Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 4, 2013	2013_250511_0003	H-000791-13	Complaint

Licensee/Titulaire de permis

PARKVIEW HEALTH CARE PARTNERSHIP (THE)
284 SUNSET DRIVE, OAKVILLE, ON, L6L-3M4

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

ROBIN MACKIE (511), LISA VINK (168)

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): December 3, 2013.

This inspection was also conducted with Inspector Irene Pasel.

During the course of the inspection, the inspector(s) spoke with wound care nurse, registered nurse, personal support workers and residents.

During the course of the inspection, the inspector(s) observed the provision of care for residents with altered skin integrity, reviewed relevant policy and procedures and clinical records of specified residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. (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 care set out in the plan of care was not provided to the resident as specified in the plan.

Directions for staff at the bedside for resident #002 indicated the air flow mattress was to be set at a specific pressure and interval. The mattress was observed to be set at an incorrect pressure on December 3, 2013, at 1050 hours and 1550 hours. Interview with the wound care nurse confirmed directions for the setting on the air flow mattress would be located at the bedside on the unit. [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 the care set out in the plan of care is provided to the residents as specified in the plans, 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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was not reassessed at least weekly by a member of the registered nursing staff.

Resident #003 had a history of skin breakdown. The resident had an area of altered skin integrity intermittently between September and December 3, 2013. This area was not consistently reassessed at least weekly by a member of the registered nursing staff, which was confirmed during an interview with the wound care nurse. [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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee did not ensure that the resident's written record was kept up to date at all times.

On review of the records for resident #002 it was identified the written record was not kept up to date to indicate the change to treatment of wounds, on the resident's return from hospital. Interview with the registered nurse confirmed she had not included into the clinical record the late entry of November 26, 2013, identifying the change in treatment of the wounds, at the time of the inspection. The registered nurse confirmed she had two conversations with the power of attorney regarding the changes to the plan of care upon the resident's return from hospital but did not ensure the written record included these discussions. [s. 231. (b)]

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Issued on this 4th day of December, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
LVink- RMackie I.Pasel