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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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 31, 2020	2020_810654_0001	020789-19, 022507-19	Complaint

Licensee/Titulaire de permis

Mississauga Long Term Care Facility Inc.
26 Peter Street North MISSISSAUGA ON L5H 2G7

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

Mississauga Long Term Care Facility
26 Peter Street North MISSISSAUGA ON L5H 2G7

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

SIMAR KAUR (654)

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): January 10 and 13-17, 2020.

The following intakes were completed during this Complaint Inspection:

Log # 020789-19, and Log # 022507-19, were related to unsafe transfer and skin and wound care program.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Care Coordinator (RCC), Resident Assessment Instrument-Minimum Data Set (RAI- MDS) Coordinator, Registered Staff RN/ RPN, and Personal Support Worker (PSW).

During the course of the inspection, the inspector made observations related to the home's care processes; staff to resident, and resident to resident interactions; conducted record reviews of residents' clinical records, and reviewed relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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 :

The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any procedure, that the procedure was complied with for resident #005.

Two complaint intakes were submitted to the Ministry of Long-Term Care (MLTC) related to skin and wound care management of resident #001.

Resident #005 was used to expand the resident sample related to skin and wound care management program.

In accordance with O. Reg. 79/10, s.48 (1) 1 and in reference to O. Reg. s. 50 (1) 2, the licensee was required to have a Skin and Wound Care Program that provided for strategies to promote residents comfort and mobility and promote the prevention of infection, including the monitoring of the residents.

Specifically, staff did not comply with the licensee's procedure related to skin and wound care program, which required registered staff to enter a treatment intervention in the electronic treatment record (eTAR) for residents who acquired new altered skin integrity to ensure it was treated and monitored.

During an interview with skin and wound care program lead #101, they reviewed resident #005's progress notes and indicated that the resident acquired an identified altered skin integrity on an identified date and an identified treatment was applied. It further indicated that there was no treatment entered in the electronic treatment administration record (eTAR) to monitor the altered skin integrity.

Interview with RAI- MDS Coordinator #102 and the home's DOC indicated that as per the home’s procedure registered staff who identified the above identified altered skin integrity was responsible to enter the treatment in the eTAR to monitor the resident's altered skin integrity. They further indicated that the home’s procedure related to monitoring the resident’s altered skin integrity was not implemented for resident #005.

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 Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, that the procedure is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

Two complaint intakes were submitted to the MLTC related to the unsafe transfer of resident #001.

Review of the resident's Resident Assessment Instrument- Minimum Data Set (RAI-MDS) Assessment indicated that the resident had severe cognitive impairment.

Review of the resident's plan of care indicated that they required two staff to assist with an identified transfer device for an identified activity of daily living (ADL).

Review of resident #001's progress notes dated on an identified date and time indicated that the resident had an incident when they exhibited identified clinical symptoms during the above identified ADL. A progress note dated on another identified date indicated that the resident had an identified altered skin integrity related to the above identified incident that occurred earlier that week.

Review of the home's policy titled Mechanical Lifter, Section: Nursing and Personal Support Services, indicated that two staff at least must be present when the mechanical transfer device was being used.

Interview with PSW #109 indicated that they were assisting PSW #110 to transfer the resident from an identified personal mobility device to an identified toileting device. PSW #109 stepped out of the washroom during the transfer to respond to a call bell and asked PSW #110 to put the resident on the toileting device. When they came back after two-three minutes the resident was still on the above identified transfer device and was exhibiting the above identified clinical symptoms. PSW #109 further indicated that PSW #110 did not provide the toileting device to the resident. They observed that the resident's incontinence product was already changed, which indicated that PSW #110 provided incontinence care to the resident while being on the transfer device.

Interview with PSW #110 denied providing incontinence care to the resident while being attached to the above identified transfer device. They indicated that during the above mentioned transfer process PSW #109 was present at all times.

Interview with RN #104 indicated that they had observed resident #001 on an identified date after the above mentioned incident and the resident had the above identified altered skin integrity on an identified area of their body.

Interview with the home’s DOC indicated that the home’s investigation identified that during the above mentioned incident on the above identified date resident #001 was being transferred by two PSWs #109 and #110. PSW #109 left the washroom before the transfer was complete. According to the home’s expectations and the policy identified above, there should have been two staff members when the resident was being transferred using a transfer device. Both PSWs received a verbal warning for the same. The DOC further indicated that the staff did not use safe transferring techniques when assisting resident #001.

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: 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 #001, #004, and #005 exhibiting 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 is specifically designed for skin and wound assessment.

(A) Two complaint intakes were submitted to the MLTC related to skin and wound care management of resident #001.

Review of resident #001's plan of care indicated that the resident had the potential for ulcer interference with the structural integrity of layers of skin related to identified physical and cognitive impairment. Interventions indicated staff to assess the skin condition during care.

Record review of resident #001's progress note dated on an identified date, indicated that the resident acquired altered skin integrity on an identified area of their body, caused by sliding down from their wheelchair. An identified treatment was applied.

Review of the resident #001's assessments on MEDe-care and clinical records did not indicate that the residents received a skin and wound assessment using a clinically appropriate assessment instrument after they had the above identified altered skin integrity.

(B) Resident #004 and #005 were used to expand the resident sample related to skin and wound care program.

Review of resident #004’s plan of care indicated that the resident was at increased risk of ulceration or interference with the structural integrity of layers of skin caused by identified physical and cognitive impairment. Interventions indicated staff to assess the skin condition during care.

Record review of resident #004’s progress note dated on an identified date indicated that the resident had an identified altered skin integrity. An identified treatment was applied.

Review of resident #005’s plan of care indicated that the resident had a potential for ulceration or interference with the structural integrity of layers of skin caused by identified physical and cognitive impairment. Interventions indicated staff to assess the skin condition during care.

Record review of resident #005’s progress note dated on an identified date, indicated that the resident had an identified altered skin integrity on an identified body area during a transfer to their mobility device by PSWs. An identified treatment was applied.

Review of resident #004 and #005’s assessments on MEDe-care and clinical records did not indicate that the residents received a skin and wound assessment using a clinically appropriate assessment instrument after they had above identified altered skin integrity. The residents were assessed, and it was documented under progress notes.

In separate interviews with RAI- MDS coordinator #102 and RN #103, they reviewed the resident #001, #004 and #005’s progress notes and indicated that the residents had acquired the above-mentioned altered skin integrity on the above mentioned dates. They further indicated that the home did not have an assessment tool which was designed for skin and wound assessment. RN #103 indicated that when a resident acquired any new skin tear, wound, or laceration registered staff was documenting their assessment in the progress notes. Residents #001, #004, and #005 did not receive skin and wound

assessments after the above mentioned incidents.

Interview with RN #104, and Skin and Wound Care Program Lead #101 indicated that the did not have a clinically approved skin and wound care assessment tool which was specifically designed for skin and wound care assessments. After a resident acquired any altered skin integrity it was documented in the progress notes by the registered staff.

Interview with the home's DOC indicated that the home did not use an assessment instrument that was specifically designed for skin and wound assessment. Nurses were documenting in the progress notes and the progress notes were not specifically designed for skin and wound assessment. The DOC further indicated that residents #001, #004, and #005 did not receive skin and wound assessments using a clinically appropriate tool which was specifically designed for skin and wound assessment after the above mentioned incidents on the above identified dates.

2. The licensee has failed to ensure that residents #001 and #005 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds were assessed by a registered dietitian who was a member of the staff of the home.

Two complaint intakes were submitted to the MLTC related to skin and wound care management of resident #001.

Record review of resident #001's progress note dated on an identified date, indicated that the resident acquired altered skin integrity on an identified area of their body, caused by sliding down from their wheelchair. An identified treatment was applied.

Resident #005 was used to expand the resident sample related to skin and wound care program.

Record review of resident #005's progress note dated on an identified date, indicated that the resident had an identified altered skin integrity on an identified body area during a transfer to their mobility device by PSWs. An identified treatment was applied.

Record review of both residents' progress notes did not indicate that they were assessed by a registered dietitian (RD) after they exhibited the above identified altered skin integrity on the above mentioned dates.

Interview and record review of resident #001 and #005 ‘s clinical records with RAI-MDS Coordinator #102 indicated that resident #001 and #005 exhibited the above identified altered skin integrity on the above identified dates. Both residents were provided with treatment by the registered staff.

The RAI-MDS coordinator further indicated that they could not find a record that a referral was sent to the home’s registered dietician (RD) after the above mentioned incidents for residents #001 and #005. Therefore, both residents were not assessed by the RD after they had identified altered skin integrity.

Interview with RN #103 indicated that registered staff were responsible to refer a resident with impaired skin integrity to the RD using a paper referral form. In separate interviews with RN #103 and Skin and Wound Care Program Lead #101 indicated that as per the home’s current process, not all the residents who acquired the above identified altered skin integrity were referred to the RD.

Interview with the DOC indicated that the home’s policy on skin and wound care program did not provide clear direction to registered staff on referring to the RD for the above identified altered skin integrity. They further indicated that both residents should have been assessed by the RD after they had acquired the above identified altered skin integrity.

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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; and that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

Issued on this 7th day of February, 2020

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

Original report signed by the inspector.