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 sions 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 |
|---|---|---|---|
| Apr 25, 2016 | 2016_440210_0004 | 007323-16 | Complaint |

**Licensee/Titulaire de permis**

Stayner Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Stayner Care Centre
244 MAIN STREET EAST 7308 HIGHWAY #26, P.O. BOX 350 STAYNER ON L0M 1S0

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

SLAVICA VUCKO (210)

## 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): March 21 and 22, 2016.**

**During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Nurse, Director of Care, Administrator, reviewed the clinical record, observed provisions of care.**

**The following Inspection Protocols were used during this inspection:**
**Medication**
**Personal Support Services**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**

**4 WN(s)**
**4 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

A review of resident 001's wound care notes revealed that on an identified date, the resident had a wound on an identified part of the body, the area was slightly bruised with scant drainage and at risk for infection. The treatment provided was to cleanse the wound, apply a topical cream and dry dressing. The section for further referral to specialist was documented as not needed. Further review of the wound care notes revealed on an later identified date, a wound on another part of the body was identified to have drainage when pressure was applied. The treatment interventions directed staff to cleanse, apply a topical cream and a dry dressing. The section for further referral to specialist indicated a note was left for the Doctor in regards to the infection.

A review of the "Skin and Wound Care Program" policy, dated September 16, 2013, revealed that the registered staff will ensure that a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcer, skin tears or wounds receives prompt interventions to promote healing according to current best practice and wound care algorithms, prompt treatment and interventions to prevent infection as required, and the physician/nurse practitioner will complete medical orders of wound treatment based on current evidence and best practice, as required.

A review of the Physician's order record revealed on an identified date, the physician prescribed a treatment for the identified part of the body. The order directed staff to cleanse the wound with wound spray, apply an identified wound care product and a dry dressing daily.

A review of the progress notes on an identified date, revealed the family discussed a concern with the Administrator regarding the wound care interventions ordered for

resident #001. The Administrator agreed to arrange a further assessment by the wound care specialist as soon as possible. A review of the wound care consultation report indicated the resident's wound was assessed and new treatment interventions were recommended along with the need to off-load the identified body part.

Interview with the registered nursing staff #101 and DOC confirmed the Physician was not involved in the assessment of the resident wound until a referral was made on an identified date. Further the DOC confirmed that the home did not request a wound care specialist assessment until a later identified date. [s. 26. (3) 15.]

***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 plan of care is based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**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 protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there was a written description of the program that includes its protocols for referral of resident to specialized resources where required.

A review of the "Skin and Wound Care Program", dated September 16, 2013, revealed that registered staff will ensure that a resident with an actual alteration in skin integrity, including skin breakdown, pressure ulcer, skin tears or wounds, receives prompt interventions to promote healing according to current best practice and wound care algorithms, is referred to registered dietitian, restorative care and as appropriate to physiotherapy and/or occupational therapy. The physician/nurse practitioner will refer the resident to specialized consultation services as needed, including entero-stomal therapy, plastic surgeon etc. as needed.

A review of the wound care notes revealed on an identified date resident #001 was identified with a wound on an identified area of the body. The registered staff initiated treatment interventions but did not record these interventions in the treatment administration record (TAR)  only in the wound care notes. The wound care notes from identified dates revealed that there was no need for a further referral to a specialist. On a later identified date, an area of the wound deteriorated and a swab was sent to the laboratory. Further, the wound care notes revealed on an identified date the Physician was notified about the infection and two days later the Physician prescribed a treatment with antibiotics. A review of the progress notes and wound care consultation form revealed the wound care specialist was notified by the home's Administrator and he/she assessed resident 001's wound for the first time on an identified date, at least one month after the Physician assessed the wound, and changed the treatment because the wound had further deteriorated.

An interview with registered nursing staff #101 and DOC, who is the leader of the skin and wound care program, revealed that the section in the " Skin and Wound Care Program" referring to prompt interventions according to current best practice and wound care algorithms was not clear to registered staff in order to know when to contact the Physician or the wound care specialist for further skin and wound assessments or treatments. [s. 30. (1) 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 for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there was a written description of the program that includes its protocols for referral of resident to specialized resources where required, to be implemented voluntarily.***

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**WN #3: 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.

A review of resident #001's clinical record including the progress notes revealed on an identified date, the resident had a wound on one part of the body and an additional wound on another part of the body with drainage and a faint odor. A review of the assessment forms in Point Click Care (PCC) did not locate a clinically appropriate assessment instrument that was completed when the wound was identified.

A review of the skin and wound care program review/evaluation on June 9, 2015, revealed the registered staff to complete a "head to toe" skin assessment upon admission, quarterly and whenever there is a change in health status of the resident's skin.

A review of the policy" Skin and Wound Care program", dated September 16, 2013, revealed that registered staff will complete wound assessment and treatment record in PCC in the assessment section with initiation of impaired skin integrity and with any change in treatment for a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

Interview with the registered nursing staff and DOC indicated that the expectation is registered staff to complete a "head to toe skin assessment" form for any new impaired skin integrity, and confirmed that the same was not completed for resident #001 until approximately two months after it was identified. [s. 50. (2) (b) (i)]

***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 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.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A review of the wound care notes indicated on an identified date, a topical medication was applied to a specified body part of resident 001. A review of the physician's orders indicated there was no order for the topical medication.

Interview with registered nursing staff revealed that the topical medication was not prescribed by the Physician and confirmed that he/she was not aware that the home should obtain a Physician's order for it because it was an over the counter medication. Interview with the DOC revealed he/she was not aware how the registered nurse obtained the topical medication, in order to use it. Furthermore, he/she was unable to refer to a home policy or protocol indicating under what circumstances registered staff may apply the specified medication [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.***

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**Issued on this 28th day of April, 2016**

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

**Original report signed by the inspector.**