Ontario

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 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
Jul 30, 2019	2019_727695_0020	011893-19	Complaint

Licensee/Titulaire de permis

Sharon Farms & Enterprises Limited
108 Jensen Road LONDON ON N5V 5A4

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

Strathcona Long Term Care
720 Princess Street MOUNT FOREST ON N0G 2L3

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

FARAH_ KHAN (695)

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): July 18, 19, 23, 24, and 25.

During the course of the inspection, the following complaints were inspected: Intake #011893-19, related to concerns with skin and wound care.

During the course of the inspection the inspectors toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: clinical records, and policies and procedures.

During the course of the inspection, the inspector(s) spoke with family members, personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), the Nurse Manager, the two co-Director of Cares (DOC), and the Administrator.

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.
- **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 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 and resident #005 who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound.

1) Resident #001 was in the home for a specified period of time in 2019. A complaint received by the Ministry of Long-term Care (MLTC) stated that the resident developed a few areas of altered skin integrity during their stay at the home. The complainant explained that the resident experienced increased pain due to the development of these new skin conditions.

i) A record review of the progress notes showed that a specific area of altered skin integrity developed on a specific date during the residents stay in the home. There were no skin assessments completed in relation to this area of altered skin integrity.

The Nurse Manager confirmed that registered staff were expected to complete a Skin and Wound assessment when a new area of altered skin integrity was identified and that it was not completed for this specific area on resident #001.

ii) A record review of the progress notes showed that on another specified date, staff discovered that resident #001 had two more areas of altered skin integrity. There were no Skin and Wound assessments completed for these areas on resident #001.

The Nurse Manager confirmed that registered staff did not complete the Skin and Wound assessment as required for the two new areas of altered skin integrity on resident #001.

2) A physician order on a specific date in 2019, provided new orders for wound care to a specific area of altered skin integrity on resident #005. Upon review of the resident's Electronic -Treatment Administration Record (E-TAR), there was documentation that staff were completing wound care to this area of altered skin integrity for almost one month. There were no progress notes found regarding when this area was first found. There was no assessment found for this area of altered skin integrity.

Personal Support Worker (PSW) #108 acknowledged that the resident had the specific area of altered skin integrity.

The Nurse Manager acknowledged that the Skin and Wound assessment was not completed for this area of altered skin integrity to resident #005.

The licensee has failed to ensure that resident #001 and resident #005 who exhibited altered skin integrity, received a skin assessment by a member of the registered nursing staff for each area, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure the resident exhibiting altered skin integrity received interventions to promote healing as required.

Resident #001 was in the home for a specific period of time in 2019. A complaint received by the MOLTC stated that a specific area of altered skin integrity worsened during their stay at the home.

According to the admission skin assessment, the resident had altered skin integrity to

this specific area upon admission. There were instructions on the E-TAR to provide wound care on two specific days per week. On one of the required dates, it was documented that the task was delegated to a PSW. On another required date, it was left blank and not signed off as completed. In addition, there were no progress notes to indicate the wound care was completed for the area of altered skin integrity on that specific date.

The Administrator acknowledged that according to the E-TAR, the wound care was not completed on that required date.

The licensee failed to ensure that woundcare for resident #001's specific area of altered skin integrity was completed on a required date, as specified in their plan. [s. 50. (2) (b) (ii)]

3. The licensee failed to ensure that resident #001 and resident #005 who had areas of altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff.

1) Resident #001 was in the home for a specific period of time in 2019. A complaint received by the MLTC stated that a specific area of altered skin integrity worsened during their stay at the home.

The resident's skin assessment was completed on admission and another assessment was completed a week after that for this specific area of altered skin integrity. The following week, the skin assessment was due to be completed as per the TAR and was not signed off. The skin assessment could also not be found for that particular week.

The Nurse Manager acknowledged that the skin assessments for that specific area of altered skin integrity to resident #001 was expected to be completed on a specific day of the week and there was no assessment completed for one of those specified dates.

2) A physician order from a specific date in 2019, provided new orders for wound care to a specific area of altered skin integrity on resident #005. There were no progress notes found regarding when the area was first found. There was no weekly skin assessment found for this area of altered skin integrity.

Upon review of the weekly skin assessments completed for another area of altered skin

integrity, the pictures also showed that this specific area of altered skin integrity was present for almost two months.

PSW #108 acknowledged that the resident had this specific area of altered skin integrity.

The Nurse Manager acknowledged that skin assessments were expected to be completed weekly for areas of altered skin integrity and that a weekly skin assessment was not completed for this specific area of altered skin integrity to resident #005.

The licensee failed to ensure that resident #001 and resident #005 who had areas of altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

4. The licensee failed to ensure that resident #001 who was dependent on staff for repositioning was repositioned every two hours.

A complaint was received regarding concerns that resident #001 developed three areas of altered skin integrity during a stay at the home in 2019, and that a pre-existing area of altered skin integrity worsened. The complainant stated they were told by the home when the resident was being discharged, that the reason the areas developed was because the family informed the home that the resident liked to lie in a particular position while in bed and therefore the resident was kept in that position. The complainant stated that they were not informed of the potential implications to the resident's skin condition.

According to the Resident Assessment Instrument - Minimum Data Set (RAI MDS), resident #001 required assistance with their activities of daily living including bed mobility, toileting and locomotion. The resident had one area of altered skin integrity upon admission to the home.

The progress notes indicated that a family member had a conversation with the DOC upon admission stating that the resident liked to lie in a particular position. The DOC agreed to inform staff. There was no indication of whether there was a discussion about the possible implications to sleeping in one position for a prolonged period of time. There was also no documentation in the resident's plan of care or point of care (POC), where the PSWs document, that the resident was turned and repositioned during their stay in the home.

PSW #108 stated that the resident would spend long periods of time during the day in

bed and that they would not turn the resident due to the instructions on top of the bed to keep the resident in a particular position.

According to a progress note documented approximately nine days into the resident's stay at the home, there was a new area of altered skin integrity found to a specific area on resident #001. The area was treated, however, the cause was not reviewed and the resident continued to lie in the same position. The day before discharge, the specific area of altered skin integrity was noted to have worsened and two more new areas were found. The note on the day of discharge stated that the three new areas of altered skin integrity were likely due to the fact that resident #001 continued to lie in one position.

According to a complaint log record from the home, the DOC acknowledged to the family that staff could have used better judgement to turn and reposition the resident.

The Administrator acknowledged that there was no evidence that the resident was turned and repositioned during their stay in the home. In addition, the Administrator acknowledged there was no evidence that a discussion took place with the family regarding the potential concerns of the resident continuously lying on one side for long periods of time.

The licensee failed to ensure that resident #001 who was dependent on staff for repositioning was repositioned every two hours. [s. 50. (2) (d)]

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 who exhibits altered skin integrity 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;
the resident exhibiting altered skin integrity receives interventions to promote healing as required.
the resident who exhibits altered skin integrity is reassessed at least weekly by a member of the registered nursing staff, when clinically indicated;
and the resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated, to be implemented voluntarily.

Issued on this 8th day of August, 2019

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

Original report signed by the inspector.