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 24, 2019	2019_803748_0008	000375-19, 002587-19, 019103-19	Complaint

Licensee/Titulaire de permis

St. Peter's Care Centres
125 Redfern Avenue HAMILTON ON L9C 7W9

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

St. Peter's Residence at Chedoke
125 Redfern Avenue HAMILTON ON L9C 7W9

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

EMMY HARTMANN (748)

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 24, 25, 26, 27, 30, October 1, 2, 4, 8, 9, 10, 16, 17, 2019.

The following intakes were completed in this Complaint Inspection:

log #000375-19, was related to admission and discharge, and responsive behaviours.
log #002587-19, was related to readmission.
log #019103-19, was related to plan of care, hospitalization, abuse, skin and wound care, continence care, and bowel management.

This inspection was completed concurrently with Critical Incident Inspection: 2019_803748_0009.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Social Worker (SW), Wound Care Nurses (WCN), RAI-Documentation Nurse, Staffing Clerk, Customer Service Supervisor, Maintenance, Storage Clerk, registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, and policies.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Hospitalization and Change in Condition
Medication
Personal Support Services
Responsive Behaviours
Skin and Wound Care

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

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 failed to ensure that the Substitute Decision Maker (SDM), was provided the opportunity to participate fully in the development and implementation of resident #001's plan of care.

Log #000375-19 and log #002587-19, were complaints submitted to the MOLTC for resident related issues.

A review of the progress notes identified that resident #001 had an altercation with another resident on an identified date.

Progress Notes documented on an identified date, by RN #102, indicated that resident #001 was discussed at a meeting, and that an order was signed by the doctor for the resident, on an identified date. The note identified that the order may be used, as needed. There was no mention of notification of the resident's SDM related to the order being signed or being in place.

Physician's Orders for resident #001 on an identified date, indicated that the order was made.

Progress Notes documented on an identified date, by RN #102, identified that the order was updated by the doctor, and there was still no mention that the SDM was informed of the order being in place or updated.

Interview with RN #102, identified that the SDM was not informed that the order had been made for the resident, to use when needed. They identified that notification of the SDM was not completed when the order was first signed, and when it was updated.

During an interview with the DOC, they acknowledged that the SDM was not notified of the order being made for use, and that the SDM was still unaware of the order, when it was used on the resident, on an identified date. They acknowledged that the SDM could not fully participate in the development and implementation of resident #001's plan of care.

The home failed to ensure that the SDM was provided the opportunity to participate fully in the implementation of resident #001's plan of care. [s. 6. (5)]

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

A review of resident #001's care plan identified that the resident had several symptoms related to their disease process. One of the interventions in the care plan, to manage resident #001's symptoms, was for a treatment to be given as prescribed by the doctor.

In review of the physician's orders for resident #001, it was identified that there was an order for a treatment to be given when needed. In review of the usage of the treatment, it was identified that resident #001 had been given the treatment four times in a span of four months, and that the treatment was noted to have been effective, the four times it was given.

During an interview with PSW #109, it was identified that they were familiar with the care of resident #001, and they confirmed the resident exhibited symptoms. They identified that they had assisted with the resident, when they previously needed the treatment administered. They identified that after the treatment was given, it was effective in controlling the resident's symptoms.

During an interview with PSW #110, it was identified that they were working when resident #001 was exhibiting symptoms, on an identified date. They indicated that they did not see the treatment being given to the resident.

During an interview with RPN #128, they identified that there was no attempt to provide the resident with the treatment on an identified date, when the resident was presenting with symptoms.

During an interview with RN #102, they verified that the doctor had ordered the treatment to manage resident #001's symptoms. They identified that this treatment was in the resident's care plan. However, they did not provide the treatment, when the resident presented with symptoms, on an identified date.

During an interview with the DOC, it was identified that interventions related to resident #001's symptoms, were contained in the care plan. They acknowledged that a part of the care plan interventions to control resident #001's symptoms, was to give the treatment that was prescribed by the doctor; however, this was not followed on an identified date.

The home failed to ensure that treatment was given as prescribed by the doctor for resident #001.

3. The licensee failed to ensure that resident #001 was reassessed and their plan of care was reviewed and revised when the care set out in the plan was no longer necessary.

Log #000375-19 and log #002587-19, were complaints submitted to the MOLTC for resident related issues.

A review of the resident's care plan identified that the resident had symptoms related to their disease process.

The care plan also identified that the resident required assistance with Activities of Daily Living (ADL) tasks related to their disease process. One of the interventions in the careplan indicated not to provide the resident with a specific treatment, related to their disease process.

Progress Notes documented on identified dates, identified that the specific treatment was successful in assisting the resident, related to their disease process; and that there was a

positive response from the resident.

During an interview with PSW #105, they identified that they were familiar with resident #001, and that in the beginning when the resident was just admitted, the intervention was not to provide the resident with a specific treatment, but that the resident started to respond well to the treatment later on.

During an interview with RN #102, it was verified that resident #001 did respond well to a specific treatment, however, this was not reflected in the care plan for the resident.

Interview with the DOC, identified that it was an expectation for the care plan to be kept current and updated when the resident's needs changed, and they acknowledged that resident #001's plan of care was not revised. [s. 6. (10) (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 and ensuring that the Substitute Decision Maker is provided the opportunity to participate fully in the development and implementation of plan of care, that the care set out in the plan of care is provided as specified in the plan, and that the plan of care is reviewed and revised when the care set out in the plan is no longer necessary, 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 :

1. The licensee failed to ensure that where the regulation required the licensee of a LTC home to have, institute, or otherwise put in place any strategy, the strategy was complied with.

In accordance with O. Reg. 79/10, s.48 (1) 2 and in reference to O. Reg. s. 50 (1) 3. the licensee was required to have a skin and wound care program that provided strategies to reduce and prevent skin breakdown, including the use of devices.

Specifically, staff did not comply with the licensee's policy "Skin and Wound Management", last revised September 2018, where it stated that each resident must be assessed for the potential risk of skin breakdown within 24 hours of admission, upon readmission from hospital, upon return from a leave of absence greater than 24 hours, quarterly, annually and with a change in condition. The policy stated that the procedure for this was to complete a Head to Toe Skin Assessment in Point Click Care (PCC) within 24 hours of admission, quarterly and annually, when care needs changed, and for a return from a leave of absence greater than 24 hours.

The ADOC informed the inspector that the home switched their wound care charting from paper to PCC in May 2019.

During a review of resident #005's clinical records, it was identified that they were admitted to the home, on an identified date, and that they only had one Head to Toe Skin Assessment on PCC, completed on an identified date, as an admission assessment. There was no Head to Toe Assessment completed since May 2019, when the home switched to PCC charting.

During a review of resident #006's clinical records, it was identified that they were admitted to the home, on an identified date, and that they only had one Head to Toe Skin Assessment on PCC, which was completed on an identified date. There was no Head to Toe Assessment completed since May 2019, when the home switched to PCC charting.

During a review of resident #007's clinical records, it was identified that they were admitted to the home on an identified date, and that they only had one Head to Toe Skin Assessment on PCC, which was completed on an identified date. There was no Head to Toe Assessment completed since May 2019, when the home switched to PCC charting.

An interview with Wound Care Nurses #129 and #130, identified that there should have been a quarterly assessment for the three residents since May 2019, on PCC.

The home failed to ensure that where the regulation required the licensee of a LTC home to have, institute, or otherwise put in place any strategy, the strategy was complied with. [s. 8. (1) (a),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 and ensuring that the policy related to the completion of Head to Toe Assessments, 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 :

1. The licensee failed to ensure that residents 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.

Log #019103-19, was submitted to the MOLTC, related to concerns about resident care.

During a review of resident #005's records, the resident was noted to have an altered skin integrity, as documented by the doctor on an identified date. The doctor ordered treatment, and indicated that the altered skin integrity would be reassessed in one week. On an identified date, the doctor indicated that the altered skin integrity was unchanged despite the treatment, and indicated that the altered skin integrity would be reassessed in two weeks. On an identified date, the doctor documented that the altered skin integrity, were raised and ulcerated and an order for a specialist referral was written.

A review of the home's policy titled "Skin and Wound Management", last revised September 2018, identified that registered staff was to assess all residents exhibiting altered skin integrity including rashes and other wounds. It identified that residents with altered skin integrity would have their wound/rash assessed weekly and their treatment reassessed at least every two weeks to evaluate effectiveness of treatment and to promote the best outcome for the resident.

During a review of resident #005's records, it was identified that they did not have a weekly skin assessment completed on their altered skin integrity.

During an interview with RPN #125, they indicated they were familiar with the care of resident #005, and they confirmed that the resident had altered skin integrity, as identified by the doctor. They identified that the altered skin integrity needed monitoring as it was receiving treatment. They identified that the weekly skin assessment by registered staff, would be found on PCC. Upon review of resident #005's assessments with the inspector, they confirmed that a weekly assessment by a member of the registered nursing staff, was not completed.

During an interview with the ADOC, they acknowledged that a weekly assessment was not completed by registered staff for resident #005's altered skin integrity. [s. 50. (2) (b) (iv)]

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 and ensuring that residents 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.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including ensuring that access to these areas were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

The inspector observed Storage Clerk #116, request for the key to an identified Home Area, from RPN #115. The medication room contained drugs in cupboards, and drugs in two medication carts. The medication cart in the identified Home Area was observed to be opened and RPN #115 confirmed that Storage Clerk #116 was provided access to the medication room and the medication cart to replenish supplies in these areas.

During an interview with Storage Clerk #116, they identified that they were not registered staff, and that a part of their role in the home was ordering supplies and equipment. They identified that they were responsible for doing an inventory, and then replenishing the home areas with the needed supplies and equipment.

The inspector was shown the home's main supply room. Storage Clerk #116 confirmed that they ordered and received medication from the Government Pharmacy, and showed the inspector the locked cupboard that the drug supplies were being stored. They indicated that they held the key to the storage cupboard, and had access to the drug supply contained in the cupboard. The inspector was shown the contents of the cupboard, and verified that the cupboard contained drug supplies.

The home's Medication Storage Policy #4-002 states "all medications are to be kept locked in the medication cart or medicine cabinet or room, that is used exclusively for this purpose. Drug storage areas must be kept locked at all times and the keys must be kept on the nurse's person at all times. Access to medication storage areas are restricted to persons who may prescribe, dispense, or administer drugs and the Administrator".

During an interview with the Administrator, they confirmed that access to the home's drug supply was not restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 2.]

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 and ensuring that access to the home's drug supply is restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

Issued on this 20th day of November, 2019

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

Original report signed by the inspector.