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 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
Dec 22, 2016	2016_325568_0028	032702-16	Resident Quality Inspection

Licensee/Titulaire de permis

SOUTHAMPTON CARE CENTRE INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

SOUTHAMPTON CARE CENTRE
140 Grey Street P.O. Box 790 Southampton ON N0H 2L0

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

DOROTHY GINTHER (568), REBECCA DEWITTE (521)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 28, 29, 30, 2016 and December 1, 2016

A Critical Incident # 2597-000003-16 log # 009893-16 related to falls was conducted in conjunction with the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care, RAI Coordinator, Maintenance Manager, Food Services Manager, Programs Manager, two Registered Nurses, two Registered Practical Nurses, three Personal Support Workers, one Housekeeper, a Resident Council representative, Family Council representative, residents and their families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing

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	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 licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of the Minimum Data Set (MDS) Assessment and related Resident Assessment Protocol (RAP) for resident #022 indicated that they had an area of altered skin integrity. The Treatment Administration Record (TAR) identified that a specific treatment was to be provided every four days commencing on a specific date.

During a review of the TAR, there was no documentation to indicate that the prescribed treatment was provided on four of the fourteen treatment days over a two month time period.

During an interview with the Assistant Director of Care (ADOC) #107, they indicated that staff were expected to sign off on the TAR when a treatment was provided. If the treatment was not provided, there should be some kind of corresponding documentation to indicate the reason that the treatment was not provided. The ADOC #107 acknowledged that the plan of care with respect to treatment for resident #022's altered skin integrity was not provided to the resident as outlined 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 care set out in the plan of care was 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's policy entitled "Falls Prevention and Management - Program" revised May 27, 2016 indicated that for a resident who has a fall a Head Injury Routine would be initiated if the head injury was evident. All un-witnessed falls would result in a Head Injury Routine being initiated unless the resident was capable of reliably communicating that they did not hit their head.

a) Record review identified that resident #006's cognition was severely impaired based on the cognitive performance scale (CPS) on their most recent Minimum Data Set (MDS) assessment. Records also identified that the resident had two un-witnessed falls in the last six months.

Observations of resident #006 during the inspection revealed that the resident's communication was impaired.

A review of resident #006's plan of care identified that the resident was not able to communicate reliably. Post- fall documentation indicated that resident #006 did not have a head injury assessment completed following the two un-witnessed falls.

During an interview with the Assistant Director of Care (ADOC) #107, they confirmed that resident #006 was not able to communicate reliably and did not receive a head injury assessment following the two un-witnessed falls. The ADOC #107 further reported that it was the homes expectation that when a resident had an un-witnessed fall and the resident was not reliable, a head injury assessment should be conducted. (521)

b) Record review identified resident #021 as being moderately impaired with respect to their cognition based on the most recent MDS assessment. The plan of care indicated that resident #021 was a high risk for falls characterized by their history of falls, poor judgement, impaired balance and unsteady gait.

During a review of resident #021's falls since their admission it was noted that the resident had multiple un-witnessed falls. Head injury assessments post fall were not conducted for all but one fall based on the resident's report that they did not hit their head. Progress notes related to the un-witnessed falls indicated on more than one occasion that the resident could not recall the circumstances of the fall and that they were sometimes dizzy.

During an interview with the Assistant Director of Care (ADOC) #107 they shared that registered staff make a judgement call when determining if a resident was reliable when communicating the circumstances surrounding their fall. The ADOC #107 stated that they do not have specific parameters that determine whether a resident was reliable. When asked if a head injury assessment should have been completed for resident #021's un-witnessed falls given the resident's level of cognition, history of repeat falls, and difficulty remembering the circumstances surrounding several of the incidents; the ADOC #107 agreed that in some of these cases a head injury assessment should have been completed. (568)

The licensee failed to ensure that the Falls Prevention and Management policy was complied with in terms of completion of the head injury routine for un-witnessed falls. [s. 8. (1) (a),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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Record review identified that resident #006 had two un-witnessed falls. During a review of the documentation there was no evidence that a post-fall assessment was completed for either fall.

A review of the homes policy entitled "Falls Prevention and Management" revised May 27, 2016 indicated that a resident would receive a post fall assessment prior to moving a resident after a fall had occurred.

During an interview with the Assistant Director of Care (ADOC) #107 they indicated that the home implemented their new post-fall assessment in August 2016. The ADOC #107 shared that it was the homes expectation that when a resident had fallen, the resident would be assessed and a post-fall assessment conducted using a clinically appropriate assessment instrument. The ADOC #107 acknowledged that post fall assessments were not conducted for resident #006's two un-witnessed falls using a clinically appropriate assessment instrument specifically designed for falls. [s. 49. (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 when a resident has fallen, the resident is assessed and a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls, 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).

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 was specifically designed for skin and wound assessment.

Review of the most recent Minimum Data Set (MDS) assessment and associated Resident Assessment Protocol (RAP) indicated that resident #022 had an area of altered

skin integrity. Pressure relieving interventions and treatment recommendations were added to the plan of care. The Head to Toe Assessment also identified an area of altered skin integrity. There was no further assessment information related to the area of altered skin integrity.

Review of the home's policy entitled "Skin and Wound Care - Program" revised September 19, 2016, identified that a resident exhibiting altered skin integrity would receive 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 assessment.

During an interview with the Assistant Director of Care (ADOC) #107 they stated that it was the home's expectation that when an area of altered skin integrity was identified, including skin breakdown or pressure ulcers, the registered staff was to complete a Wound Assessment on Point Click Care (PCC). The ADOC #107 acknowledged that the area of altered skin integrity identified for resident #022 was not assessed by a registered staff using a clinically appropriate assessment instrument. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Review of the most recent MDS assessment and related RAP identified that resident #022 had an area of altered skin integrity.

During an interview with the Assistant Director of Care #107, they indicated that once an area of altered skin integrity was identified, including pressure ulcers, registered staff were expected to complete a weekly skin / wound assessment and document a progress note in their electronic documentation system. These assessments were to continue until the area of altered skin integrity had resolved.

Review of the home's policy entitled "Skin and Wound Care - Program" revised September 19, 2016, indicated that registered staff were to complete a wound / skin progress note, weekly, if the area of altered skin integrity was a wound or something other than a wound. This would reflect a weekly assessment of the resident related to their skin status.

During a review of the progress notes for resident #022 it was identified that weekly

wound assessments were not documented for the identified area of altered skin integrity until the area had resolved. The Assistant Director of Care #107 reviewed the skin assessment notes with Inspector #568. The ADOC #107 acknowledged that weekly skin and wound assessments had not been conducted for resident #022's area of altered skin integrity. [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 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including resident bedrooms, floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces.

During an interview with resident #001 in stage one of the Resident Quality Inspection (RQI), they identified that the home was not thoroughly cleaned, particularly the hand rails in the hallways.

Observations during stage one of the RQI identified that there was dry crusted debris, hand prints, and visible dust particles on the hand rails in the hallways throughout the building.

During an interview with Housekeeper #102 they shared that the railings were to be cleaned every Monday when there were two housekeepers on duty. The staff member acknowledged that the handrails in the hallways were not clean and there was visible crusted debris and dust.

A review of the policy entitled "Housekeeping – Cleaning Procedure – Hallways", effective July 12, 2016, revealed that hand rails were to be wiped down using disinfectant and a cloth on a daily basis.

During an interview with the Maintenance Manager # 103 they indicated that the railings were to be cleaned once per month on a Thursday when there were two housekeeping staff completing tasks under the manager's verbal direction. The Maintenance Manager #103 was not aware when the railings were last cleaned as there was no specific process in place to document the additional cleaning tasks and when they were completed. Maintenance Manager #103 confirmed that the hand rails were unclean and it was the homes expectation that procedures were developed and implemented for cleaning contact surfaces within the home. [s. 87. (2) (a)]

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 procedures were developed and implemented for cleaning of the home, including resident bedrooms, floors, carpets, furnishings, privacy curtains, contact and wall surfaces, to be implemented voluntarily.

Issued on this 4th day of January, 2017

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

Original report signed by the inspector.