Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 15, 2019	2019_648741_0021	017426-19	Complaint

Licensee/Titulaire de permis

County of Oxford
21 Reeve Street WOODSTOCK ON N4S 7Y3

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

Woodingford Lodge - Tillsonburg
52 Venison Street West TILLSONBURG ON N4G 1V1

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

AYESHA SARATHY (741)

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): September 16-20, 2019

The following Complaint was inspected as a part of this inspection:

IL-70037-LO/ Log #017426-19 related to Skin and Wound Care

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Nurses (RNs), a Nurse Practitioner (NP), the Manager of Woodingford Lodge Satellites and a resident.

The inspector also observed residents, reviewed relevant policies and procedures and clinical records for identified residents.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

A complaint was received by the Ministry of Long-Term Care (MOLTC) in relation to concerns about the way an identified resident's skin and wound issues had been handled by the home. The complainant reported that for an identified period of time, the resident suffered from an unknown skin issue.

Inspector #741 reviewed the "Treatment Assessments" forms used by staff to assess the resident's skin and they indicated that the resident's skin issues worsened in the identified period of time.

A review of the resident's Care Plan on Point Click Care (PCC) indicated that the resident was at risk for altered skin integrity and an intervention to reduce that risk was implemented.

Inspector #741 met with the resident and observed that the identified intervention was not implemented and the resident had areas of altered skin integrity.

During interviews, Personal Support Workers (PSWs), a Registered Nurse (RN) and a Nurse Practitioner (NP) all said that the identified resident had areas of altered skin integrity. In an interview, a PSW said that staff offer an intervention to reduce the risk of altered skin integrity and that it would be important to implement the intervention to ensure that skin was not compromised. When asked if the resident resisted having the

intervention implemented, two PSWs stated, in different interviews, that the resident was compliant with care and had not resisted having the intervention implemented.

Inspector #741 reviewed the documentation that was completed by staff for the implementation of the identified intervention and it was documented that the intervention had not been completed as scheduled.

In an interview with the Manager of Woodingford Lodge Satellites, they said that it would be important to implement the identified intervention for the resident to reduce the risk of altered skin integrity. They also said that staff did not implement the intervention that was specified in the resident's care plan and it was the home's expectation that they would.

The licensee failed to ensure that the identified resident's intervention was implemented to reduce the risk of altered skin integrity as specified in their plan of care.

2. The licensee has failed to ensure that a resident was reassessed and the plan of care revised when the care set out in the plan was not effective.

Further to the concerns reported by the complainant in complaint IL-70037-LO, they also reported that the resident's skin was treated with identified interventions but none were able to resolve the skin condition. The complainant said that they requested a referral at an identified time, however, the resident still did not have an appointment.

A review of the identified resident's progress notes indicated that they acquired the skin condition in the home at an identified time and were referred by their physician shortly after acquiring the skin condition. The physician also documented an order for an identified treatment with specific direction.

The resident's skin was assessed by staff using the home's "Treatment Assessments" forms. A review of the resident's assessments indicated that their skin issues worsened over an identified period of time. The resident received the prescribed treatment for an identified period of time with no documentation to indicate that the resident was reassessed to determine whether the treatment was effective.

A Nurse Practitioner (NP)'s Communication Book was reviewed and showed that on a particular date a staff member documented that the resident's skin issues were still

present and that they had been receiving the same treatment for an extended period of time. The staff member documented a note asking the NP to confirm whether to continue the same treatment or whether something else could be implemented. The Physician's orders, NP Communication Book and progress notes were reviewed and there was no documentation to indicate that alternative treatments were considered or implemented to treat the resident's skin condition.

A NP said in an interview that something else should have been implemented for the resident's skin. In another interview, the Manager of Woodingford Lodge Satellites said that in most cases if a treatment was ineffective they would switch to a different treatment and that a different approach or treatment should have been implemented for this resident. They said that there were many interventions that could have been used and that they would expect that different approaches should be implemented for the resident.

A review of the Physician's Communication Book and NP's Communication Book indicated that the complainant inquired about the status of the referral at various times over an identified period of time and was told by staff members that the physician would be notified of their inquiry. A progress note documented by the physician stated that they would track the referral down, however, there was no documented evidence of follow up regarding the referral.

The NP and the Manager of Woodingford Lodge Satellites both said in separate interviews that the home did not follow up with the referral for the resident and that they should have followed up sooner. They stated that the home "dropped the ball" on following up with the referral.

The licensee failed to ensure that the identified resident was reassessed and the plan of care revised when the resident's prescribed treatment was not effective.

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 care set out in the plan of care is provided to the resident as specified in the plan, and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure that where the Act or 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 O. Reg. 79/10, s. 30, the licensee was required to have a written description of each of the interdisciplinary programs, including skin and wound care, required under section 48 of this Regulation that included relevant policies and provided for methods to reduce risk and monitor outcomes. Specifically, staff did not comply with the home's "Skin and Wound Care Program" policy #T 6.382, revised February 2019, which was part of their skin and wound care program.

A complaint was received by the Ministry of Long-Term Care (MOLTC) in relation to concerns about the way an identified resident's skin and wound issues had been handled

by the home. The complainant reported that for an identified period of time, the resident suffered from an unknown skin issue. The complainant also said that during an identified period of time, the resident's skin condition became worse.

A review of the identified resident's clinical record identified that they had ongoing skin issues.

The home's policy, "Skin and Wound Care Program" policy #T 6.382, revised February 2019, was reviewed, and stated that venous, arterial and other wounds must be assessed weekly by registered staff using the Wound Assessment and Treatment Form #NC-035. Rashes, lesions and Stage 1 Pressure Wounds were to be assessed by registered staff using the Treatment Assessments Form #NC-031.

Inspector #741 reviewed the "Tips for Initiating and Discontinuing Treatment and Wound Assessments" sheet in the Treatment Assessment Records (TAR) binder kept in the nursing station. The tip sheet stated that the Treatment Assessments Form was to be used for rashes, lesions and Stage 1 wounds that were still intact, and the Wound Assessment and Treatment Form was to be used for any wound or skin tear that was open and measurable. A Registered Nurse (RN) said, in an interview, that the Treatment Assessments Form would be used for a skin condition that was not open or measurable, but if an open area developed that was measurable, the Treatment Assessment Form would be canceled and the Wound Flow Sheet #NC-035 would be started.

Wound Assessment and Treatment Forms were reviewed by Inspector #741 for the identified resident. The review indicated that on a particular date, the resident's skin condition changed, however, there was no documentation to indicate that staff completed weekly assessments using the appropriate assessment form for four consecutive weeks.

In an interview, the Manager of Woodingford Lodge Satellites said that registered staff had been trained on the home's skin and wound policy and were aware of when to use the Treatment Assessments Forms and Wound Assessment and Treatment Forms and the frequency at which various skin conditions were to be assessed. The Manager of Woodingford Lodge Satellites said that staff should have discontinued the Treatment Assessments Form and started the Wound Flow Sheet the day the resident's skin condition changed. They further stated that staff did not follow the home's policy when completing skin and wound assessments and it was the home's expectation that they would.

The licensee failed to ensure that staff complied with the home's "Skin and Wound Care Program" policy #T 6.382, revised February 2019.

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 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 is complied with, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that a 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 received by the Ministry of Long-Term Care (MOLTC) in relation to concerns about the way an identified resident's skin and wound issues had been handled by the home. The complainant reported that for an identified period of time, the resident suffered from an unknown skin issue which caused altered skin integrity.

A review of the identified resident's progress notes indicated that they acquired the skin condition in the home at an identified time and had been referred by the resident's physician. The physician also documented an order for an identified treatment with specific direction.

The home's policy, "Skin and Wound Care Program" policy #T 6.382, revised February 2019, was reviewed, and stated that rashes, lesions and Stage 1 Pressure Wounds were to be assessed by registered staff every three to five days to monitor effectiveness of treatments, using the Treatment Assessments Form #NC-031.

A review of resident's Treatment Assessments Forms indicated that staff were required to reassess the resident's skin every five days and document the assessments on the Treatment Assessments Form. The review completed by Inspector #741 identified that registered staff did not consistently reassess the resident's skin at least weekly and at times their skin was not reassessed for up to 15 days.

In an interview with the Manager of Woodingford Lodge Satellites, they acknowledged that staff did not reassess the resident's skin at least weekly, and more specifically, every five days as required by the home's Skin and Wound Care Program policy, revised February 2019 and the resident's Treatment Assessment Form.

The licensee failed to ensure that when the resident presented with altered skin integrity, the resident was reassessed at least weekly by a member of the registered nursing staff.

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 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.

Issued on this 23rd day of October, 2019

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

Original report signed by the inspector.