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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 14, 2017	2017_619550_0008	032579-16	Complaint

Licensee/Titulaire de permis

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 Russell Road OTTAWA ON K1G 5Z6

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

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 RUSSELL ROAD OTTAWA ON K1G 5Z6

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

JOANNE HENRIE (550)

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): February 28, March 1 and 2, 2017.

This Complaint Inspection is related to a complaint regarding skin and wound care.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing Operations, a Resident Care Manager, the Director of Clinical Practice, a Registered Dietician, Registered Nurse (RN), Personal Support Worker (PSW) and a family member.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs change or care set out in the plan is no longer necessary.

An anonymous complaint was submitted to the Director at the Ministry of Health and Long Term Care on a specified date in 2016, regarding skin and wound issues to residents.

Inspector #550 reviewed resident #002’s health care records and observed documented in the progress notes on a specified date that the resident had developed a stage 2 pressure ulcer to a specific body part. On another specified date, approximately three months later, another progress note indicated that the stage 2 pressure ulcer had progressed to a stage 4 pressure ulcer.

The inspector noted that there were no notes documented in the progress notes regarding the resident’s pressure ulcer to a specific body part for a specified period of time. A review of the resident’s plan of care dated a specified date in 2016 revealed that there was no indication of the presence of a pressure ulcer to the specified body part.

During an interview on March 2, 2017, RN #100 and the Resident Care Manager #101 indicated to the inspector that when resident #002's care needs changed when he/she developed a stage 2 pressure ulcer to a specified body part, his/her plan of care was not reviewed and revised. [s. 6. (10) (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 residents who are exhibiting skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed and their plan of care reviewed and revised when the residents' care needs change, 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 the resident 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.

An anonymous complaint was submitted to the Director at the Ministry of Health and Long Term Care on a specified date in 2016, regarding skin and wound issues to residents.

Inspector #550 reviewed the health care records of three residents selected from a list of residents with skin and wound issues provided by the home.

It was documented in resident #002's progress notes on a specified date in 2016, that the resident was identified as having a stage 2 pressure ulcer to a specific body part. On another specified date in 2016, approximately three months later, the stage 2 pressure ulcer had progressed to a stage 4 pressure ulcer. The inspector was unable to find any documentation indicating that resident #002 received a skin assessment using a clinically

appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #003 was admitted to the home on a specified date in 2017 and identified as having a stage 4 pressure ulcer to a specific body part amongst other medical issues. The resident's actual plan of care dated a specified date in 2017 indicated that the resident had an ulcer to a specific body part and staff were to apply a specific antiseptic solution twice daily. The latest MDS assessment dated a specified date in 2017 indicated that the resident had a stage 4 stasis ulcer to a specific body part. Inspector #550 reviewed the resident's health care records and was unable to find documentation indicating that the resident had been assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A progress note on a specified date in 2015 in resident #004’s health care records indicated resident #004 was identified by a registered staff as having two stage 1 pressure ulcers; one on two specific body parts. A review of the resident's current plan of care dated a specified date in 2017 indicated that the resident had a stage X pressure ulcer to two specific body parts, to ensure the resident was wearing an identified pressure relieving equipment at all times, to protect skin from any pressure and incontinence and to turn and reposition with skin care every 2 hours. The latest MDS assessment dated a specified date in 2017, indicated that the resident had a stage 4 pressure ulcer. Inspector #550 reviewed the resident's health care records and was unable to find any documentation indicating that the resident had been assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

During an interview on March 2, 2017, RN #100 indicated to inspector #550 that residents exhibiting pressure ulcers are to be assessed using the electronic wound assessment tool called ‘’weekly wound assessment’’ but most staffs are not using the tool; they will document in the progress notes. After reviewing resident #002, #003 and #004's health care records, RN #100 indicated to the inspector that these residents were not assessed using the electronic wound assessment tool.

The Manager for Resident Care #101 indicated that there is also a paper copy of a skin and wound assessment tool the registered staff can use to assess wounds and further indicated that neither an electronic or paper copy of the wound assessment tool was completed for resident #002, #003 and #004.

As evidenced above, residents #002, #003 and #004 who exhibited pressure ulcers did not 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. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

On a specified date in 2016, a progress note in resident #002's health care records indicated that the resident had developed a stage 2 pressure ulcer to a specific body part, that the wound was cleansed and a dressing was applied. Another progress note six days later, indicated that the resident was assessed by the Occupational Therapist and a specific pressure relieving equipment was provided. A review of the treatment administration records for a specified period of time in 2016 revealed that no further treatment had been done to treat the pressure ulcer after the initial treatment. A review of the resident's plan of care at the time the pressure ulcer was discovered, indicated that no other interventions were put in place to promote healing and prevent infections.

During an interview on March 2, 2017, RN #100 and Resident Care Manager #101 indicated to the inspector that there was no indication that any treatment had been done for the resident's pressure ulcer for a specified period of time in 2016. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure that the resident who is 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.

An anonymous complaint was submitted to the Director at the Ministry of Health and Long Term Care on a specified date in 2016, regarding skin and wound issues to residents.

Inspector #550 reviewed resident #002’s health care records and observed documented in the progress notes a specified date in 2016, that the resident had developed a stage 2 pressure ulcer to a specific body part. On another specified date, approximately three months later, another progress note indicated that the stage 2 pressure ulcer had

progressed to a stage 4 pressure ulcer. A review of the progress notes revealed that the resident was not reassessed weekly by a member of the registered staff after the initial assessment of the wound on a specified date in 2016, until another specified date in 2016.

Resident #004 was identified has having a stage 1 pressure ulcer on two specific body parts on a specified date in 2015. A review of the resident's current plan of care dated a specified date in 2017 indicated that the resident had a stage X pressure ulcer to two specific body parts. Inspector #550 reviewed the resident's health care records for a specified period of time and noted that the resident was not assessed weekly by a member of the registered nursing staff other than on a specified date in 2017.

During an interview on March 2, 2017, RN #100 and the Resident Care Manager #101 indicated to the inspector that residents #002 and #004 were not reassessed weekly by a member of the registered nursing staff and indicated that they should have been reassessed at least weekly. [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 that residents who are 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, receive immediate treatment and interventions and are reassessed weekly, to be implemented voluntarily.

Issued on this 14th day of March, 2017

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

Original report signed by the inspector.