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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 15, 2017	2017_363659_0018	006450-17, 010446-17	Complaint

Licensee/Titulaire de permis

LUTHERAN HOMES KITCHENER-WATERLOO
2727 KINGSWAY DRIVE KITCHENER ON N2C 1A7

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

TRINITY VILLAGE CARE CENTRE
2727 KINGSWAY DRIVE KITCHENER ON N2C 1A7

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

JANETM EVANS (659)

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 17,18,19, 20, 21, 24, 25, 26, 27 and 28, 2017.

The following complaint intakes were completed concurrently with RQI 2017_363659_0017 / 014539-17:
IL-NC-50015/006450-17 related to care concerns
IL-51041-LO/010446-17 related to care concerns, alleged abuse and retaliation

During the course of the inspection, the inspector(s) spoke with the Chief Operating Officer, Director of Resident Care, Assistant Director of Resident Care, Social Worker, Registered Nurses, Registered Practical Nurses, Personal Support Workers.

The inspector(s) completed observations of care and staff to resident interactions; reviewed clinical records; reviewed Medication Administration Record, Treatment Administration Records and plan of care for relevant resident(s); reviewed pertinent policies and procedures and reviewed the complaints log.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 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. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident who was incontinent received an assessment that: included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

Review of the clinical record for an identified resident showed a Minimum Data Set (MDS) assessment which documented the resident's bladder continence status had changed. The MDS assessment also documented changes to the resident's bowel continence status. There was no documented evidence of a bladder or bowel continence assessment completed at this time.

The home's policy Bowel and Bladder Function/Level of Continence Assessment documented "Resident continence level and care should be assessed within 7 days of admission and as health status effects continence".

The RPN and Director of Resident Care (DoRC) stated that the continence assessment should be completed upon admission and with any change in continence status. The RPN and DoRC acknowledged that the continence assessments had not been completed for the changes in the resident's continence status. DoRC acknowledged that the home's policy had not been followed and stated that the continence assessment should have been completed with the associated changes in the resident's continence status.

The licensee failed to ensure that the resident who was incontinent received an

assessment that:
- included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and
- was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

The severity was determined to be a level one as there was minimal harm/risk or potential for actual harm/risk to residents. The scope of this issue was isolated during the course of the inspection. There was a compliance history of this legislation being issued in the home on November 29, 2016 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2016_263524_0040. [s. 51. (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 the resident who is incontinent receives an assessment that: includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to immediately forward any written complaints that had been received concerning the care of a resident or the operation of the home to the Director.

The home's Customer Satisfaction Monitoring Concerns and Complaints policy documented the procedure for handling complaints as :

"Residents and their responsible parties are encouraged to make known their problems or complaints. Open discussion encouraged to resolve problems for our preferred process see the Trinity Village Concern Process posted in each resident room, staff room and across from reception.
1. The concern form is to be completed and submitted to COO.
-all written complaints concerning the care of a resident or the operation of the home (if a complaint is about possible harm to a resident. How to report a concern or complaint about a long-term re home document) shall immediately forward it to the Director with supporting documentation".

Review of the home's complaints binder showed the home received written complaints related to an identified resident's care and the operation of the home; from one of identified resident's Power of Attorney (POA).

Review of the Critical Incident System (CIS) did not show evidence that a copy of the written complaints concerning the identified resident's care were immediately forwarded to the Director.

In interviews, the Director of Resident Care (DoRC) stated when they received a concern, they investigate the concern. A Critical Incident report (CI) was not initiated unless there is something found in the investigation. Chief Operating Officer (COO), acknowledged that a copy of complaints related to care had not been forwarded to the Director.

The licensee failed to immediately forward any written complaints that had been received concerning the care of a resident or the operation of the home to the Director.

The severity of this non-compliance was determined to be level one as there was minimal risk or potential for actual harm/risk and the scope isolated. The home does not have a history of non-compliance in this subsection of the legislation. [s. 22. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated: (i) abuse by anyone.

Review of notes from a meeting involving the Social Worker (SW) and one of the identified resident's Power of Attorney (POA), alleged that an incident of abuse had occurred.

A handwritten incident investigation form dated nine days following the meeting between the SW and POA, documented the resident did not remember the alleged incident of abuse and did not want the home to look into this. The incident investigation form did not have documented evidence of an investigation being completed for the alleged incident.

In interviews, the SW stated they were uncertain if they had immediately reported the alleged abuse to the Director of Resident Care (DoRC) or Assistant Director of Care. The DoRC stated that the home had put a process in place for this POA to bring their concerns forward to the home. When they receive a concern, they investigate the concern. The DoRC stated that the Chief Operating Officer (COO) had tried to complete an investigation into the allegation of abuse but the POA had not given a date as to when this alleged incident occurred and they were told to forget about it.

The licensee failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated: (i) abuse by anyone.

The severity of this non-compliance was determined to be level one as there was minimum risk or potential for actual harm/risk and the scope was isolated. There was a compliance history of this legislation being issued in the home on June 15, 2016, as a Written Notification (WN) #2016_263524_0040. [s. 23. (1) (a)]

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.

An identified resident had a history of a pressure ulcer.

A review of Point of Care (POC) documentation survey report showed documentation that the identified resident had an identified area of skin concern and the nurse was notified. Documentation indicated there was an open area (unspecified) and the nurse was notified.

A review of progress note and prescriber's orders showed documentation by Registered Nurse (RN) which documented an area of concern. Treatments were ordered to be completed. A review of progress notes showed referrals to the dietitian, physiotherapy and occupational therapy (OT) which documented the resident had an area of concern.

Review of the hard copy of the identified resident's chart as well as the progress notes and assessment tab on Point Click Care (PCC) assessment did not show documented evidence that a skin and wound assessment was completed.

In interviews, the Registered Practical Nurse (RPN) stated that they notify the Registered Nurse (RN) of a wound and the RN would come and assess the wound and measure the wound. The RN would instruct the RPN related to the wound care management. The RN stated that the RN assesses the skin and stages the wound according to the home's protocol and they would document the assessment under an "ulcer" note for a pressure ulcer. A reminder to complete the assessment should be documented to the eTreatment Assessment Record (eTAR). Stage II pressure ulcers should be assessed weekly by the RN, usually on the resident's bath day. The RPN and RN acknowledged they did not see any assessment for resident's wound.

In an interview, the Director of Resident Care (DoRC) stated the expectation was that any Stage II wound or above would have weekly measurements and weekly pressure ulcer assessments completed by the RN. The DoRC acknowledged that the identified resident had not 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 care.

The severity of this non-compliance was determined to be level one as there was minimal risk or potential for actual harm/risk and the scope was isolated. The home does not have a history of non-compliance in this subsection of the legislation. [s. 50. (2) (b) (i)]

Issued on this 19th day of September, 2017

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

Original report signed by the inspector.