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 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
Feb 12, 2019	2018_759502_0022	002741-18, 003851-18, 009153-18, 015480-18, 017097-18	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

JULIENNE NGONLOGA (502)

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): December 14, 17, 18, 19, 20, 21, 27, 28 and 31, 2018, January 2, 3, 4, 8 and 10, 2019.

The following intakes were inspected:
- Four complaints (#002741-18, #009153-18, #015480-18, and #017097-18) were submitted to the Director related to multiple care concerns.
- One complaint (#003851-18) was submitted to the Director related to neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Office Manager, Behaviour Support Ontario (BSO) Lead, Physiotherapist (PT), Registered Dietitian (RD), Dietary Aide, residents and family's members of the residents.

The inspector(s) also observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, home's internal investigations, home's policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Skin and Wound Care

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	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. 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has 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.

Review of a complaint was that submitted to the Ministry of Health and Long-Term Care (MOHLTC) in May 2018 indicated that the resident had altered skin integrity with unknown cause.

Review of #015's progress notes indicated that on an identified date in January 2018, PSW #114 reported to RPN #118 identified areas of altered skin integrity on resident #015's identified body parts from unknown cause. The RPN provided specified treatment and left a note for the attending physician to assess, and wrote "please monitor".

Review of the skin and wound assessment record on the home's electronic documentation system from an identified period of time in 2018 did not identify a completed skin assessment for the altered skin integrity identified above.

In an interview, PSW #114 indicated that during care, they noted the altered skin integrity on resident #015's identified body part and they reported them to the nurse on the unit.

In an interview, RPN #118 indicated that the altered skin integrity on resident #015's identified body parts were reported to them by the PSW after an identified care. The RPN indicated that it is the nurse's responsibility to complete a skin and wound assessment and document administration of the treatment. RPN #118 indicated that they did not complete the skin assessment.

In an interview, the DOC indicated that when staff observe an alteration of a resident's skin integrity, registered nursing staff are expected to complete a skin assessment, start the treatment protocol depending of the type of altered skin integrity, inform the physician, and the resident's family, and send a referral to the Registered Dietitian (RD). The DOC acknowledged that the registered nursing staff did not complete the skin assessment for resident #015. [s. 50. (2) (b)(i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration had been implemented.

Review of a complaint that was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in May 2018 indicated that the resident had altered skin integrity with unknown cause.

Review of resident #015's progress notes indicated that on an identified date in January 2018, PSW #114 reported to RPN #118 identified areas of altered skin integrity on resident #015's identified body parts from unknown cause.

Review of the dietary assessment record on the home's electronic documentation system from an identified period of time in 2018 did not identify a skin assessment completed by the home's registered dietitian, for the altered skin integrity identified above.

In an interview, the DOC indicated that when staff observe an alteration in a resident's skin integrity, registered nursing staff are expected to send a referral to the RD. The DOC acknowledged that the registered nursing staff did not send a referral to the RD for

assessment of resident #015's altered skin integrity.

In an interview, the RD indicated the home's expectation is for nursing staff to send them a referral for any altered skin integrity. The RD indicated that they did not assess the resident as they were not aware of resident #015's altered skin integrity identified above. [s. 50. (2) (b) (iii)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has 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, and
- the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required.

Review of a complaint that was submitted to the MOHLTC on an identified date in February 2018, indicated that resident #014 was being ignored by staff due to a lack for treatment and monitoring of an identified symptom of infection.

Review of an email sent by the complainant to the home on an identified date in January 2018, indicated that the resident had an identified symptom of infection and was complaining of pain. Later on the same day the complainant visited resident #014 and noted that the resident exhibited some signs and looked uncomfortable while in the bed. The complainant indicated that the resident asked for a beverage and drank it so quickly. The complainant reported that the nurse told them the symptom of infection was monitored at the end of the previous shift a day before, and an identified medication was administered.

Review of resident #014's progress notes and vital signs record on PCC for an identified three day period, indicated that the symptoms of infection were not recorded on an identified day. Further review of the resident's progress notes indicated that the resident was transferred to the hospital the next day and admitted with a specified diagnosis.

In an interview, ADOC #109 indicated that registered staff are expected to monitor residents for symptoms of infection and document on each shift in the progress notes. ADOC #109 acknowledged that the symptoms of infection for resident #014 were not recorded on an identified date in January 2018, during an identified shift although it was endorsed to them by the staff of the previous shift. [s. 229. (5) (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 to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required, to be implemented voluntarily.

Issued on this 19th day of February, 2019

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

Original report signed by the inspector.