Ontario

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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 8, 2019	2019_486653_0002	010497-17, 012230-17, 018052-17, 027910-18	Complaint

Licensee/Titulaire de permis

City of Toronto
365 Bloor Street East 15th Floor TORONTO ON M4W 3L4

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

Seven Oaks
9 Neilson Road SCARBOROUGH ON M1E 5E1

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

ROMELA VILLASPIR (653)

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): January 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 29, 30, 31, February 1, and 4, 2019.

During the course of the inspection, the following complaint intakes had been inspected:
-Log #(s): 010497-17, 012230-17, and 027910-18, related to skin care, plan of care, continence care, nutrition and hydration, and medications;
-Log #018052-17 related to a medication incident.

During the course of the inspection, the inspector conducted observations of resident care provision, staff to resident interactions, reviewed staff schedule, clinical health records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist (PT), Occupational Therapist (OT), Registered Dietitian (RD), Nurse Manager Clinical (NMC), Nurse Managers Operational (NMOs), Social Worker (SW), and the Director of Nursing (DON).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 had failed to ensure that the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint related to resident #004's care in the home. The complainant indicated the home never updated resident #004's Substitute Decision-Maker (SDM) in regards to their condition.

During a telephone interview, the complainant indicated on an identified time period, the registered staff were administering an identified treatment to the resident, that the SDM was not made aware of.

An interview with Registered Practical Nurse (RPN) #107, indicated that when new physician orders were received, registered staff were to notify the resident's SDM, initial on the box for "POA notified" on the physician orders form, and document on progress notes that the SDM had been notified.

A review of resident #004's original physician orders form revealed on an identified date, the attending physician ordered an identified treatment, discontinued it after an identified number of days, and ordered a new treatment. Further review of both orders revealed that the box for "POA notified" had not been signed off by the registered staff who processed the orders.

A review of resident #004's progress notes from an identified period, did not identify documentation indicating the SDM had been notified of the new orders.

During an interview, the Director Of Nursing (DON) reviewed resident #004's above mentioned physician orders form and progress notes and acknowledged that the SDM was not notified when the attending physician had ordered the identified treatments.

The licensee had failed to ensure that resident #004's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

2. The licensee had failed to ensure that the care set out in the written plan of care was provided to the resident as specified in the plan.

The MOHLTC received a complaint related to resident #004's care in the home. The complainant indicated the home never updated resident #004's SDM in regards to their condition.

During a telephone interview, the complainant had mentioned that the SDM had a discussion with the attending physician on an identified time period, regarding medications that resident #004 would be receiving. The complainant indicated the SDM was not updated whether the resident had received the medications or not.

A review of resident #004's original physician orders form revealed on an identified date, the attending physician ordered to give the resident an identified medication.

A review of resident #004's MARs from an identified time period, revealed that the order for the identified medication had been transcribed, however, there was no documentation that it had been administered. A review of resident #004's identified record form did not identify documentation that the medication had been administered.

An interview with the DON indicated that the home supplied the identified medication, and acknowledged that based on the records presented, the identified medication was not administered to resident #004 as specified in the plan of care.

The licensee had failed to ensure that the care set out in the written plan of care was provided to the resident as specified in the plan. [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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, and;
-that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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. The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy, or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

According to O. Reg. 79/10, s. 48 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

According to O. Reg. 79/10, s. 30 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

A review of the home's policy titled "Skin Care and Wound Prevention and Management" policy #RC-0518-02 published on January 4, 2016, indicated the following under treatment for protocol c: (for identified altered skin integrity): Referral to the Enterstomal Nurse for treatment recommendations and High Intensity Needs assessment.

A review of the home's policy titled "Enterstomal Therapy Services" policy #RC-0518-26 published on January 4, 2016, indicated the homes will develop and maintain a process to access High Intensity Needs funding through Enterstomal Therapy specialty services.

The MOHLTC received three separate complaints related to resident #004's skin care.

A review of resident #004's progress notes revealed the resident was sent to the hospital on an identified date, and returned to the home with an alteration in skin integrity. Further review of the resident's progress notes revealed the attending physician had seen resident #004 on an identified date, and noted they had an identified alteration in skin integrity.

An interview with RPN #107 indicated the Enterstomal (ET) nurse would be involved if the area of altered skin integrity worsened or in identified situations. The registered staff would send a referral to the Skin Care Co-Ordinator (SCC) and the SCC would refer the resident to the ET nurse.

During an interview with Registered Nurse (RN) #100, the inspector asked when would the ET nurse be involved with a resident's skin care. The RN indicated that the registered staff would notify the SCC that the area of altered skin integrity was not healing, and to refer the resident to the ET nurse.

During an interview, the DON acknowledged that resident #004 was not referred to the ET nurse as required by the home's policy.

The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy, or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with. [s. 8. (1) (b)]

2. According to O. Reg. 114 (2), The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A review of the Medical Pharmacies' policy titled "Medication Administration Record" policy #8-1 dated February 2017, indicated the following: Chart all medications administered by signing your initials in the appropriate box corresponding to correct medication, date, and time on the MAR sheet.

During a telephone interview, the complainant had mentioned a medication incident that had occurred on an identified date, wherein a registered staff had allegedly administered medications to resident #004 outside of the prescribed time.

A review of resident #004's Medication Administration Record (MAR) revealed a missing signature on an identified date for an identified medication.

During an interview, RPN #116 confirmed they had worked on the identified date, and that they had forgotten to sign off on the MAR after administering resident #004's identified medication. The RPN further indicated they had received a discipline letter and was suspended at the time due to the incident.

During an interview, the DON confirmed that RPN #116 did not comply with the home's policy when they had forgotten to sign off on the MAR after administering resident #004's medication. The DON further indicated that the home's expectation was for the registered staff to sign the MAR immediately after providing the medication.

The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy, or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with. [s. 8. (1) (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 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, that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

An interview with Nurse Manager Clinical (NMC) #103 indicated resident #004 had been under the home's skin care program.

A review of resident #004's progress notes revealed the resident was sent to the hospital on an identified date, and returned to the home with an alteration in skin integrity. Further review of the resident's progress notes revealed the attending physician had seen resident #004 on an identified date, and noted they had an identified alteration in skin integrity.

Separate interviews with RPNs #102, #107, and RN #100 indicated that the registered staff were supposed to initiate the identified section on the resident's written plan of care

upon discovery of the alteration in skin integrity. RPNs #102 and #107 stated that the section would include the location and cause of the alteration in skin integrity, as well as interventions and the prescribed nutritional supplements. RN #100 indicated the section on the written plan of care should indicate when the treatments and assessments would be done, the goal that the alteration in skin integrity would be reduced or healed, and evaluation of the progress of the alteration in skin integrity, the effectiveness of interventions and the resident's responses to the interventions.

A review of resident #004's written plan of care obtained from Goldcare revealed that the section related to their alteration in skin integrity had only been initiated six months after it had been discovered.

During an interview, the DON acknowledged the above mentioned information and that the section related to the resident's alteration in skin integrity on their written plan of care had only been initiated six months after it had been discovered. The DON further indicated that the home's expectation was for the registered staff to document the following on the written plan of care: the stage of the alteration in skin integrity and interventions such as treatments, nutrition, method of transferring, and turning and repositioning. The DON further indicated the above mentioned must be initiated immediately upon the discovery of the alteration in skin integrity.

The licensee had failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: 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 had failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of resident #004's progress notes revealed the resident was sent to the hospital on an identified date, and returned to the home with an alteration in skin integrity. Further review of the resident's progress notes revealed the attending physician had seen resident #004 on an identified date, and noted they had an identified alteration in skin integrity.

A review of the home's policy titled "Skin Care and Wound Prevention and Management" policy #RC-0518-02 published on January 4, 2016, indicated under procedure for RN/ RPN to: Reassess all identified areas using the identified assessment record weekly or more frequently as indicated.

An interview with RPN #102 indicated that the identified alteration in skin integrity was assessed at least once a week and the TAR would indicate weekly assessments and the day of the week it had to be done. The RPN further indicated the registered staff would assess the alteration in skin integrity using the identified assessment record, sign off the box on the TAR, document on the progress note sheet attached to the TAR, as well as on the progress note in the resident's chart. The RPN stated that the registered staff would fill out the identified assessment form, indicate the measurement, location, depth, and colour of the alteration in skin integrity.

A review of resident #004's health records including their progress notes, TAR, and the identified assessment record forms from an identified time period, revealed the weekly assessments on the alteration in skin integrity were only completed on four identified dates.

An interview with NMC #103 indicated that the identified alteration in skin integrity required weekly assessments using the identified assessment record. Inspector #653 asked the NMC to find documentation of resident #004's assessment records from an identified time period, and the NMC provided the same sheet the inspector initially found through record reviews. The identified assessment record only had documented assessments from four identified dates.

During an interview, the DON reviewed the above mentioned health records with the inspector, and acknowledged there was no documentation to support that resident #004's alteration in skin integrity had been reassessed at least weekly by a member of the registered nursing staff for an identified period of time.

The licensee had failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)]

2. The licensee had failed to ensure that the resident who was dependent on staff for repositioning had been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

A telephone interview with the complainant indicated resident #004 was admitted to the

home with an alteration in skin integrity that had worsened in the home. The complainant further indicated that staff were not turning and repositioning the resident every two hours as required which had contributed to the worsening of their alteration in skin integrity.

A review of resident #004's written plan of care for indicated they required an identified number of staff for bed mobility and for repositioning in their assistive device.

A review of resident #004's progress notes revealed the resident was sent to the hospital on an identified date, and returned to the home with an alteration in skin integrity. Further review of the resident's progress notes revealed the attending physician had seen resident #004 on an identified date, and noted they had an identified alteration in skin integrity.

An interview with RPN #102 stated the turning and repositioning schedule would be indicated in the written plan of care.

Separate interviews with RPN #107 and RN #100 indicated the turning and repositioning schedule would be indicated on the TAR sheet for days, evenings, and nights, and the registered staff had to sign for it.

A review of resident #004's written plan of care obtained from Goldcare revealed that the section related to their alteration in skin integrity had only been initiated six months after it had been discovered.

A review of resident #004's progress notes for an identified time period revealed sporadic documentation by the registered staff of the resident being turned and repositioned every two hours.

A review of resident #004's TAR from an identified time period did not indicate the resident had to be repositioned every two hours.

During an interview, the DON acknowledged the above mentioned information from record reviews and staff interviews and indicated that education to staff needed to be done. The staff automatically perceived that an identified mattress was turning the resident in bed, however, the staff still needed to turn the resident every two hours.

The licensee had failed to ensure that the resident who was dependent on staff for repositioning had been repositioned every two hours or more frequently as required

depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated. [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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated and;
-that 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that the staff participated in the implementation of the infection prevention and control program.

On an identified date and time, Inspector #653 conducted an observation of resident #004's skin care treatment carried out by RN #100. The inspector noted the RN used an identified disposable treatment tray package for the procedure. The label on the package identified the supplies and their quantity.

In the middle of the procedure, the inspector noted RN #100 had taken out an identified number of supplies from the third drawer of resident #004's bedside table and used them during the treatment in addition to the three identified supplies from the package they had been using. After completing the identified treatment, the RN discarded the disposable treatment tray package they had used with the exception of the identified supplies. When asked by the inspector how they normally discarded the identified supplies, RN #100 indicated they wash the them with liquid soap and water and reuse them for another week. Inspector #653 noted an identified number of supplies had been washed by the RN with liquid soap and water in resident #004's washroom.

At an identified time, the DON entered the resident's room and the inspector asked the DON in regards to the use of the disposable treatment trays, particularly reusing the identified supplies. The inspector showed the DON the identified supplies that RN #100 had washed with soap and water, with the RN present in the room. The DON indicated that the disposable treatment trays were only for single use as indicated on the package, and that the identified supplies were not supposed to be washed and reused in keeping with the implementation of the infection prevention and control program in the home.

The licensee had failed to ensure that the staff participated in the implementation of the infection prevention and control program. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 13th day of March, 2019

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

Original report signed by the inspector.