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 12, 2016	2016_536537_0043	033687-16	Resident Quality Inspection

Licensee/Titulaire de permis

S & R NURSING HOMES LTD.
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

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

TWIN LAKES TERRACE LONG TERM CARE COMMUNITY
1310 MURPHY ROAD SARNIA ON N7S 6K5

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

NANCY SINCLAIR (537), AMIE GIBBS-WARD (630)

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): December 5, 6, 7, 8 and 9, 2016

The following intakes were completed within the RQI:
Log #031803-16/CI #2889-000002-16 regarding an injury that resulted in transfer to hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager Resident Care (MRC), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Life Enrichment Staff, Dietary Aide, two Registered Nurses (RN), four Registered Practical Nurses (RPN), six Personal Care Workers (PCW), Resident's Council Representative, residents, and families.

The inspector(s) also conducted a tour of resident areas and common areas, observed residents and care provided to them, medication passes, medication storage areas, reviewed health care records and plans of care for identified residents, policies, procedures and meeting minutes, and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

2 WN(s)
2 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. (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).

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 plan of care provided clear direction to staff and others who provide direct care to the resident.

During an interview with Personal Care Worker (PCW) #104, PCW #104 stated that an identified resident used incontinence products daily, but was not able to state specifically what the required product should be. PCW #104 stated that there was a "Resident Profile Worksheet" posted in the Clean Utility room for reference if required, but that it was a night shift responsibility to distribute the required products and then staff used what had been delivered. PCW #104 stated, that if required, the "Resident Profile Worksheet" or the care plan could be reviewed, and both should have the required product listed.

During an interview with Registered Practical Nurse (RPN) #105, RPN #105 stated that the home had a Continence Champion who completed assessments when required for resident use of incontinence products. RPN #105 stated that there was a referral form that was to be completed and submitted. When an assessment was completed, the Continence Champion would update the "Resident Profile Worksheet" that was posted in the Clean Utility Room of each floor, and also the Product list that was kept on the Continence Care Cart that night staff used to deliver the required products to each resident. RPN #105 stated that the night staff would distribute continence products to residents as per the direction on this list. RPN #105 also stated that the Continence

Champion would update the care plan to reflect the changes at the time of the assessment.

Observation of the "Resident Profile Worksheet" posted in the Clean Utility room was dated July 5, 2016 and stated that the identified resident required specific products on days, evenings and nights. The care plan on Point Click Care for the identified resident required the same products as listed on the July 5, 2016 "Resident Profile Worksheet". The "Resident Profile Worksheet" on the Continence Care Cart was dated Sept 12, 2016, and identified products different than the July 5, 2016 "Resident Profile Worksheet" and the care plan. Observation of the products present in the resident's room for use was different than identified in the care plan or on either "Resident Profile Worksheet".

Administrator #100 and RPN #105 stated that the "Resident Profile Worksheet" in both the clean utility room and on the Continence Care Cart should have been consistent and the product in the resident room should also be what was listed. Administrator #100 stated that the direction for staff was not clear in all places. [s. 6. (1) (c)]

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

PCW #107 reported to Inspector #630 that an identified resident was often incontinent and identified specific continence products used by the resident. PCW #107 said they would use the products that had been stocked in the resident's room and if they did not know what product to use they would look in the plan of care in the computer as well as the list in the clean utility room on second floor.

RPN #105 reported to Inspector #537 that an up to date list of continence products was to be kept in the clean utility room for each resident who had been assessed as requiring an incontinence product and that it was a reference for the staff. RPN #105 acknowledged to Inspector #537 that there was not a list posted on second floor for staff reference. RPN #105 also told Inspector #537 that it was the expectation that the plan of care in Point Click Care (PCC) would be up to date and include the type of product the resident had been assessed as requiring. RPN #105 also said the September 12, 2016 "Resident Profile Worksheet" was the most up to date list that should be available and used by staff in the clean utility room and when delivering products.

Review of the "Urinary Incontinence" plan of care in PCC for the identified resident, observations by Inspector #630 of the continence products stored in the room for this

resident, and a review of the "Resident Profile Worksheet" dated September 12, 2016 found that the care plan and the "Resident Profile Worksheet" dated September 12, 2016, listed different products than what was present in the residents room.

Resident Care Manager (RCM) #111 acknowledged that the continence care product for the identified resident as per the plan of care in PCC was not consistent with the Resident Profile Worksheet. RCM #111 said it was the expectation in the home that the plan of care would provide clear direction for staff regarding the continence care products to be used based on the residents assessed needs. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care set out clear direction to staff and others who provided direct care to a resident using a Personal Assistance Service Device (PASD).

An identified resident was observed using a specific PASD.

During an interview, PCW #107 reported that staff used the specified PASD and stated a specific use. PCW #107 also said staff would ask the resident before utilizing the PASD.

RPN #109 reported to Inspector #630 that RPN #109 was unsure if the resident used the specified PASD. RPN #109 reviewed the plan of care and progress notes for the resident and said that there was not direction or documentation regarding use of the PASD. RPN #109 said that their understanding was that the use of the PASD for this resident would not be included in the plan of care as it was not considered a restraint or a PASD.

Review of the plan of care in Point Click Care and Point of Care (POC) as well as the electronic Medication Administration Record (eMAR) and physician's orders identified that there was no direction provided for staff regarding the use of the specific PASD.

During an interview, RPN/Nursing Rehab (RPN) #110 reported to Inspector #630 and Inspector #537 that they were the main person responsible for assessing residents and updating the plan of care regarding PASDs. RPN #110 reported that the practice in the home had not included the specific PASD as a PASD and the plan of care had not been developed and updated to include when and how the PASD would be used. RPN #110 indicated they reviewed the plan of care for this resident and identified that it did include direction for repositioning but did not include clear direction for staff regarding using the specific PASD.

Manager of Resident Care (MRC) #111 told Inspector #630 that it was the expectation in the home that the use of the specific PASD for a resident would be assessed and the plan of care would provide clear direction for staff. MRC #111 reviewed the plan of care for this resident and acknowledged that it did not provide clear direction to staff regarding use of the PASD. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the care set out in the plan of care for a PASD was provided to the resident as specified in the plan of care.

Inspector #630 observed an identified resident utilizing a PASD and that the PASD was not being used for the specific purposes identified in the plan of care.

The identified resident told Inspector #630 on two occasions they thought staff used the PASD for reasons other than identified in the care plan.

PCW #113 and PCW #114 reported that the resident used the PASD, stated the reasons and times that were identified in the care plan, and reported that the resident used the PASD for reasons and times other than as was identified in the care plan.

PCW #115 said the resident used the PASD for reasons other than as identified in the care plan and confirmed that the PASD was used for times other than as specified for the use. PCW #115 acknowledged to Inspector #630 that at the time of the interview the resident did have the PASD in place and that none of the reasons for use as identified in the care plan were occurring. PCW #115 said they would look in the plan of care in the computer if they needed direction regarding the use of a PASD for a resident.

RN #116 said they were not sure what was in place regarding the use of the PASD for this resident without looking at the plan of care in the computer. RN #116 looked in the plan of care and identified the use the specific PASD and the identified reasons for use. RN #116 reported that the resident mostly had the PASD in place at all times throughout the day.

A review of the paper medical record for this resident revealed that the Restraint and PASD Application Forms had been initialled by staff for September, October and November 2016, showing that the PASD for this resident had been applied at times beyond those specified in the care plan for use of the PASD.

MRC #111 said it was the expectation in the home that staff would follow the plan of care and remove the PASD at times when it was not being used for the intended purpose as identified in the plan of care. MRC #111 acknowledged that based on the observations, the staff had not been providing the care to the identified resident as specified in the plan of care for the PASD. [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 plan of care sets out clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

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:

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.

The home's policy titled "RCM 10-06-01 Skin and Wound Care Program" last reviewed August 30, 2016, indicated that "Skin Assessment - The skin status of each resident is assessed using the appropriate Skin Assessment. The skin status of residents is assessed using this tool under the following conditions: For all resident - quarterly, re-admission/return from hospital, significant change in status, LOA greater than 24 hours and post fall using the Skin Assessment - LOA greater than 24 hours, return from hospital, post fall and quarterly"

An identified resident was noted to have an area of altered skin integrity, and a progress note was recorded in Point Click Care by Registered Nurse (RN) #112.

During an interview with RN #112, RN #112 stated that other than the note in Point Click Care, they had not completed any further assessment, and that the Enterostomal Therapist (ET) nurse would be in to assess the residents' wound.

During an interview with the Manager of Resident Care (MRC) #112, they stated that it would be expected that an assessment of the area of altered skin integrity for the identified resident would be completed using the tool as indicated in the home's policy and that the assessment had not been completed. [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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.

Issued on this 12th day of December, 2016

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

Original report signed by the inspector.