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
Jan 20, 2020	2019_715672_0021	019150-19	Critical Incident System

Licensee/Titulaire de permis

Markhaven, Inc.
54 Parkway Avenue MARKHAM ON L3P 2G4

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

Markhaven
54 Parkway Avenue MARKHAM ON L3P 2G4

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

JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 30 and 31, 2019, January 2 and 3, 2020

The following intake was inspected during this Critical Incident System inspection:

Log #019150-19, related to a Critical Incident Report regarding a formal complaint received by the licensee from resident #001's Substitute Decision Maker.

During the course of the inspection, the Inspector made observations of staff and resident interactions and the provision of care; reviewed health records, staffing schedules, internal investigation records, internal complaint records and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), RAI-MDS Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Human Resources Manager, Staffing Clerks, residents, family members, and visitors to the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or Regulation requires the licensee to have a policy in place, that the policy is implemented and complied with according to applicable requirements.

According to LTCHA, 2007. O. Reg. 79/10, r. 48. (1) 2., every licensee of a long term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Inspector #672 reviewed an internal policy which indicated interventions for staff to follow when a resident sustained an area of altered skin integrity.

A Critical Incident Report was submitted to the Director related to a complaint received by the Director of Care (DOC) from resident #001's substitute decision maker (SDM), specific to wound care. The Critical Incident Report further indicated that when RPN #102 provided first aid intervention and treatment to resident #001's injury, they had not followed the licensee's internal skin and wound care policies and placed an incorrect treatment on resident #001's injury. The incorrect treatment contributed to the area becoming infected for identified reasons. Remedial education was provided to the registered staff in the home regarding the internal skin and wound care policies.

During an interview, the DOC indicated the home had an internal protocol for treatment of areas of altered skin integrity. The internal protocol listed the directions for the registered staff to follow when completing first aid intervention and treatment to areas of altered skin

integrity. The DOC further indicated the internal protocol for resident #001's identified treatment related to the resident's injury were not followed by RPN #102.

Inspector #672 reviewed resident #001's electronic Treatment Administration Record (eTAR) from a specified date, which indicated interventions for staff to follow when completing first aid intervention and treatment of the resident's identified injury.

Inspector #672 reviewed the internal investigation notes which indicated the DOC reviewed the camera footage of RPN #102 completing resident #001's first aid intervention and treatment on a specified date and time. The video footage showed RPN #102 applying a specified treatment to the injury, instead of applying the treatment identified in the resident's eTAR.

Inspector #672 reviewed resident #001's physician's orders from an identified time period, which indicated that during a specified time period, resident #001 was assessed by the nurse practitioner, skin care coordinator and physician. Resident #001 also received a specialized treatment for the injury, along with an identified number of other interventions.

RPN #102 was not available for interview during this inspection.

During an interview, RN #101 indicated when resident #001's SDM requested the identified intervention be changed, they assessed the area first and observed the injury had received a specified treatment. RN #101 further indicated after assessing resident #001's treatment, they directed RPN #114 to provide first aid intervention and treatment to resident #001's injury. RN #101 indicated that prior to resident #001 sustaining the identified injury, the registered staff in the home had received specified education related to how to care for injuries similar to resident #001's. RN #101 further indicated there were several other internal educational supports, policies and protocols for staff to follow in order to care for specified resident injuries and areas of altered skin integrity. Lastly, RN #101 indicated they believed the incorrect treatment applied by RPN #102 to resident #001's injury had contributed to the area becoming infected, which then required a number of different treatments for the infection to recede.

During an interview, the DOC indicated the expectation in the home was for registered staff to follow internal policies and procedures, which included the policies related to skin and wound care and all internal protocols related to the treatment of areas of altered skin integrity.

The licensee failed to ensure that an internal policy was complied with, when RPN #102 applied an incorrect treatment to resident #001's identified injury which led to the area becoming infected. [s. 8. (1) (a),s. 8. (1) (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 to ensure that where the Act or Regulation requires the licensee to have a policy in place, that the policy is implemented and complied with according to applicable requirements,, to be implemented voluntarily.

WN #2: 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 tears were reassessed at least weekly by a member of the registered nursing staff.

During record review, the progress notes indicated that after RPN #102 applied an incorrect treatment to resident #001's identified injury, the area became infected. During a specified time period, resident #001 was assessed by the nurse practitioner, skin care coordinator and physician. Resident #001 received a specialized treatment for the injury, along with an identified number of other interventions.

Inspector #672 reviewed resident #001's identified weekly assessments related to the identified injury and noted there were no assessments completed on a specified number of dates.

During further review of resident #001's progress notes and assessments, it was noted that resident #001 had several other areas of altered skin integrity during a specified period of time. Inspector #672 reviewed resident #001's identified weekly assessments and noted there were no assessments completed on a specified number of dates.

To expand the scope of the inspection to determine if residents who exhibited altered skin integrity were reassessed at least weekly by a member of the registered nursing staff, Inspector #672 received the names of residents #002 and #003 from RN #101 and the DOC. RN #101 and the DOC indicated both residents had exhibited areas of altered skin integrity within the previous 180 days.

Related to resident #002:

During review of resident #002's progress notes and assessments, Inspector #672 noted the resident had several areas of altered skin integrity during a specified period of time. Resident #002 was observed to have sustained an identified injury on a specified date. Review of the electronic Treatment Administration Record (eTAR) indicated the area healed on a later specified date. Inspector #672 reviewed resident #002's identified weekly assessments and noted there were no assessments completed on a specified number of dates.

Related to resident #003:

During review of resident #003's progress notes and assessments, Inspector #672 noted the resident had several areas of altered skin integrity a specified period of time. Resident #003 was observed to have sustained an identified injury on a specified date. Review of the progress notes indicated the area healed on a later specified date.

Inspector #672 reviewed resident #003's identified weekly assessments and noted there were no assessments completed on a specified date.

During separate interviews, RN #108, RPNs #104, #110, #111, #112, #113 and #114 and the RAI Coordinator indicated the expectation in the home was for the registered staff to assess each resident with an area of altered skin integrity on a weekly basis and document the assessment under the "Weekly skin/wound assessment" in Point Click Care.

During an interview, the DOC indicated the expectation in the home was for registered staff to create an entry on the resident's eTAR to indicate a weekly assessment of the area of altered skin integrity was required, every time a resident was observed to have an area of altered skin integrity. The registered staff were then expected to assess the resident weekly and document the assessment within the Point Click Care documentation system. The DOC reviewed residents #001, #002 and #003's eTARs and assessments with Inspector #672 and indicated it appeared that weekly assessments had not been completed as expected for all areas of altered skin integrity.

The licensee failed to ensure that residents #001, #002 and #003, who were exhibiting areas of altered skin integrity, 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 that residents exhibiting areas of altered skin integrity, including skin tears, are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Inspector #672 reviewed the internal policy related to complaints, which met the legislative requirements.

A Critical Incident Report was submitted to the Director related to a complaint received by the Director of Care (DOC) from resident #001’s substitute decision maker (SDM), specific to wound care.

On a specified date, Inspector #672 requested a copy of the internal notes and investigation file into resident #001's SDM complaint. On that date, the Administrator, DOC, Human Resources Manager and the RAI Co-ordinator were not available. The charge nurse on duty indicated they would search for the documentation but was unable to locate it. The following day, Scheduling Clerk #115 indicated they had communicated with the DOC and the identified complaints binder was located. Scheduling Clerk #115 further indicated all complaints received in the home during a specified period of time were located in the complaints binder. Inspector #672 reviewed the entire binder and could not locate any documentation related to the complaint received from resident #001's SDM.

During an interview on a specified date, the DOC indicated the expectation in the home was for all complaints received in the home during a specified period of time to be located within the complaints binder. The DOC reviewed the complaints binder and was unable to locate the complaint received from resident #001's SDM complaint. Later that morning, the DOC was able to provide documentation related to the internal investigation and complaint. The DOC further indicated the expectation in the home was for all complaints received in the home to be stored within the complaints binder, as there were no internal tracking forms completed to track which complaints had been received or if any complaints were missing from the complaint binder.

During the record review for resident #001's SDM complaint, Inspector #672 reviewed two other internal complaints stored within the complaints binder from a specified period of time, related to residents #006 and #007. Each of the complaints reviewed were missing some part of the documentation required under the legislation, as follows:

Related to the complaint received from resident #001's SDM, the Client Service Response Form (CSRF) was missing documentation related to the date identified actions were taken and the date the complainant was contacted to discuss the outcome of the internal complaint investigation.

Related to the complaint received regarding resident #007, the CSRF indicated the resident's family had specified concerns related to areas of altered skin integrity and personal care. Resident #007's SDM requested an internal investigation and follow up. Inspector #672 observed the CSRF was missing documentation related to the date the meeting was held with the POA to discuss the concern; the date identified actions were taken and the date the complainant was contacted to discuss the outcome of the internal complaint investigation.

Related to the complaint received regarding resident #006, the CSRF indicated the resident's family had concerns related to the resident missing two baths and suspicions over how a possible identified injury occurred as they were concerned staff may have caused the injury of unknown origin. Inspector #672 observed the CSRF was missing documentation related to the dates of the occurrences when the resident missed the first and second bath; the date identified actions were taken, the date of required follow up with the staff and the date related to when the complainant had been contacted via telephone to discuss the complaint.

During separate interviews, the Human Resources Manager and the DOC indicated they were aware of the legislative requirements related to documentation of internal complaints. The Human Resources Manager and the DOC further indicated they were unaware that some of the complaints documented on the internal Client Service Response Forms were missing some part(s) of the required documentation, as per the legislation.

The licensee failed to ensure that three out of three complaints reviewed included all information required under O. Reg. 79/10, LTCHA, 2007. [s. 101. (2)]

2. The licensee has failed to ensure that a documented record of complaints received in the home were reviewed and analyzed for trends, at least quarterly.

Inspector #672 reviewed the internal policy related to complaints which indicated the complaint forms were expected tol be reviewed and analyzed for trends at least quarterly by the Continuous Quality Improvement Committee.

A Critical Incident Report was submitted to the Director related to a complaint received by the Director of Care (DOC) from resident #001’s substitute decision maker (SDM), specific to wound care.

On a specified date, Inspector #672 requested a copy of the internal notes and investigation file into resident #001’s SDM complaint. On that date, the Administrator, DOC, Human Resources Manager and the RAI Co-ordinator were not available. The charge nurse on duty indicated they would search for the documentation but was unable to locate it. The following day, Scheduling Clerk #115 indicated they had communicated with the DOC and the identified complaints binder was located. Scheduling Clerk #115 further indicated all complaints received in the home during a specified period of time

were located in the complaints binder. Inspector #672 reviewed the entire binder and could not locate any documentation related to the complaint received from resident #001's SDM.

During an interview on a specified date, the DOC indicated the expectation in the home was for all complaints received in the home during a specified period of time to be located within the complaints binder. The DOC reviewed the complaints binder and was unable to locate the complaint received from resident #001's SDM complaint. Later that morning, the DOC was able to provide documentation related to the internal investigation and complaint. The DOC further indicated the expectation in the home was for all complaints received in the home to be stored within the complaints binder, as there were no internal tracking forms completed to track which complaints had been received or if any complaints were missing from the complaint binder. Lastly, the DOC indicated all complaints received within the home were expected to be reviewed on a quarterly basis during internal continuous quality improvement meetings, which would be documented within the meeting minutes transcribed and kept by the Human Resources Manager (HRM) but could not recall when the last continuous quality improvement meeting had been held.

During an interview on a specified date, the HRM indicated the expectation in the home was for all complaints received to be reviewed and analyzed for trends on a quarterly basis during internal continuous quality improvement meetings. The HRM further indicated the last continuous quality improvement meeting had been held on a specified date in 2018, and provided the meeting minutes to Inspector #672. The meeting minutes indicated the complaints review had been deferred during that meeting. The HRM indicated they could not recall the last time complaints received in the home had been reviewed and analyzed for trends, or any meetings held during 2019 which had reviewed and analyzed for trends the complaints received.

During an interview on a specified date, the DOC indicated the last continuous quality improvement meeting had been held on a specified date in 2018, as indicated by the HRM. the DOC further indicated they could not recall any meetings held during 2019 which had reviewed and analyzed for trends the complaints received within the home.

The licensee failed to ensure that a documented record of complaints received in the home was reviewed and analyzed for trends at least quarterly, during the 2019 year. [s. 101. (3)]

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 documented record is kept in the home that includes all of the information required under the legislation and the complaints received in the home are reviewed and analyzed for trends, at least quarterly, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that staff on every shift recorded symptoms of infection in residents who received antibiotic therapy.

A Critical Incident Report was submitted to the Director related to a complaint received by the Director of Care (DOC) from resident #001's substitute decision maker (SDM), specific to wound care. The Critical Incident Report indicated on a specified date, resident #001 sustained an identified injury to a body part, which required first aid intervention and treatment. The complaint indicated that on a later date, resident #001's SDM was visiting the resident when they noted the resident had an identified intervention applied to the injury which had a large amount of fluid accumulating beneath it. The complainant had requested the identified intervention be changed, and when the intervention was removed, the injury appeared to be infected. The Critical Incident Report further indicated that the DOC met with the SDM to discuss their concerns related to resident #001's identified injury and first aid intervention and treatment, as they had concerns an incorrect intervention and treatment had been applied which led to the injury becoming infected. Following the meeting, the DOC initiated an internal investigation

which found that when RPN #102 provided first aid intervention and treatment to resident #001's injury, they had not followed the licensee's internal skin and wound care policies and placed an incorrect treatment on resident #001's injury. The incorrect treatment contributed to the area becoming infected for identified reasons.

During an interview, the DOC indicated the home had an internal protocol for treatment of areas of altered skin integrity. The internal protocol listed the directions for the registered staff to follow when completing first aid intervention and treatment to areas of altered skin integrity. The DOC further indicated the internal protocol for resident #001's identified treatment related to the resident's injury were not followed by RPN #102.

Inspector #672 reviewed resident #001's physician's orders from an identified time period, which indicated that during a specified period of time, resident #001 was assessed by the nurse practitioner, skin care coordinator and physician. Resident #001 also received an order for an identified medication on a specified date.

Inspector #672 reviewed resident #001's progress notes from a specified period of time, and observed there was no documentation on an identified number of shifts regarding the resident's infection symptoms or vital signs when the resident received an identified medication.

During separate interviews, RN #101, RPNs #104, #110, #111, #112 and #113 and the RAI-Coordinator indicated the "usual practice" in the home was for staff to document on the resident for 72 hours when the resident received an identified medication.

During an interview the DOC indicated the expectation in the home was for staff to document on the resident for 72 hours when the resident received an identified medication and then document a progress note when the identified medication completed, to indicate if the therapy was successful.

The licensee failed to ensure that staff on every shift recorded symptoms of infection in resident #001 as required, when the resident received an identified medication. [s. 229. (5) (b)]

Issued on this 21st day of January, 2020

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

Original report signed by the inspector.