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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 5, 2018	2017_566669_0029	024184-17, 024298-17	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF ESSEX
360 Fairview Ave West ESSEX ON N8M 1Y6

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

SUN PARLOR HOME FOR SENIOR CITIZENS
175 TALBOT STREET EAST LEAMINGTON ON N8H 1L9

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

ANDREA DIMENNA (669)

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): October 20, 23, 24 and November 24, 2017.

The following critical incident was completed with this inspection:

M579-000052-17/log #024298-17, related to alleged abuse.

A Follow Up Inspection (Logs #022831-17 and #022832-17) for Compliance Orders #002 and #003 from the Resident Quality Inspection #2017_566669_0005, related to abuse, was completed concurrently with this inspection.

PLEASE NOTE: A Written Notification and Compliance Order under the Long-Term Care Homes Act, 2007, s.24 identified in this inspection (Log #024184-17) will be issued under a Follow Up Inspection #2017_566669_0032 (Logs #022831-17 and #022832-17) concurrently inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, the Director of Care, the Manager of Resident Services and Clinical Practice, the Manager of Building Services, three Registered Nurses (RNs), two Registered Practical Nurses (RPNs), the Laundry Charge Person, two Healthcare Aides, three Personal Support Workers (PSWs), one Wash Person, and one Housekeeper.

During the course of the inspection, the Inspector made observations of residents, activities, interactions with staff, and provisions of care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **3 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	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 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, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A Complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date, which alleged that an identified resident's treatment for an area of altered skin integrity was not being completed as required.

In the Complaint, the identified resident stated that their treatment was not being provided as frequently as it should have been.

The home's policy, Skin and Wound Care Management (#0105-03-00), last revised March 15, 2017, was reviewed and stated that a Skin and Wound Assessment on Point Click Care (PCC) was initiated and completed for all skin breakdown or pressure injuries, and that the assessments continued weekly until healed. The policy also included that it was the registered staff's responsibility to document weekly using the Skin and Wound Assessment on PCC.

A) The identified resident's Treatment Administration Record (TAR) was reviewed and included treatment for an area of altered skin integrity. The resident's skin assessments in PCC were reviewed and showed no assessments completed over a period of 20 days and over another period of 12 days for the resident’s identified area of altered skin integrity.

A RPN was interviewed and shared that skin assessments were done weekly and documented in PCC under the Skin and Wound Assessment. The RPN explained that the identified resident had an area of altered skin integrity and should have a weekly assessment until healed. The RPN reviewed the resident’s skin assessments and progress notes, and acknowledged that there should have been at least one assessment within the period of 12 days, and that two assessments were missing in the period of 20 days.

The Manager of Resident Services and Clinical Practice (MRSCP) was interviewed and explained that skin assessments were completed weekly for any area of altered skin integrity by the RPN and documented in a PCC assessment. The MRSCP clarified that the resident's identified area of altered skin integrity would be considered a skin condition that would require weekly assessments. The MRSCP checked the resident’s skin assessments and progress notes in PCC, and acknowledged that the resident did not have weekly skin assessments completed over a period of 12 days and over a period of 20 days. The MRSCP stated there was no documented reason for the identified resident not to have skin assessments during those periods.

B) A second identified resident's care plan and TAR were reviewed and included that the resident had multiple areas of altered skin integrity. The resident’s skin assessments in PCC showed the initial assessment on a specified date, but no completed assessments over the next 14 days.

A RPN, who was the home's wound care champion, was interviewed and stated that the home assessed any area of altered skin integrity weekly, but acknowledged that when part-time registered staff worked, skin assessments were not always done. The RPN reviewed the identified resident's progress notes and skin assessments for the specified areas of altered skin integrity and stated that there should have been another assessment within the period of 14 days after the initial assessment.

A RN was interviewed and stated that the home assessed areas of altered skin integrity

weekly, at minimum. The RN reviewed the resident's skin assessments for the specified areas of altered skin integrity and stated that there should have been another assessment within the period of 14 days after the initial assessment. The RN added that all skin assessments were documented in PCC using the skin assessment tool, and that there were no other appropriate locations to document skin assessments.

Another RN was interviewed and explained that RPNs completed the skin assessments in PCC weekly for all areas of altered skin integrity.

The Administrator was interviewed and stated that skin assessments should be completed weekly.

The licensee has failed to ensure that the areas of altered skin integrity for two identified residents were reassessed at least weekly by a member of the registered nursing staff.

The severity of this issue was determined to be a level two as there was minimal harm or potential for actual harm, and the scope was a pattern during the course of this inspection. This area of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) during the Resident Quality Inspection (RQI) (#2016_206115_0008) on March 9, 2016, and as a Written Notification (WN) during a Critical Incident (CI) inspection (#2015_349590_0040) on September 4, 2015. [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, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

In the Complaint, the identified resident stated that their treatment was not being provided as frequently as it should have been.

The home's policy, Skin and Wound Care Management (#0105-03-00), last revised March 15, 2017, was reviewed and stated that it was the registered staff's responsibility to update the plan of care to reflect any interventions to prevent skin breakdown.

The resident's TAR was reviewed and there was no information related to the specified treatment for the resident's identified area of altered skin integrity.

The Skin and Wound Communication binder on the resident's unit was reviewed and the RPN Treatment Sheet did not list the specified treatment for the resident's identified area of altered skin integrity.

The resident's skin assessments were reviewed and two assessments from specified dates stated that the specific treatment was provided for the resident's area of altered skin integrity. The subsequent skin assessments on four specified dates did not include documentation about the specific treatment.

The identified resident's care plan was reviewed and did not include the specific treatment for the resident's identified area of altered skin integrity.

A PSW was interviewed and acknowledged that the resident had received the specific treatment for the identified area of altered skin integrity. The PSW believed the treatment

was provided at a specified frequency.

A RPN was interviewed and recalled that when the resident complained about their identified area of altered skin integrity, the RPN would provide the specified treatment at a specified frequency.

Another RPN was interviewed and stated that the resident's area of altered skin integrity was treated with the specified treatment per the resident’s request. The RPN shared that they had been informed of the treatment by another nurse and, to their knowledge, the specified treatment was not provided all the time but only when the resident requested it. The RPN acknowledged the specified treatment was not in the resident’s TAR, but should have been listed in the TAR with instructions. The RPN reviewed the resident’s electronic chart, including the physician’s orders, skin assessments, progress notes, and TAR, and acknowledged that it was unclear when to provide the specified treatment.

A RN was interviewed and reported that if a resident had the specified treatment provided to them, it would be listed in their TAR, and in the Skin and Wound Communication Binder. The RN continued that even if the specified treatment was provided because it was the resident’s preference, it should be in the TAR to provide instruction to staff on when to provide the treatment.

The MRSCP was interviewed and stated that the identified resident received the specified treatment at the RN’s discretion, but it was not really a treatment and was for the resident’s comfort. The MRSCP acknowledged that the resident’s TAR did not mention the specified treatment, and that there was no clear direction for staff about the treatment, such as when to provide it.

The Administrator was interviewed and stated that if a resident received the specified treatment for an area of altered skin integrity, it should be included in their plan of care along with instructions on when to provide the treatment, even if the treatment was only provided because it was the resident's preference.

The licensee has failed to ensure that the plan of care set out clear directions to staff related to the specified treatment for the resident's identified area of altered skin integrity.

The severity of this issue was determined to be a level one as there was minimum risk, and the scope was isolated during the course of this inspection. This area of non-compliance was previously issued as: a VPC during the RQI (#2017_566669_0005) on

March 3, 2017; a VPC during the RQI (#2016_206115_0008) on March 9, 2016; a WN during a CI inspection (#2015_256517_0019) on June 24, 2015; a Compliance Order (CO) during the RQI (2015_216144_0010) on March 26, 2015, which was complied on May 27, 2015. [s. 6. (1) (c)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constituted a criminal offence.

A Complaint was submitted to the MOHLTC on a specified date, which alleged that an identified resident was abused by a staff member.

The home's policy, Zero Tolerance of Abuse and Neglect (#0104-08), dated September 18, 2017, was reviewed and stated that the home's staff would notify police if it was suspected that an alleged, suspected or witnessed incident of abuse or neglect of a resident may have constituted a criminal offence. The policy also said that all incidents of nonconsensual sexual behaviour must be reported to the police.

The identified resident's progress notes were reviewed and included documentation that the resident voiced allegations to an RN on a specified date and time. The RN charted that they had contacted the nurse leader on-call, the MRSCP, and updated them about the allegations. The note continued that the resident was aware that the police would likely be in to question them, and that the MRSCP would follow up in the morning.

The home's risk management system in PointClickCare was reviewed, and included an incident entered by the MRSCP related to alleged abuse of the identified resident. The incident note said that the MRSCP followed up with the resident approximately 12 hours

after the resident's allegation of abuse was made. The note included that the MRSCP explained that police would be called and the resident stated they were okay with that. The note stated that the police non-emergent line was called and a statement was provided to an officer approximately 13 and a half hours after the resident's allegation was made.

A RN was interviewed and recalled that the identified resident reported the allegation of abuse to them. The RN shared that they informed the resident that the home's management, police, and the MOHLTC would be notified. The RN stated that once the resident was calmed and situated, they called the on-call manager, the MRSCP, to inform them of the resident's allegation. The RN said that they offered to call the police, but the MRSCP declined and said they wanted to first clarify the allegation by speaking with the resident.

The MRSCP was interviewed and stated that the home's process when alleged or actual abuse was reported was to investigate, call the police, and report it to the MOHLTC immediately. The MRSCP recalled becoming aware of the allegation through a phone call they received on a specified date and time from the RN. The MRSCP explained that after they met with the identified resident approximately 12 hours later to discuss the allegation, the home called the police.

The Administrator was interviewed and stated that the police should be called immediately for alleged abuse, and acknowledged that the MRSCP should have called the police immediately after becoming aware of the resident's allegation of abuse.

The licensee has failed to ensure that the appropriate police force was immediately notified of the alleged abuse of a resident that the licensee suspected may have constituted a criminal offence.

The severity of this issue was determined to be a level one as there was minimum risk, and the scope was isolated during the course of this inspection. This area of non-compliance was previously issued as VPC during a CI inspection (#2015_256517_0019) on June 24, 2015, and as a WN during a CI inspection (#2014_257518_0048) on November 26, 2014. [s. 98.]

Issued on this 10th day of January, 2018

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

Original report signed by the inspector.