Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue


Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Nov 21, 22, 23, 26, 27, 28, Dec 3, 2012 | 2012_198117_0009 | Complaint |

**Licensee/Titulaire de permis**

MOHAWK COUNCIL OF AKWESASNE
P.O. Box 579, CORNWALL, ON, K6H-5T3

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

TSIIONKWANONHSOTE
70 Kawehnoke Apartments Road, Akwesasne, ON, K6H-5R7

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

LYNE DUCHESNE (117)

## Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Acting Director of Care (ADOC), several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), the home's Medical Director, Occupational Health Therapist (OT), Physiotherapist (PT) and Physiotherapy Aid (PTA), as well as to several residents.

During the course of the inspection, the inspector(s) reviewed several residents health care records; observed resident care and services; observed three resident transfers; examined a bath stretcher, a mechanical lift, a Broda chair, and several residents wheelchair lap belts; reviewed the home's 2012 Training and Education program related to transfers and nursing practice; reviewed the home's policies #4.1.6 Resident Rights and Safety: Critical Incidents, dated August 2008 and # 4.16.1 Wound and Skin Care Program, dated March 2008; as well as reviewed the home's Critical Incidents Reports for 2012.

It is noted that two complaint inspections, log #O-000735-12 and #O-000876-12, were conducted during this inspection.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Minimizing of Restraining

**Personal Support Services**

**Responsive Behaviours**

**Skin and Wound Care**

**Training and Orientation**

**Findings of Non-Compliance were found during this inspection.**

| 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

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

**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;**
**(b) the goals the care is intended to achieve; and**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**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 failed to comply with LTCHA s. 6 (1) (c ) in that a resident's plan of care does not set out clear directions to staff and others who provide care to the residents.

A) Resident #1 was observed to be physically aggressive with staff during a transfer and provision of personal care on November 21 and 23 2012. Interviewed PSWs, Acting DOC and Administrator state that the resident becomes verbally and physically aggressive during the provision of care and transfers. The resident's plan of care does not identify the resident's behavioural triggers and responsive behaviours of verbal and physical aggression during provision of care and transfers. (#O-000735-12)

B) Resident #2 plan of care identifies that the resident requires a two person supervision and physical assist with mechanical aid for transfers. Resident #2 was observed to be transferred on November 21 and on November 23 2012. Staff were observed to do a two-person side by side pivot transfer, while holding the back of the resident's pants, with no mechanical aids. PSWs S109 and S110 stated that staff do not use any mechanical aids with the resident transfer as the resident would become too agitated.

Inspector #117 noted that there was no graphic signage in the resident's room that might identify the type of transfer assistance that the resident requires. Inspector spoke with the home's PT and PTA regarding Resident #2's transfer needs. Both stated that Resident #2 was assessed in October, 2012 as now requiring a 2-person mechanical lift transfer. Both the PT and PTA state that this was communicated to the home's director of care and new transfer signage was placed in the resident's room. Resident #2's plan of care does not identify any changes related to the resident's current transfer needs.

Residents #1 and #2 plans of care do not set out clear direction to staff who provide care as it relates to responsive behaviours and transfers.

2. The Licensee failed to comply with LTCHA s. 6 (4) (a) in that staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A) Resident #2 has a large mass/bruise to a limb. Interviewed PSWs S108 ,S117, S116, and S115 stated that they reported the mass /bruise approximately 4-5 weeks ago to an RPN when it was smaller. Interviewed registered staff S102, S101 and S100 state that they did hear about the mass/ bruise, but are unaware if it was assessed at that time. No documentation and no assessment of the mass/bruise is found in the resident's health care record for that time period.

PSWs S108 and S114 state that approximately 2 weeks ago, the bruise was reported again to the registered staff. S101 and S102 state that they did assess the resident's mass/bruise when it was reported to them at that time. They report that the mass/bruise was smaller then it's current size but larger then what is said to have been reported 4-5 weeks ago. On a specified day in November, 2012 the resident's Bath Skin Assessment Form documents the mass/bruise. No other documentation was found in the resident's health care record or in the 24-hour Nursing Report book until twelve days later regarding Resident #2's mass/bruise. Since then, the mass/bruise has been assessed three times and its status is communicated to staff.

Interviewed registered staff S100 and S101 state that nursing staff are not consistent in reporting changes in residents skin integrity, including bruises, and these are not consistently communicated to other care team members at shift reports and for monitoring.

There was no collaboration between nursing staff in the reporting, assessment and monitoring of Resident #2's mass/bruise prior to a specified day in November, 2012. (#O-000735-12)

B) Resident #2 plan of care dated May, 2012, identifies that the resident is to have a bed/chair alarm pinned to his/her

clothing when he/she is either in bed or in a wheelchair. It was observed on November 21, 22 and 23, 2012 that PSW staff do not apply a chair alarm when the resident is up in his/her wheelchair. Interviewed PSW staff S108, S114, S109, S110 and S112 state that they have never applied a chair alarm to the resident when he/she is up in his/her wheelchair.

Resident #2's November 2012 Medication Administration Record (MAR) indicates that the resident has an Order for the use of a lap belt restraint. The Order is dated February 2012. The resident's care plan does not identify that the resident now has a lap belt restraint. Interviewed PSW staff state that they were not aware that the resident's lap belt was a restraint.

There was no collaboration between staff related to the assessment the resident's care plan as it relates to the use/discontinuance of a chair alarm and a lap belt restraint

3. The Licensee failed to comply with the LTCHA s.6 (7) in that the care set out in the plan of care was not provided to several residents as specified in their plans of care.

A) Resident #3 plan of care identifies that the resident requires one-person assistance with transfer belt for all transfers at this time. It was observed on November 23 2012, that graphic transfer signage in the resident's room indicates that the resident is a side by side - 2 person transfer with aid of a transfer belt. Resident #3 stated that staff do not use the transfer belts for any of his/her transfers.

B) Resident #4 plan of care identifies that the resident requires two-person assistance with transfer belt for all transfers at this time. It was observed on November 23 2012, that graphic transfer signage in the resident's room indicates that the resident is a side by side - 2 person transfer with aid of a transfer belt. Resident #4 stated that staff do not use the transfer belts for any of his/her transfers.

Interviewed PTA states that she has not seen any nursing staff use a transfer belt when assisting residents #3 and #4 with their transfers.

Interviewed PSWs stated that they do not use transfer belts when assisting the residents with their transfers.

PSW staff do not follow the resident's plan of care as it relates to the use of transfer belts when assisting Residents #3 and #4 with their transfers.

***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) residents plan of care give clear directions to staff who provide direct care to residents; b)that staff collaborate with each other in their assessments so that their assessments are integrated and consistent, and c) that the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

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

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,**
**(i) within 24 hours of the resident's admission,**
**(ii) upon any return of the resident from hospital, and**
**(iii) upon any return of the resident from an absence of greater than 24 hours;**
**(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;**
**(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and**
**(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 failed to comply with O.Reg 50 (2) (b) (i) in that a resident exhibiting altered skin integrity did not receive 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.

Resident #2 has a large mass/bruise to a limb. Interviewed PSWs S108 ,S117, S116, and S115 stated that they reported the mass /bruise approximately 4-5 weeks ago to an RPN when it was smaller. Interviewed registered staff S102, S101 and S100 state that they did hear about the mass/ bruise, but are unaware if it was assessed at that time. No documentation and no assessment of the mass/bruise is found in the resident's health care record for that time period.

PSWs S108 and S114 state that approximately 2 weeks ago, the bruise was reported again to the registered staff. S101 and S102 state that they did assess the resident's mass/bruise when it was reported to them at that time. They report that the mass/bruise was smaller then it's current size but larger then what is said to have been reported 4-5 weeks ago. On a specified day in November, 2012 the resident's Bath Skin Assessment Form documents the bruise. No other documentation was found in the resident's health care record or in the 24-hour Nursing Report book until twelve days later regarding Resident #2's mass/bruise. Since then, the mass/bruise has been assessed three times and its status is communicated to staff.

Registered Nursing staff did not assess the resident's mass/bruise with a clinically appropriate assessment instrument when the mass/bruise was first noted 4-5 weeks ago and it was not regularly assessed and monitored prior to an identified day in November, 2012.

It is noted that the resident's attending physician assessed the mass/injury on November 23, 2012. He stated that he is unable to determine the cause of the injury but suspects that the resident's wheelchair lap belt restraint may have contributed to the injury. (#O-00735-12)

*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 presenting with altered skin integrity are assessed by a member of the registered staff, using a clinically appropriate instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.*

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WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

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Findings/Faits saillants :

1. The Licensee failed to comply with O.Reg. 79/10 s. 107 (3) (4) in that the licensee failed to inform the Director no later than one business day after the occurrence of an incident related to an injury in respect of which a resident is taken to hospital.

On a specified day in March, 2012, Resident #1 complained of pain to an arm after his/her personal care. No injury was noted at that time. Later, Resident #1 complained of pain to the same arm after being transferred to bed. PSW S108 and S118 noted that the resident had a small bruise to the arm. This was reported to the RN, who assessed the resident and monitored the bruise. The RN notified the resident's family and attending MD of the resident's bruise. The resident was transferred to hospital for assessment. Resident #1 was diagnosed with a pathological fracture.

The home's current acting DOC reports and showed to Inspector #117, the internal incident report completed by the RN and the two attending PSWs S108 and S118. The acting DOC and the home's Administrator report that they are not aware of the Director being notified of Resident #1 injury and transfer to hospital. A review of the Ministry of Health and Long Term Care (MOHLTC) Critical Incident Reporting system was completed by the Inspector #117. No information related to this incident was found in MOHLTC reporting system. The home did not notify the Director of Resident #1's injury and transfer to hospital. (#O-000735-12 and # O-000876-12)

The Licensee failed to comply with O.Reg. 79/10 s. 107 (4) in that the licensee who is required to inform the Director of an incident under subsection (1) or (3) , within 10 days of becoming aware of the incident, or sooner if required by the Director, did not make a report in writing to the Director setting out the following with respect to the incident (1) a description of the incident, (2) a description of the individuals involved in the incident, (3) actions taken in response to the incident as well as (4) an analysis and follow-up action.

On a specified day in March, 2012, Resident #1 had an injury to an arm and was transferred to hospital for assessment. Resident #1 was diagnosed with a pathological fracture.

The home's current acting DOC reviewed with Inspector #117, the internal incident report completed by the RN and the two attending PSWs related to Resident #1's injury. The incident report does not identify if any follow up action was done by the home's then DOC in regards to the resident's injury.

Interviewed acting DOC, Administrator, PSW S108, PT and PTA confirm that home did not conduct an investigation as to the cause of the resident's injury, review the resident's care needs and transfer processes post injury.

The acting DOC and the home's Administrator report that they are not aware if a Critical Incident Report was completed related to Resident #1's injury and transfer to hospital. A review of the MOHLTC Critical Incident Reporting system was completed.

The home did not notify in writing the Director of Resident #1's injury, transfer to hospital, immediate actions taken in regards to the resident's injury, nor of any follow-up action taken by the home in regards to Resident #1's injury. (#O-000735-12 and # O-000876-12)

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

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

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**1. The circumstances precipitating the application of the physical device.**
**2. What alternatives were considered and why those alternatives were inappropriate.**
**3. The person who made the order, what device was ordered, and any instructions relating to the order.**
**4. Consent.**
**5. The person who applied the device and the time of application.**
**6. All assessment, reassessment and monitoring, including the resident's response.**
**7. Every release of the device and all repositioning.**
**8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).**

**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg 79/10 s. 110 (7) in that every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, the licensee shall ensure that the following are documented:
(5) the person who applied the device and time of application
(6) all assessments, reassessment and monitoring, including resident response
(7) every release of the device and repositioning
(8) the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Resident #2 has an Order for a lap belt restraint for when the resident is up in his/her wheelchair. On November 21, 22 and 23 , 2012, Resident #2 was observed to have the lap belt restraint applied when he/she was up in his/her wheelchair.

The resident's care plan, dated May 23 2012, does not identify the use of lap belt restraint when the resident is up in his/her wheelchair. No documentation was found in either the resident's hard copy or electronic health care record of the application, assessment, reassessment and monitoring, including the resident's response, to the use of the lap belt restraint. There is also no documentation of repositioning of the resident, the release of the device and the removal of the device.

Interviewed PSWs S108, S112, S111, S110, S109 and S114 state that they were not aware that the resident's lap belt is a restraint. Nor are they aware of the need to document the use, monitoring, repositioning, resident response and removal of the lap belt restraint.

**Issued on this 3rd day of December, 2012**

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

Lynn Duchesne #117