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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 14, 2017	2017_542511_0009	031666-16, 031824-16	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD OAKVILLE ON L6M 3L1

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

CREEK WAY VILLAGE
5200 Corporate Drive BURLINGTON ON L7L 7G7

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

ROBIN MACKIE (511)

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 10, 11, 12, 19, 20, 21, 2017.

The following were inspected: Complaint #031666-16 for Falls management and Plan of Care, Complaint #031824-16 Skin and Wound Care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Manager of Resident Care (MORC #1), Manager of Resident Care (MORC #2), MDS-RAI co-ordinator, Staff Educator, Registered Practical Nurses (RPNs), Registered Nurses (RNs), housekeeping staff and identified family members.

The Inspector observed resident care, reviewed clinical records and reviewed applicable home policies, practices and medical directives.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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. (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. (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 has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) A review of resident #002's Minimum Data Set (MDS) assessment, 2016 quarterly review, identified the Registered Dietitian (RD) had documented the description of an alteration in resident #002's skin integrity. In the same MDS assessment, a Registered Practical Nurse (RPN) documented the resident had no alteration in resident #002's skin integrity.

Interview with the MDS-RAI coordinator confirmed the staff and others involved in the different aspects of care of the resident had not collaborated with each other in the assessments of the resident so that their assessments were integrated and were consistent with and complemented each other.

B) A review of resident #001's clinical record identified on admission the resident had a communication barrier and was cognitively impaired. They required care for their activities of daily living and had been admitted with alterations in their skin integrity.

A review of the Minimum Data Set (MDS), 2016 quarterly review assessment, identified an RPN documented the resident had started on a new medication. The resident had a fall on a specified date in 2016, shortly after the resident had been started on a new medication. Review of the Nurse Post Falls assessment, on the specified date, had not identified any high risk medication or any new medications for the last 30 days.

A review of the Minimum Data Set (MDS), 2016 quarterly review assessment, identified the MORC #1 documented resident #001's responsive behaviour had improved. The RPN note, documented on the same quarterly assessment that resident #001's responsive behaviour had worsened.

Interview with the MORC #1 confirmed the staff and others involved in the different aspects of care of the resident had not collaborated with each other, in the assessment of the resident, so that their assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident’s care needs changed or care set out in the plan was no longer necessary.

A) A review of Resident #002's clinical record indicated the resident sustained a change in their condition on an identified date in 2016. The resident received treatment within the home and the home's physician ordered further testing. The resident was sent to the hospital a few days later and returned from the hospital with a report that confirmed a new diagnosis and treatment.

A review of the Resident Assessment Protocol (RAP) and the MDS assessment for resident #002, on a specified date in 2016, had not identified the resident's new diagnosis and treatment plan that had been received from the hospital in 2016.

Interview with the MDS-RAI coordinator and the MORC #1 confirmed the resident experienced a change in their condition and that the resident's plan of care had not been revised when the resident’s care needs changed.

B) A review of resident #001's clinical record identified the resident had a cognitive impairment and required care for their activities of daily living. They had not been identified as having a risk for falls based on their admission Minimum Data Set (MDS)

and Resident Assessment Protocol (RAP). On the resident's next quarterly MDS assessment, the RAP for Falls was triggered from the resident starting on a new medication. The resident had a fall during this time and a resident fall risk assessment was completed on two separate dates. The plan of care had not been updated to reflect the resident's increased risk for falls and interventions had not been added to address the fall risk at the time the resident went from a low risk for falls to a high risk for falls.

Interview with the MORC #1 confirmed the resident's fall risk increased when they had been placed on a new medication, had a history of a fall and the plan of care had not been reviewed and revised when the resident's care needs changed. [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 to 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, (b) the resident's care needs change or 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Ontario Regulation 79/10.s.48 (4) required the home to have a Pain Management Program.The home's Pain Management Program described the pain assessment tools for both cognitively intact and cognitively impaired residents and the frequency of these assessment for residents with pain. The Pain Management Program highlighted that staff were to complete pain assessments when pain was indicated by verbal or non verbal indicators and that comprehensive pain management was achieved through effective use of both non-pharmacological and pharmacological interventions. Further pharmacological interventions were provided for the administration of pain medications, as ordered, and required reassessment of the effectiveness of the intervention one hour post administration. If the PRN medication was administered more than three times in one week the staff were to refer to the physician for assessment.

A) A review of the clinical record, for resident #001, identified missing staff signatures for the administration of a narcotic, on two separate occasions over a three month review period. A review of the Electronic Medication Administration Record (EMAR) revealed the staff had not signed for the administration of the drug nor the reassessment of the the resident's response to the intervention.

B) Resident #001 had multiple alterations in their skin integrity. A review of the clinical record identified the resident experienced multiple levels of pain on identified dates and a call was placed to the family on an identified date in 2016 to notify them that the resident's pain was not controlled. A review of the resident's EMARs for three consecutive months in 2016 was completed. This review identified resident #001 received an increasing number of doses of an analgesic medication, progressively, during the three month review. During this period there was inconsistent documentation of pain assessments, reassessments and non pharmacological interventions used to treat the resident's pain. Interview with the DOC and the MORC #1 confirmed the resident had increased pain, that had not been controlled with medication, and that there was no documentation of other non-pharmacological measures that staff had taken to reduce pain. The MORC confirmed the pain assessment tools were not always completed nor were they completed in there entirety, as outlined in the Pain Management Program, during the three month review period in 2016. [s. 30. (2)]

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 has failed to ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) A review of resident #002's plan of care indicated the resident required multiple staff for assistance, during all transfers, as a result of an injury in 2016. A review of resident #002's progress notes identified the resident sustained another injury, a few months later, that resulted in an alteration in the resident's skin integrity. A progress note indicated another alteration to the resident's skin integrity on a later date in 2016. The progress note documented the altered skin integrity required treatment. A review of the resident's clinical record identified the staff had completed Wound Care notes and Skin and Wound notes interchangeably for the resident's multiple alterations in skin integrity. A Head to Toe assessment had been completed for resident #002, that was identified as a clinical appropriate assessment tool by the home's MORC #1, on admission only and not when new alterations in skin integrity where identified. A review of the clinical record did not

indicate that when the resident had observations of new altered skin integrity that they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Interview with MORC #1 confirmed the licensee failed to ensure resident #002 received a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

B) A review of the clinical record for resident #001 identified they were admitted with an alteration in their skin integrity. It was identified in resident #001's plan of care for staff to inspect the resident's skin every shift during care for signs of breakdown and report any concerns immediately to the registered staff. Interview with RN #102 confirmed, upon being notified of any new alteration in skin integrity, the RN responsible for resident #001 would be required to complete a skin assessment using a clinically appropriate skin assessment instrument designed for skin and wound.
A review of resident #001's progress notes identified the resident received care for new alterations in their skin integrity on several dates in 2016. Interview with RN #102 confirmed that after a review of the multiple treatment notes and weekly skin notes over an eight month period, it was difficult to follow the progression of the alterations in skin integrity and that this documentation had been completed inconsistently. RN #102 stated resident #001's alterations in skin integrity were not assessed using a clinically appropriate assessment instrument, that was specifically designed for skin and wound.

A review of the licensee's Skin and Wound Care program, provided by the home on April 13, 2017, was reviewed by the licensee's skin and wound designate on February 2014 and revised in March 2016. The home's Skin and Wound Care program identified the home would use screening protocols and assessment instruments to assess risk factors but no assessment or reassessment tools were listed or referenced for residents who had actual alterations of skin integrity for registered staff. Procedure #17-02-01, Prevention of Pressure Ulcers, was provided by the home and identified the Personal Support Workers (PSW) would complete a visual head to toe assessment on bath days and document the evidence of altered skin integrity on the PSW Bath Assessment Record and report the findings to the registered staff. The registered staff were directed to identify any wound care issues, every shift, by reviewing the PSW Bath Assessment Record and reporting changes to Registered Nurse or Skin and Wound Care designate. Procedure #17-02-01 did not identify the assessment or reassessment tool that should be used for identification of alterations in skin integrity. The Registered Nurse or Skin

and Wound Care designate was required to complete a baseline wound assessment in Point Click Care (PCC).

Interview with the MORC #1, confirmed the home's registered staff had used PCC skin progress notes and wound assessment notes inconsistently in their documentation for initial and weekly skin reassessments and this reassessment tool or direction was not specified in the home's Skin and Wound Care program. Interview with the Administrator stated the clinically appropriate skin assessment instrument designed for skin and wound was the Skin and Wound assessment-Designate RN referral form. [s. 50. (2) (b) (i)]

Issued on this 14th day of August, 2017

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

Original report signed by the inspector.