titulaire de permis

Heritage Green Nursing Home
353 Isaac Brock Drive STONEY CREEK ON L8J 2J3

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

Heritage Green Nursing Home
353 Isaac Brock Drive STONEY CREEK ON L8J 2J3

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

CATHY FEDIASH (214), ROSEANNE WESTERN (508), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): March 26, 28, 29, April 3, 4, 5, 10, 11, 12, 13, 16, 18 and 19, 2018.

Please note: The following complaint inspection was conducted simultaneously with the RQI:

Complaint Inspection #005011-18 related to end of life care. This complaint was inspected during inspection #2018_551526_0006 in relation to complaints related to skin and wound and pain management.

During the course of the inspection, the inspector(s) spoke with the Administrator; Interim Administrator; Director of Care (DOC); Assistant Director of Care/Clinical Coordinator and Infection Control lead (ADOC #240); Assistant Director of Care and Staff Development Coordinator(ADOC #241); Programs Manager; Environmental Manager; Ward Clerk; Physiotherapist; Occupational Therapist; Resident Assessment Instrument (RAI) Coordinator; Registered staff; Personal Support Workers (PSW); President of Residents' Council; President of Family Council; residents and families.
During this inspection the Inspector's toured the home; reviewed resident's clinical records; policy and procedures; complaint documents; education documents; meeting minutes and observed the provision of care; meal service and medication administration.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **6 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A review of resident #013's clinical records indicated that on a specified date, the resident was identified as having an alteration to their skin integrity to an identified area. A review of an identified electronic assessment indicated that the resident's alteration to their skin integrity had healed on a specified date.

A review of progress notes dated approximately two months later, indicated that the resident's alteration to their skin has been assessed to be present. A review of identified clinical records indicated that the resident's alteration to their skin had been present at the time of this inspection and indicated a specified stage. A review of treatment records for a specified period of time indicated that identified treatment had been in place.

A review of the current electronic care plan indicated that the resident's identified alteration to their skin integrity had healed. A review of the care plan history for this focus item indicated that it was revised with this information four days following the identification of the alteration to the resident's skin integrity.

An interview with staff #240 on an identified date, confirmed that the resident had a

current alteration to their skin integrity; treatment was in place as per the current treatment records and that the written plan of care for the resident had not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in plan of care was based on an assessment of the resident and the needs and preferences of that resident.

On two identified dates, resident #008 was observed sitting in their mobility device with an identified device in place. The resident was unable to undo the device upon the inspector's and staff #227's requests. Interview with staff #185 on an identified date, identified that the resident used the device to prevent leaning forward. Review of the most recent written plan of care, indicated that the resident used the device for safety and that the resident could undo the device. Review of Minimum Data Set (MDS) assessment, dated with an identified date, indicated that the device was not used. Review of the Resident Assessment Protocol (RAP), dated with an identified date, indicated that the resident used the device; that they were able to undo the device and that they were at risk for falls, had periodic identified movements and unsteady gait. Review of the resident's clinical records indicated that no assessment for the identified device had been completed, which was confirmed by staff #212 on an identified date.

On an identified date, an interview with the DOC confirmed the use of the device for resident #008, which had been included in their plan of care had not based on an assessment of the resident and the needs and preferences of that resident. [s. 6. (2)]

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

A) Resident #004 had an identified health diagnosis and required the use of a specified device. The device was ordered to be changed monthly on an identified schedule. During a review of the resident's clinical record it was identified that the resident's device was due to be changed on a specified date and month; however there was no signature documented or notes to indicate this had been done.

On an identified date, registered staff #236 documented that they had provided a procedure to the device as it was indicated to not be working properly. Documentation indicated that following the provided procedure, the device had improved.

During an interview with registered staff #211 on an identified date, it was confirmed that

the resident's device had not been changed as per the resident's plan and indicated that the resident's device was going to be changed later that day. It was later confirmed that the resident's device was changed later that day, five days following the date the device was to have been changed.

Record reviews and interview with staff #211 confirmed that the device had not been changes as per the resident's plan of care, and that the care set out in the plan of care was not provided as specified in the plan.

B) Record reviews indicated that during a specified period in time, resident #004 had an identified alteration to their skin integrity to a specified location which required identified treatment to be completed on two identified days of the week. A review of the resident's clinical record indicated that during this specified period in time, on two identified dates, the resident's scheduled treatment had not been provided.

On a specified date, there was no documentation to indicate that the resident's treatment had been done. Interview with staff #211 confirmed that they did not provide the treatment as ordered. Four days later, records indicated that the treatment could not be provided by staff #324 as they had indicated in the resident's record that they did not have time to complete this and therefore this was not done until the next scheduled treatment date which was three days later.

It was confirmed during record reviews and during an interview with staff #211 on an identified date, that the care set out in the plan of care was not provided to the resident as specified in the plan.

C) A review of the resident's plan of care revealed that resident #004 required an identified treatment device to a specified area on their body, while in bed to ensure that an identified area on the resident was elevated to minimize pressure on the resident's identified area of altered skin integrity.

During record review it was identified that on two identified dates, the resident did not have the identified device in place as per their plan of care. Staff #211 documented in the resident's clinical record on these identified dates that on the first date, the resident was found to have a different identified device in place and not the device that was to be in place and therefore staff #211 documented a reminder in the resident's record to ensure that staff follow the resident's plan of care.

On the second identified date, staff #211 documented that again they had found the resident in bed with a different device in place and that the device that was to be in place had been sitting on the resident's bed side table. An interview with staff #211 on an identified date, confirmed that the care set out in the plan of care had not been provided to the resident as specified in the plan on two identified dates.

D) Resident #011 had an identified incident on a specified date, with no injury. Approximately two months later, resident #011 was observed to be provided assistance with identified activities of daily living (ADL) by one identified staff member. Interview with staff member indicated that the resident required one to two person extensive assistance depending on the resident's condition. Review of the resident's current plan of care, indicated that they required two person extensive to total assistance with one of the identified ADL's and two persons for physical assistance to complete another identified ADL. Review of the resident's room logo posted inside of the resident's closet for staff, with an identified date, indicated two staff assistance were required to perform the identified ADL's. Review of the most recent MDS assessment, with an identified date, indicated that the resident required extensive assistance by two staff to complete the identified ADL's. Review of the Physiotherapy transfers assessment for the resident, dated with an identified date, indicated that resident #011's was identified as requiring two person assistance for a specified ADL, which was confirmed by the PT on an identified date.

On an identified date, the DOC confirmed that the resident's identified ADL's were to be completed by two staff based on the resident's assessment. The care set up for resident #011 for their identified ADL's, had not been provided to the resident as specified in the plan. (Inspector #632)

E) Resident #008's clinical records were reviewed and the resident was identified to have an alteration to their skin integrity to an identified area on their body on an identified date. Approximately three months later, identified treatment to the area of skin alteration indicated it was required to be completed every day shift. Review of the electronic Treatment Administration Record (e-TAR) and the resident's plan of care records failed to identify any documentation that the treatment on an identified date, had been completed. An interview with the DOC on an identified date, confirmed that the treatment for resident #008's alteration to their skin integrity, had not been provided on the identified date, as specified in the plan of care for the resident.

F) A review of electronic progress notes for resident #013's, indicated that on an

identified date and time, the resident's was assessed to have an identified area of alteration to their skin.

An identified electronic assessment, dated with a specified date, indicated that the altered skin integrity was assessed to be at an identified stage.

A review of the e-TAR for a specified period of time, indicated that identified treatment was to be completed every day shift.

i) A review of the e-TAR for a specified period of time, indicated that on an identified date, documentation of a code of "9" was in place indicating, "Other/See Nurses Notes". A review of progress notes on the identified date, indicated that treatment to the altered skin integrity was unable to be done and that the charge nurse would address on the next day shift. No further documentation was observed on this date. An interview with registered staff #240 indicated that if a treatment was unable to be completed on the day shift, the evening shift was to be notified to complete the treatment and to document completion on the e-TAR and in the progress notes. Registered staff #240 confirmed that the care set out in resident #013's plan of care was not provided as specified in their plan on an identified date.

ii) A review of e-TAR and progress note documentation for a specified period of time, indicated that on an identified date, no documentation was present for this day. An interview with registered staff #211, indicated that on the identified date, they did not have enough time to complete the treatment and had not asked the registered staff on the following shift to complete. Registered staff #211 confirmed that the care set out in resident #013's plan of care was not provided as specified in their plan on an identified date.

iii) A review of the e-TAR for a specified period of time, indicated that on an identified date, documentation of a code of "9" was in place indicating, "Other/See Nurses Notes". A review of progress notes on the identified date, indicated that the treatment in place for the resident's alteration to their skin integrity, was intact and would be changed the following day. An interview with registered staff #211 indicated on an identified date, the the treatment was intact and dry and had not required changing. Registered staff #211 indicated that the treatment should be checked daily to ensure it was dry and intact and only changed every second day. Registered staff #211 confirmed that the care set out in the resident's plan of care instructed staff to complete the treatment every day shift and that resident #013's plan of care was not provided as specified in their plan on an

identified date.

iv) A review of the e-TAR for a specified period of time, indicated that on an identified date, documentation of a code of "9" was in place indicating, "Other/See Nurses Notes". A review of progress notes on the identified date, indicated that resident #013 had refused to have treatment to their identified area altered skin integrity. An interview with registered staff #225 indicated that the resident had refused to have treatment at the time if was offered and that the next shift was not asked to attempt to offer the treatment to the resident. Registered staff #225 confirmed that the care set out in resident #013's plan of care was not provided as specified in their plan on an identified date. (Inspector #214) [s. 6. (7)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses'

**station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules were complied with: 1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, i. kept closed and locked, ii.equipped with a door access control system that is kept on at all times.

A) During a tour of the home on an identified date, an exit door at the end of an identified unit was observed to be unlocked. The Long Term Care Homes (LTCH) Inspector was able to open this exit door by pushing on the door handle and observed a stairwell. Upon opening this door, the alarm to the adjoining key pad sounded. Staff #225 responded and reset the adjoining key pad, silencing the alarm. The exit door was checked again and the alarm sounded and the door opened again. Staff #225 confirmed that this exit door should not be able to be opened without entering the access code into the key pad. Staff #225 immediately contacted the Environmental Manager and PSW staff attended to monitor the unlocked door.

B) On an identified date, during initial tour, an emergency exit door on two identified units, was observed to be unlocked. Upon opening this door, the alarm to the adjoining key pad sounded. On the identified date, staff #112 and # 225 were interviewed and indicated that emergency doors should be locked. (Inspector #632).

An interview with the Environmental Manager on an identified date, indicated that approximately one week prior, during a fire alarm, the home's front door had been disengaged from the electrical supply as it was designed to do during a fire alarm; however, it was identified that the front door was unable to open from the outside when the fire department attempted to enter the home. The Environmental Manager indicated that in discussion with the fire department, it was determined that the front door could be wired to have a continuous power supply, even in the event of a fire alarm.

The Environmental Manager indicated that during the re-wiring of the front door, the vendor used existing wiring that also powered the doors on the identified units. As a result, there was enough electrical voltage to power the front doors and the alarms on the identified unit exit doors but not enough electrical voltage to power the magnetic locks on the identified unit exit doors.

The Environmental Manager confirmed that the identified unit exit doors were re-wired on an identified date, to ensure enough electrical voltage was available to keep the exit doors safe and secure.

Observation of the exit doors on the identified units on three identified dates, indicated that the doors were safe and secure and unable to be opened when the Inspectors pushed on the door handles.

On an identified date, the interim Administrator and Assistant Administrator

acknowledged that the doors leading to stairways and to the outside of the home had not been kept locked. [s. 9. (1)]

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 doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, i. kept closed and locked, ii.equipped with a door access control system that is kept on at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A) The licensee failed to ensure that the home's 2017 Falls Prevention, Protection and Management Program annual evaluation included a summary of the changes made and the date that those changes were implemented.

On an identified date, registered staff #240 indicated that the 2017 Falls Prevention, Protection and Management Program's objectives and their annual evaluation were discussed during the Falls Committee and Annual Evaluation of Goal and Objectives meeting on an identified date. Registered staff #240 confirmed that the goals and objectives from 2016 and 2017 program evaluations were identical and were included in the 2017 Falls Prevention, Protection and Management Program evaluation. Registered staff #240 confirmed that the home discussed but did not keep a written record of the summary of the changes made and the date that those changes were implemented in relation to the 2017 Falls Prevention, Protection and Management Program evaluation. Review of the home's 2017 Falls Prevention, Protection and Management Program evaluation records included goals and objectives for the upcoming year and a list of residents who had sustained falls for a specified period of time.

On an identified date, registered staff #240 confirmed that the home's 2017 Falls Prevention, Protection and Management Program annual evaluation did not include a summary of the changes made and the date that those changes were implemented.

B) On an identified date, the Inspector requested a copy of the 2017 annual Continence Care and Bowel Management program evaluation. A copy of the Continence Committee Meeting minutes dated with an identified date, were provided.

During review of the meeting minutes it was identified that the goals and objectives had been discussed as part of the home's program for 2018; however, there was no documented review of the 2017 annual evaluation.

Registered staff #240 indicated during an interview that the 2017 program evaluation had been reviewed and discussed at this meeting but the annual program review had not been documented (Inspector #508) [s. 30. (1) 4.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) Resident #008's clinical records indicated that they had an alteration to their skin integrity to an identified area on their body which was initially assessed on an identified date. The altered skin integrity required an identified treatment to be completed every day shift as ordered. Review of the e-TAR contained no documentation that treatment on an identified date, had been completed. A review of the resident's plan of care indicated

no additional information about the treatment on the identified date. Interview with staff #324 on a specified date, indicated that treatment was provided on the identified date, but had not been documented in the e-TAR, which was acknowledged by the DOC during an interview on a specified date.

The home's staff did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

B) On two identified dates, resident #008 was observed sitting in their mobility device with an identified device in place. The most recent plan of care, indicated that the resident was to have an identified ADL every two hours for identified reasons. Review of the task for the identified ADL in Point of Care (POC) for an identified period of time, indicated that the documentation was not completed every two hours by staff. Interviews with staff #179 on an identified date, indicated that the identified ADL was provided to the resident every two hours and the staff were to record the intervention in POC, once the ADL was completed.

Interview with registered staff #241 on an identified date, indicated that the home's staff did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions had been documented.

C) A review of resident #013's electronic progress notes indicated that on an identified date and time, documentation indicated that the resident had been assessed for an alteration to their skin integrity to an identified area on their body.

A review of an electronic assessment, in PCC dated with a specified date, indicated that the altered skin integrity was assessed as a specified stage.

A review of the e-TAR for a specified period of time, indicated that an identified treatment was in place and to be changed every day shift.

i) A review of the e-TAR and progress note documentation indicated that on a specified date, no documentation was present for this day. An interview with registered staff #324, indicated that treatment was administered for the resident's altered skin integrity to an identified area on their body; however, these actions had not been documented.

ii) A review of the e-TAR and progress note documentation indicated that on two identified dates, no documentation was present for these dates. An interview with registered staff #225, indicated that they were unable to recall if treatment was administered for the resident's altered skin integrity to an identified area on their body; however, confirmed that actions of administration or inability to administer the treatment, were to have been documented. (Inspector #214) [s. 30. (2)]

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 a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes are implemented and to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: 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 the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

The following additional non-compliance, issued as a Written Notification (WN) is further evidence to support the order issued on an identified date during complaint inspection 2018_551526_0006 to be complied May 8, 2018.

Resident #004 had multiple identified health conditions. The resident also had on-going alterations to their skin integrity to identified areas of their body between a specified period in time, that would heal and re-open. During review of the resident's clinical records it was indicated that on a specified date, staff identified a new alteration to the resident's skin integrity to an identified area on their body. Treatment interventions were implemented.

A review of the clinical record for resident #004 for an identified period of approximately one month, revealed that assessments had been completed with the exception of one on an identified date; however staff had not used a clinically appropriate assessment instrument for these assessments. On the identified date, no assessment or treatment

had been completed.

It was confirmed during interview with staff #211 on a specified date, that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had not 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 on these identified dates. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of resident #013's clinical records indicated that on an identified date, the resident was identified as having an alteration to their skin integrity to a specified area on their body. A review of an assessment in PCC, titled, "Wound Assessment" and dated with a specified date, indicated that the resident's altered skin integrity had healed.

A review of progress notes approximately two months later, indicated that the resident was assessed to have an alteration to the skin integrity to the same identified area on their body. Treatment was applied. A progress note dated three days later, indicated that the resident's altered skin integrity was assessed to have declined and required a change in treatment. A review of assessments in PCC titled, "Wound Assessment" and dated approximately 20 days later, indicated that the alteration to the resident's skin integrity remained.

A review of wound assessments in PCC and progress notes for an identified period of 23 days, indicated that weekly reassessment of the resident's altered skin integrity to their coccyx had been conducted on two identified dates. A "Wound Assessment" in PCC on a specified date, indicated that this assessment was in progress and had not contained an assessment of the resident's identified altered skin integrity. A review of progress notes and assessments in PCC indicated that the next assessment of the resident's altered skin integrity was a "Wound Assessment" in PCC, two weeks later.

An interview with registered staff #240 confirmed that resident #013's altered skin integrity had not been reassessed weekly. (Inspector #214) [s. 50. (2) (b) (iv)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to the residents received, as a condition to continuing to have contact with residents, training in the areas set out in the following paragraph, at times or at intervals provided for in the regulation 5. Palliative care in accordance with O. Reg. 79/10, s. 221(1)(2), in relation to the following s. 76(7)(5) of the Act.

A review of complaint log #005011-18 submitted by family member #326 on an identified date, to the Ministry of Health and Long-Term Care (MOHLTC) indicated specified concerns of care provided for resident #015. Interview with staff #214 on a specified date, identified that staff had informal meetings in relation to the specific care for the resident. Interview with registered staff #241 indicated that the specified care needs for the residents were discussed during staff meetings but there was no documentation related to the formal specified care training of the home's staff. On an identified date, staff #244 identified a specific number of nursing staff that worked in the home during 2017.

The home failed to ensure that all staff, who provided direct care to the residents, received, as a condition to continuing to have contact with residents, training in the specified area of care.

PLEASE NOTE: The above noted non-compliance was identified while conducting a concurrent complaint inspection # 005011-18. [s. 76. (7) 5.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

A) During an interview with the DOC on a specified date, it was identified that a specified discontinued medication for resident #019 had been locked in a single locked desk drawer in the DOC's locked office.

The DOC indicated that they had removed the specified discontinued medication approximately one week prior from the medication cart on the resident's unit; completed a count of the specified medication with the registered staff on shift and then placed the discontinued medication in their locked desk drawer. The DOC indicated that they had not had the opportunity at the time to take the discontinued medication to the identified location where specific discontinued medications are stored, until destruction. The DOC confirmed that this resident's discontinued medication had not been stored in a double-locked stationary cupboard.

B) Observation of the locked medication room on an identified unit on a specified date, where specific discontinued medications are stored until destruction, indicated that the home used two toolboxes to place these medications into. The first tool box was observed to be locked and when opened, revealed a second locked tool box inside. The second locked tool box was observed to contain the identified discontinued medications; however, this system was not observed to be stationary as the LTCH Inspector was able to lift the tool boxes up. The DOC confirmed that specified medications were not stored in a stationary cupboard. [s. 129. (1) (b)]

Issued on this 29th day of May, 2018

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

Original report signed by the inspector.