Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 24, 2020	2020_780699_0003	013408-19, 018119-19	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Main Street Terrace
77 Main Street TORONTO ON M4E 2V6

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

PRAVEENA SITTAMPALAM (699), BABITHA SHANMUGANANDAPALA (673)

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): November 21, 22, 25; December 4,5,6, 10, 11, 13, 16, 17 and 20, 2019; and off-site inspection dates of December 18, 19, 23 and 24, 2019.

The following complaints inspections were conducted:
-Log #013408-19 related to staffing, continence and skin and wound care programs; and
-Log # 018119-19 related to skin and wound care program.

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), associate directors of care (ADOC), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), nurse practitioner (NP), physiotherapist (PT), resident services coordinator (RSC), residents and family members.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care
Sufficient Staffing

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 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with s.50 (1) (d), the licensee was required to ensure that the Skin and Wound Care program provides for strategies to promote resident comfort and mobility, prevent infection, to transfer and position residents to reduce and prevent skin breakdown, and to reduce and relieve pressure including the use of equipment, supplies, devices and positioning aids.

Specifically, staff did not comply with the licensee's Prevention of Skin Breakdown policy which is part of the licensee's Skin and Wound Care Program.

The MLTC received a complaint related to improper care of resident #006 related to skin and wound issues.

A review of policy Care12-010.01, Skin and Wound Care, Prevention of Skin Breakdown, dated August 31, 2016, indicated that the Pressure Ulcer Risk Scale (PURS) is to be reviewed upon move-in, quarterly, annually, or with a significant change in status. If the PURS was greater than 4, the resident is to be referred to the Wound Care Champion who would collaborate with the interdisciplinary team to determine appropriate prevention strategies, positioning needs, pressure reduction devices, and referrals as needed. These strategies were to be updated in the plan of care and communicated to staff as they occur.

In an interview, the complainant stated that the resident was admitted to the home with

agreement from the home that a specific skin integrity intervention would be provided to resident #006. The complainant stated that resident #006 had a history of identified altered skin integrity and that RSC #112 had agreed to provide a specific intervention for resident #006 upon admission.

A review of resident #006's InterRAI Home Care Assessment Form stated that they had identified altered skin integrity to a specific area with the previous caregiver stating it was improving with an identified intervention.

A review of resident #006's medical records indicated that they were admitted to the home on a specific date. A review of their progress note and their Application for Admission Tracking Record stated that resident #006 required a specific skin integrity intervention.

In an interview, RSC #112 stated that resident #006 was provided a specific skin integrity intervention on admission as it was asked for ahead of time and that it was up to the nursing staff to complete assessments related to these types of interventions and include them in the resident's plan of care.
A review of resident #006's medical records did not indicate a PURS assessment was completed on admission, or that a referral to the wound care champion had been made.

Furthermore, a review of the progress notes on the identified dates indicated resident #006 was identified as having altered skin integrity to specific areas of their body. A referral to the wound care champion was sent several weeks after the initial altered skin integrity was identified.

A review of the resident's assessment records indicated that the PURS was first completed on a specific date. Resident #006's plan of care was updated on the same date related to their identified altered skin integrity.

Due to noncompliance with resident #006, the scope was expanded to include resident #003. A review of resident #003's medical records indicated that they were admitted on a specific date; however, a PURS assessment was not completed on admission for this resident either. This did not result in harm to resident #003; however, a review of their plan of care did not indicate interventions specifically focused on skin and wound care, and support required for bed mobility to prevent skin breakdown was seen to have only been initiated on a specific date.

In an interview, RPN #113 stated that based on resident #006 being incontinent, and their previous history of reoccurring altered skin integrity to a specific area, a PURS assessment should have been completed on admission. RPN #113 acknowledged that the home's policy related to the prevention of skin breakdown, which is part of the skin and wound care program, had failed to be implemented for resident #006 and resident #003 upon admission. RPN #113 also stated that the delay in completing the PURS assessment and updating the plan of care for risk for impaired skin integrity, bed mobility and continence may have contributed to the failure to provide effective skin and wound care interventions and prevent the development of wounds and pressure ulcers for resident #006. [s. 8. (1) (b)]

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 ensure that the skin and wound care program is developed and implemented in the home that promotes skin integrity, prevents the development of wounds and pressure ulcers and provides effective skin and wound care interventions, to be implemented voluntarily.

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 the continence care and bowel management program in the home was evaluated and updated at least annually in accordance with evidence-based practices and that a written record of this evaluation was kept including the date of the evaluation, names of the persons who participated, summary of the changes made and the date those changes were implemented.

Due to noncompliances being identified related to the annual evaluation of required programs, the scope was expanded to include another required program. As the MLTC received a complaint regarding shortage of incontinence care supplies, the continence care and bowel management program was selected to be reviewed.

In interviews, RPN #114 and PSW #115 stated that there was often a shortage of incontinence supplies used for residents particularly at the end of the month. Both RPN #114 and PSW #115 stated that the process in the home was to verbally inform RPN

#114 when there was a shortage of incontinence care supplies as they were responsible for re-ordering these supplies. They further stated that the issue had been raised to ADOC #106 on several occasions. PSW #115 stated this issue had been ongoing for the past two years.

In an interview, ADOC #106 stated that there was no process in the home for documenting and tracking how many times and what kinds of incontinence care supplies the home was short of as it was done verbally and could only provide the order receipts from individual orders. ADOC #106 stated that an evaluation of the continence care and bowel management program, including supplies of products, had not been completed for 2018. ADOC #106 acknowledged the importance of documented evaluation of the program in communicating, evaluating and resolving issues related to the program such as those related to shortage of incontinence supplies.

In an interview, DOC #103 acknowledged that the continence care and bowel management program required an annual evaluation and that it had not been completed by the home in 2018. [s. 30. (1) 3.]

2. The licensee has failed to ensure that the skin and wound care program in the home was evaluated and updated at least annually in accordance with evidence-based practices and that a written record of this evaluation was kept including the date of the evaluation, names of the persons who participated, summary of the changes made and the date those changes were implemented.

The MLTC received a complaint regarding shortage of wound care supplies required for residents. The MLTC also received an additional complaint regarding concerns with the home regarding a skin and wound care intervention. In an interview, the complainant expressed several concerns related to the skin and wound care program.

In interviews, RPN #114 who was the current wound care champion for 2019, and the end of 2018, and RPN #113 who had been the previous wound care champion in 2018, stated they were responsible for the wound care program and that there were often shortages of wound care supplies especially near the end of the month.

In an interview, ADOC #106 stated that there was no process in the home for documenting and tracking how many times and what kinds of wound care supplies the home was short of as it was done verbally and could only provide the order receipts from individual orders.

Upon request of the home's evaluation of the skin and wound care program, RPN #114 and ADOC #106 stated that a skin and wound care program evaluation had not been completed for 2018. RPN #114 acknowledged the importance of documented evaluation of the skin and wound care program in communicating, evaluating and resolving issues related to the program.

In an interview, DOC #103 acknowledged that the skin and wound care program required an annual evaluation and that it and had not been completed by the home in 2018. [s. 30. (1) 3.]

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 ensure that the continence care and bowel management program and skin and wound care program in the home is evaluated and updated at least annually in accordance with evidence based practices and that a written record of this evaluation is kept including the date of the evaluation, names of the persons who participated, summary of the changes made and the date those changes are implemented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

Findings/Faits saillants :

1. The license has failed to ensure that the staffing plan gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The MLTC received a complaint regarding shortage of personal care staffing affecting resident showers.

A review of the Daily Staffing Complement schedules from August to October 2019 for all floors indicated the home worked short on 43 out of the 92 days, with August having the highest number of days.

A review of the home's Alternate Staffing Contingency Plan indicated that the plan/strategy if the home was short one PSW during the day or evening shifts was to call available PSWs, bring staff in early or ask them to stay late, and reassign staff such as those from bath shift to regular shift. It stated that duties that must be completed in this case were ADLs and baths. When the day or evening shifts were two or three PSWs short, the plan was to follow the same strategy as when one is short, and in addition to call agency staff at the discretion of the manager on call/DOC pending care levels in the home. It stated that all duties must be completed but baths to be rescheduled for the next day/shift pending complexity of care needs of the unit and to be determined by the Registered Staff.

In an interview, ED #104 stated that the home has not actually implemented the use of agency staff as mentioned in their plan to address situations when PSW staff could not come to work. ED #104 also identified staffing issues with PSWs during previous years during the summer months due to shifts not being filled when staff took vacations; however, ED #104 stated that an evaluation and update of the staffing plan had not been completed for 2018. ED #104 acknowledged the importance of completing this evaluation to identify and address specific staffing needs. [s. 31. (3)]

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 ensure that the staffing plan gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The MLTC received a complaint regarding shortage of personal care staffing affecting resident care.

In interviews, RPN #114 and PSW #115 stated that there was often a shortage of PSW staff, and that when this happened, the staff normally scheduled to provide showers was re-assigned to fill the shortage; however, this resulted in residents not receiving their showers as per their plan of care. They identified this issue to be a concern specifically on the first floor as it was usually the PSW on the first floor that was re-assigned.

A review of the home's staffing plan dated October 2019 indicated that during day shifts, there was one PSW scheduled from 0800hrs to 1600hrs. A review of the home's Job Routine description for this position dated January 2018 indicated that baths/showers that were required for residents on the first floor were part of the responsibility of the

PSW in this position. A review of the home's Daily Staffing Complement schedules from August to October 2019 indicated that this position was scheduled every day, including weekends on the first floor.

A review of the home's Alternate Staffing Contingency Plan indicated that the plan/strategy if the home was short one PSW during the day or evening shifts was to call available PSWs, bring staff in early or ask them to stay late, and reassign staff such as those from bath shift to regular shift. It stated that duties that must be completed in this case were Activities of Daily Living (ADLs) and baths. When the day or evening shifts were two or three PSWs short, the plan was to follow the same strategy as when one is short, and in addition to call agency staff at the discretion of the manager on call/DOC pending care levels in the home. It stated that all duties must be completed but baths to be rescheduled for the next day/shift pending complexity of care needs of the unit and to be determined by the Registered Staff.

The plan of care related to scheduled showers and Point of Care (POC) records, where PSWs documented the care that was provided, were reviewed for residents #001, #009 and #010 for the periods of August, September, and October 2019, and they indicated the following:

- Resident #001 did not receive eight scheduled showers in August; four showers in September; and two showers in October.
- Resident #009 did not receive four scheduled showers in August; three showers in September; and five showers in October.
- Resident #010 did not receive four scheduled showers in August.

A review of each of the resident's progress notes on the identified dates indicated that these showers were missed and did not indicate any further details of the reason for these missed showers or whether they were rescheduled.

In an interview, ED #104 confirmed the practice of reassigning PSW staff from the bath shift to fill other PSW positions when they were short. ED #104 further stated that the home has not actually implemented the use of agency staff as mentioned in their plan to address situations when PSW staff could not come to work and if they were unable to fill the shift after calling the PSW staff of the home, they worked short. ED #104 acknowledged that residents #001, #009 and #010 were not bathed at least twice a week by their method of choice and that short staffing may have been a contributing factor. [s. 33. (1)] [s. 33. (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 ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

Issued on this 31st day of January, 2020

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

Original report signed by the inspector.