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
Mar 31, 2016	2016_393606_0005	003590-16	Complaint

Licensee/Titulaire de permis

FRIULI LONG TERM CARE
7065 Islington Avenue Woodbridge ON L4L 1V9

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

VILLA LEONARDO GAMBIN
40 Friuli Court Woodbridge ON L4L 9T3

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

JANET GROUX (606)

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): March 1, 2, and 3, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Director of Care (A)DOC, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers(PSW), and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector conducted observation of residents and home areas, observation of staff and resident interactions, reviewed clinical health records, staffing schedules/assignments, and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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. (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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Review of an intake indicated resident #001 sustained a skin impairment to an identified area of the body and was observed to be infected on an identified date and resulted in the resident's transfer to hospital.

Review of resident #001's progress notes on an identified date indicated the resident sustained a skin impairment to an identified area of the body from a previous skin impairment reported on an identified date, that he/she sustained. Further review indicated that on an identified date the identified area was observed bleeding and inflamed.

Interview with RPN #101 revealed he/she assessed resident #001 on an identified date, and indicated the skin impairment had signs and symptoms of an infection. RPN confirmed that he/she did not notify the SDM of the resident's change in condition and treatment plan.

Interview with RPN #101 RN #104, and DOC revealed that it is the home's practice to notify the SDM of any changes in the resident's condition and inform him/her of the treatment plan and confirmed this was not done. [s. 6. (5)]

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

Review of a critical incident report on an identified date, indicated resident #001 had sustained a skin impairment to an identified area of his/her body. It was identified through the home's investigation that an identified care giver witnessed resident #002 enter resident #001's room between an identified date and time and observed resident #002 standing behind resident #001 and holding and touching an area of resident #001's body.

Review of resident #002's current written plan of care, indicated for staff to monitor resident's whereabouts hourly.

Review of resident #002's monitoring record on an identified date, was not completed.

Interview with the ADOC revealed resident #002 was to be monitored hourly of his/her whereabouts as indicated in his/her written careplan and confirmed staff did not do this. [s. 6. (7)]

3. The licensee failed to ensure that when a resident is reassessed and the plan of care reviewed and revised that different approaches are considered in the revision of the plan of care.

Review of an intake indicated resident #001 sustained impaired skin integrity on the three identified dates.

Review of resident #001's written care plan dated on an identified date, identified resident #001 had a potential for impaired skin integrity and was updated on an identified date to include a description of the resident's skin and associated behaviours that may contribute to impaired skin integrity.

Interview with PSW #103, #105, #106, #107, #112, RPN #101, and RN#104 indicated resident has behaviours that can impeded interventions implemented to prevent skin impairment.

Interview with RPN #101 confirmed the plan of care did not consider different approaches when the resident continued to behave in this manner.

Interview with the ADOC confirmed the plan of care did not consider different approaches to manage the resident's behaviours as mentioned above. [s. 6. (11) (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 there is a written plan of care that sets clear directions 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 a resident that exhibited altered skin integrity, a skin tear, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Review of an intake indicated resident #001 sustained impaired skin integrity on three identified dates.

Review of resident #001's progress notes on an identified date indicated resident sustained a skin impairment to an area of his/her body on an identified date, and the skin impairment opened up resulting in further skin impairment after resident engaged in an identified behaviour. The progress notes indicated resident was removing the dressing to the identified area of his/her body a number of times and was observed to be touching the area with his/her hand. The progress notes further revealed on an identified date, the impaired skin integrity was observed to be bleeding and the surrounding area to be inflamed.

Interview with RPN #101 and RN #104 revealed resident #001 had been observed removing the dressing to the area a number of times and would be touching the area and indicated this was a contributing factor to becoming infected.

Interview with RPN #101 revealed he/she assessed resident #001 on an identified date, and indicated the area of the skin impairment had signs and symptoms of an infection. RPN confirmed that he/she made a progress note for the physician to assess the resident but did not notify the physician immediately of the suspected infection. RPN revealed he/she obtained a telephone order for an oral medication and treatment cream from the physician on an identified date, four days after he/she assessed the resident.

Interview with the ADOC, revealed that the home's practice is for him/her and the physician to be notified by phone or email so treatment can be initiated immediately and the RPN did not do this. [s. 50. (2) (b) (ii)]

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 a resident exhibiting altered skin integrity, a skin tear, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, to be implemented voluntarily.

WN #3: 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 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, was complied with.

Review of a CI report, indicated resident #001 had a skin impairment to an identified area of his/her body. It was identified through the home's investigation that an identified caregiver witnessed resident #002 enter resident #001's room between an identified time and date, and observed resident #002 standing behind resident #001 and holding on to an identified area of resident's body.

A review of resident #002's clinical records revealed no progress note or incident report was documented.

Review of an identified home policy, indicated the RN/RPN will, following the incident, complete documentation as required including: progress notes, resident incident report, and revisions to the careplan.

Interview with RN #104 revealed the home's practice is to document a progress note and complete an incident report when a resident is involved in an incident.

Interview with RPN #101 confirmed there was no progress note or an incident report completed for resident #002.

Interview with the ADOC revealed the home's policy is to document in the progress notes and complete an incident report for incidents as mentioned above and confirmed this was not done for resident #002. [s. 8. (1) (b)]

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Issued on this 18th day of April, 2016

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

Original report signed by the inspector.