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 sions 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
May 4, 2016	2016_449619_0017	009635-16	Complaint

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH BRAMPTON ON L6Y 5A7

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

GRACE MANOR
45 Kingknoll Drive BRAMPTON ON L6Y 5P2

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

SAMANTHA DIPIERO (619)

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): April 26, 27, 29, 2016, and May 4, 2016

The following complaint inspection was completed: #009635-16 related to skin and wound

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), registered nurses, registered practical nurses, personal support workers, Occupational Therapist, private care provider, residents, and the complainant. The inspector also toured the facility, observed the provision of care, reviewed the resident's health records and the homes policies and procedures.

The following Inspection Protocols were used during this inspection: Hospitalization and Change in Condition

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. (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 ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On an identified date in March 2016, the resident was noted as displaying responsive behaviours during the provision of care. PSW #105 confirmed that while displaying behaviours during the provsion of care, the resident became injured. Care plan dated January 2016, indicated the use of 1 or 2 staff depending on the resident's mood/behaviour for safety. PSW #105 indicated that they were aware of the resident's requirement for an extra care provider and continued to provide care to the resident in bed on their own and confirmed that an extra care provider would have been appropriate. Interview with the Director of Care (DOC) confirmed that the resident required an extra care provider to help reduce the behaviours while care was being provided and confirmed that care was not provided as per the written plan of care. [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 with 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, 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 failed to ensure that a resident exhibiting altered skin integrity received 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.

On an identified date in March 2016, resident #001 was injured while being cared for in bed while displaying responsive behaviours. As a result of the injury the resident developed wounds and experienced pain. The changes in the resident's skin condition were noted in the resident's progress notes on three identified dates in March 2016, and five identified dates in April 2016, however no indication of shape, colour, or size of the injuries was noted and no record of a formal assessment completed with a clinically appropriate assessment tool was found.

On an identified date in April 2016, staff noted another wound on resident #001's body from an unknown cause. Registered staff recorded the presence of the injury in the progress notes on five identified dates in April 2016. On an identified date in April 2016, resident #001 was transferred to hospital after staff discovered that the injury needed further assessment. The resident returned from hospital the following day with the injury confirmed.

Interview with registered staff #102 stated that when a resident returns from hospital or has a significant change in the status of their skin integrity a formal head to toe skin assessment should be completed. Staff #102 indicated that the residents injury was noted in the progress notes and was unsure of where the skin and wound assessment should be documented. Registered staff #102 confirmed that a skin assessment with the use of a clinically appropriate assessment tool was not completed after the resident was injured on an identified date in March 2016, nor was it completed upon the residents return from hospital on an identified date in April 2016. A review of the homes policy titled, "Skin and Wound Care Management", policy # NUR-GM-01-100, last revised November 2014, stated that "each resident shall receive a head to toe skin assessment…. Upon readmission…. [and] when there is a change in health status that affects skin integrity." An interview with the DOC confirmed that resident #001 did not receive skin and wound assessments related to the injuries obtained in March and April 2016, and that the resident should have been assessed on an ongoing basis by registered staff with the use of a clinically appropriate assessment tool designed specifically for skin and wound assessments. [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 with r. 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, to be implemented voluntarily.

Issued on this 12th day of May, 2016

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

Original report signed by the inspector.