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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 12, 2013	2013_157210_0029	T679-13	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

SLAVICA VUCKO (210)

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 09, 10 and 11, 2013

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Nurses (RN), Assistant Director of Care (ADOC), Director of care (DOC), Administrator, family member

During the course of the inspection, the inspector(s) observed provision of care, reviewed clinical records

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Personal Support Services
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Review of the clinical record confirms the health status of Resident #1 changed on an identified date in 2013. Review of the "Care plan" indicates Resident #1 was walking independently by using a walker. Review of clinical notes indicate on two occasions after the health status change Resident #1 expressed a concern that she\he was "afraid of walking".
Interview with RNs and ADOC indicates staff started using a wheelchair since the health status change to transport resident to the dining room when she\he didn't feel safe to walk with the walker. This information was not shared with PSWs and they were not involved in development and implementation of the resident's plan of care. One week after the health status change, Resident #1 had a fall in front of her\his room and was sent to hospital. Interview with a PSW indicates resident was assisted with morning personal care and sat on the bench in front of her\his room ready to go for breakfast with the walker as per the usual routine before the health status change. The PSW was not aware of changes in resident's plan of care. [s. 6. (4) (b)]

2. The licensee failed to ensure the designate of the resident/SDM has been given an opportunity to participate fully in the development and implementation of the plan of care.
Review of the clinical record and interview with RNs confirm on an identified date in 2013 a new treatment was prescribed by the Physician for Resident #1 and it was not communicated with SDM. [s. 6. (5)]

3. The licensee failed to ensure the care set out in the plan of care in relation to continence care is provided to the resident as specified in the plan.

The written plan of care in relation to toileting and urinary incontinence for Resident #1 indicates resident participates actively in toileting. Staff to provide peri-care twice a day and after each voiding attempt or incontinent episode. Interview with PSWs confirm staff provided peri-care in the morning but not after each voiding attempt, during day shift. [s. 6. (7)]

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 the resident exhibiting altered skin integrity, including pressure ulcers 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 the clinical record and interview with RN confirm on an identified date in 2013 Resident #1 exhibited a pressure ulcer. RN recorded the skin problem in progress notes and applied dressing but did not complete a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure the resident exhibiting pressure ulcer has been assessed by a registered dietitian who is a member of the staff of the home.

Review of the clinical record and interview with RN confirm on an identified date in 2013 Resident #1 exhibited a pressure ulcer and a referral was not sent to the Registered Dietitian in order to implement changes to the plan of care related to nutrition and hydration. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure the resident exhibiting altered skin integrity including pressure ulcers has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
Review of the clinical record and interview with RN and ADOC indicate on an identified date in 2013, Resident #1 exhibited a pressure ulcer and has not been assessed at least weekly. [s. 50. (2) (b) (iv)]

Issued on this 17th day of December, 2013

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

SLAVICA VUCKO