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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 4, 2019	2019_543561_0010	003112-19	Complaint

Licensee/Titulaire de permis

The Parkview Health Care Partnership on behalf of 593405 Ontario Limited as General Partner
201-80 Speers Road OAKVILLE ON L6K 2E6

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

Parkview Nursing Centre
545 King Street West HAMILTON ON L8P 1C1

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

DARIA TRZOS (561)

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): May 13, 14 and 15, 2019.

A Complaint Inspection log #003112-19 related to management of altered skin integrity was completed during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Services (DoRS), the Assistant Director of Care (ADOC), Registered Dietitian (RD), Nurse Practitioner (NP), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

During the course of the inspection, the inspector observed the provision of care, reviewed clinical records, policies and procedures and training records.

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

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

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (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 the care set out in the plan of care related to interventions for wound healing was provided to the resident as specified in the plan.

A complaint log #003112-19, was submitted to the Director on an identified date in 2019, related to the management of resident #001's altered skin integrity.

A) Resident #001 had a plan of care indicating they had an identified diagnosis and had altered skin integrity. The clinical records indicated that they required an intervention to assist with healing. The Electronic Medication Administration record (EMAR) was reviewed for an identified month in 2018, and the identified intervention was not provided to the resident on four different dates. In an interview with RPN #105, they confirmed that resident #001 did have an order for the identified intervention; however, it was not provided in the days indicated as it was not available. The RPN also stated that no alternatives were provided on those days.

B) Resident #003 had a plan of care indicating they had an identified diagnosis, had altered skin integrity and had an order for an intervention. The EMAR was reviewed for an identified time period in 2018, and indicated that resident #003 did not receive the intervention on an identified day. RPN #105 was interviewed and confirmed that identified intervention nor an alternative was provided to the resident, as it was not available in the home on the identified date.

C) Resident #004 had a plan of care indicating they had an identified diagnosis and had altered skin integrity. The resident had an order for an intervention to promote healing of altered skin integrity. EMAR was reviewed for an identified month and indicated that the identified intervention was not provided to the resident on four different dates during that month. The progress notes from the identified time period stated that the intervention was not available and no alternative was provided. The interview with RPN #105 confirmed that the identified intervention was not available in the home and no other alternative was provided to the resident.

Interviewed the Registered Dietitian and they stated that if the identified intervention was not available the staff were informed to provide an alternative intervention.

The Director of Resident Services (DoRS) was interviewed, and confirmed that the identified intervention was not available in the home for the identified time period and the staff were instructed to provide an alternative to residents that required it. The DoRS stated that the residents should have received the alternative on those days.

The licensee failed to ensure that the care specified in the plan was provided to residents

#001, #003 and #004 as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care for residents #001 and #002 was provided to the residents as specified in the plan.

A) Plan of care for resident #001 indicated they had an identified diagnosis and required a specific monitoring of their condition as indicated in the physician order written on an identified date in 2018.
The written plan of care reviewed for the identified time period, stated to monitor for signs and symptoms of the identified condition. The written plan of care stated that symptoms were to be immediately reported to registered staff and registered staff to assess, notify Medical Director (MD) and administer treatment as ordered.

EMAR was reviewed for an identified month in 2018, and indicated that on an identified date the resident was monitored and the test indicated a reading indicative of identified symptoms of the condition. Clinical records indicated that the resident was re-assessed and the reading did not change. There was no evidence that the physician was notified after the resident was re-assessed. RPN #103 who worked on the identified day was interviewed and stated that they did not notify the physician when the resident's symptoms of the condition were present. They stated that there was no need, since the resident was on regular treatment of the condition and no other symptoms were present.

The interview with the DoRS confirmed that the physician was not notified and should have been called right away when the symptoms of the condition were present, as per the plan of care.

B) The plan of care for resident #002 indicated they had an identified diagnosis. The current written plan for care stated to avoid episodes of the identified condition and to monitor for signs and symptoms. The written plan of care also stated that symptoms were to be immediately reported to registered staff and registered staff to assess, notify MD and administer treatment as ordered.
The clinical records indicated that the resident's condition was assessed on an identified date in 2019, and the reading was indicative of the identified symptoms of the condition. There was no documentation indicating that the resident was re-assessed and no evidence as to what actions were taken; the physician was not notified. RPN #108 who assessed the resident on that day, was interviewed, and stated that the resident was on regular treatment and there was no medical directive in place which would give specific direction as to what action to take in this case. The RPN stated that the physician was

not notified.

The home's identified policy, section 4.13, revised on February 2007, indicated that when a resident has a high reading of the identified condition, and if it remains high the Nurse must contact the Attending Physician to notify them of the change. A resident with the identified condition may look perfectly well or they may appear unwell. If the reading of the identified condition remains high for a long time, the person can become sick, fall into a coma, or even die.
If the identified reading of the test is greater than the identified number increase intake of water, offer two or more glasses of water, recheck it in 15 minutes, repeat water intake, notify physician.

The manufacturer's instructions for the identified test stated if the test result is above a specific value, or you see HI on the display, call your health care professional as soon as possible.

The licensee failed to ensure that the care set out in the plans of care for residents #001 and #002 was provided to the residents as specified in the plan related to management of the identified condition. [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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 12th day of June, 2019

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

Original report signed by the inspector.