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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 13, 2015	2015_325568_0017	011669-15	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF RIVERSIDE GLEN
60 WOODLAWN ROAD EAST GUELPH ON N1H 8M8

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

DOROTHY GINTHER (568)

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): June 12 & 15, 2015

The CI log #011729-15 pertaining to this complaint was completed as part of the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Nursing, Neighborhood Coordinator, two Registered Practical Nurses, and five Personal Care Aides.

The Inspector also observed care being provided to the identified resident and other residents on the neighborhood, reviewed the identified resident's clinical record, related home policies and procedures; and the investigation notes for the critical incident.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
3 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance

of abuse and neglect of residents is complied with.

The Home's policy entitled Prevention of Abuse in Long-Term Care approved January 15, 2015, under the section PROCEDURE - Team leader and/or Charge Nurse revealed:
Any Team member with reasonable grounds to suspect that any type of abuse or neglect has occurred, or may occur, must immediately report. Upon receiving a report of suspected abuse, the Team member would immediately involve their Charge Nurse and/or Neighborhood Coordinator. If after hours the Team would advise the On-Call leadership Team member and would report the incident to the Ministry of Heath and Long Term Care.

Record review and staff interview indicated that the Team Lead and Neighborhood Coordinator were notified that resident #001 had several areas of altered skin integrity. Records indicated that the resident had shared with family that they had been grabbed roughly by staff.

Review of the home's investigation notes revealed that prior to the home being notified, a Personal Care Aide noted an area of altered skin integrity during the resident's bath. The staff member notified the Registered Practical Nurse immediately and the nurse applied a dressing to the area. According to the staff member's statement, the resident had advised them that someone had been rough with them which resulted in the altered skin integrity.

Interview with a second Personal Care Aide (PCA) revealed that while providing care for resident #001 they observed several areas of altered skin integrity. The PCA indicated that they reported the altered skin integrity to the Registered Practical Nurse. Staff interview with a third PCA revealed that while providing care for resident #001 they noticed several areas of altered skin integrity. When asked, the resident reported that they were unsure how it happened. The staff member shared that they did not report the altered skin integrity at that time, as they assumed it had already been reported.

Interview with a Registered Practical Nurse revealed that a PCA had reported to them that resident #001 had several areas of altered skin integrity. The staff member reported that it was a busy day and they did not have a chance to assess the resident. There was no documentation in the resident's clinical records of the altered skin integrity reported to registered staff by the two Personal Care Aides. Documentation and staff interviews confirmed that the altered skin integrity and resident reports that they were treated

roughly by staff, were not reported to the Charge Nurse and/or Neighborhood Coordinator prior to the home being notified by family.

The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

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 written policy that promotes zero tolerance of abuse and neglect of residents is complied with, 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 failed to ensure that 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.
(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.

Record review revealed that resident #001 had an area of altered skin integrity. The Treatment Administration Record indicated that dressing changes were conducted on five subsequent dates.

The home utilized a Wound Assessment Tool adapted from the BWAT/Bates-Jansen Wound Assessment Tool. Record review did not identify a Wound Assessment and there was no referral, progress notes or assessment by the Registered Dietitian (RD) related to the area of altered skin integrity. There was no documentation that the altered skin integrity was re-evaluated for a three week period.

During an interview with the Assistant Director of Nursing / Wound Care lead they acknowledged that there was no record that the area of altered skin integrity identified for resident #001 had been assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments. They also confirmed that the RD had not assessed the resident with regards to the identified altered skin integrity; and it was not assessed weekly by the registered staff. [s. 50. (2) (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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds; 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; is assessed by a registered dietitian, and is 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. 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. This finding of non-compliance was previously issued as a compliance order during the Resident Quality Inspection initiated May 11, 2015. The complaint inspection was completed prior to the compliance due date of June 30, 2015.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with

The home's policy entitled Wound/Skin Care approved January 9, 2015, outlines the following under Assessment:

On an ongoing basis, the Personal Care Aide (PCA) would complete the Skin Assessment, typically on each bath day and record on the resident's Flow Sheets if no concerns needed to be addressed. If there was a concern, it would be documented using the Twice Weekly Skin Assessment Form and a Skin Assessment Concern Form would be completed and given to the Registered Team Member.

Record review and staff interview revealed that the Team Lead and Neighborhood Coordinator were notified that resident #001 had several areas of altered skin integrity.

Review of the clinical record indicated that the Twice Weekly Skin Assessment for resident #001 had not been completed for four weeks.

Review of the home's investigation notes revealed that prior to the home being notified, a Personal Care Aide noted an area of altered skin integrity during a resident's bath. The staff member notified the Registered Practical Nurse immediately and the nurse applied a dressing to the area. During an interview with the PCA they acknowledged that a Skin Assessment Concern form had not been completed for the area of altered skin integrity. The PCA also acknowledged that the Twice Weekly Skin Assessment had not been completed for resident #001 at the time of their bath.

Interviews with three other PCA's revealed that when they identify any type of skin issue including bruising, skin tears or pressure ulcers they are suppose to alert registered staff and complete a Skin Assessment Concern Form. The three staff indicated that they had observed altered skin integrity on resident #001 but they had not completed the required Skin Assessment Concern Form.

The Assistant Director of Care confirmed that staff did not follow the home's Skin/Wound Care policy in terms of completing the Skin Assessment Concern Form when a skin issue was identified, completing the Twice Weekly Skin Assessment at the time of a resident's bath, and notifying the Power of Attorney of any new skin issues. [s. 8. (1) (b)]

Issued on this 27th day of July, 2015

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

Original report signed by the inspector.