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
Dec 4, 2018	2018_727695_0016	013396-17, 029115-17, 008546-18, 009288-18, 010380-18, 015987-18, 028014-18, 028069-18	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Wellington
74 Woolwich Street GUELPH ON N1H 3T9

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

Wellington Terrace Long-Term Care Home
474 Wellington Road 18 FERGUS ON N1M 0A1

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

FARAH_ KHAN (695)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 20, 21, 22, 23, 26, 27, and 28, 2018

During the course of the inspection, the following Critical Incident intakes were inspected:
Log# 013396-17, related to a fall with injury
Log# 029115-17, related to a fall with injury
Log# 028069-18, related to a fall with injury
Log# 009288-18, related to a fracture with unknown cause
Log# 008546-18, related to an acute respiratory illness outbreak
Log# 010380-18, related to resident to resident altercation
Log# 015987-18, related to resident to resident altercation
Log# 028014-18, related to resident to resident altercation

During the course of the inspection the Inspector observed the provision of care and services, reviewed relevant documents including: clinical records, policies and procedures, training records, and observed infection prevention and control practices.

During the course of the inspection, the inspector(s) spoke with with residents, personal support workers (PSW), environmental staff, registered practical nurses (RPN), registered nurses (RN), Behavioural Support Ontario (BSO) lead, physiotherapist, Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Assistant Administrator, the Resident Care Manager, the Director of Care (DOC), and the Administrator.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Pain
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

2 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	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. 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 a required plan, policy, protocol, procedure, strategy or system under the Act or Regulation under Falls Prevention and Management was complied with.

In accordance with s. 49 (1), the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

a) A Critical Incident (CI) was submitted to the Ministry of Health and Long Term Care (MOHLTC) in 2018 stating that resident #004 sustained an injury. The resident was sent to hospital and returned within a few days. It was believed that the resident had a fall which caused the injury.

According to the policy, "Falls Prevention Management Program," staff were directed to identify all new residents at high risk for falls initially, as well as initiate the Falling Leaf Program upon admission to the home for 72 hours unless it was obvious the falls risk was low.

According to the Falling Leaf assessment and the written plan of care, the Falling leaf program was initiated for the resident upon return from hospital but not when the resident was initially admitted to the home.

Registered Nurse (RN) #104 could not find where the Falling Leaf program was initiated upon admission for resident #004.

The Resident Care Manager (RCM) acknowledged that the Falling Leaf program had not been initiated for resident #004.

b) A CI was submitted in 2017 to the MOHLTC stating that resident #001 was found lying on the floor. The resident was eventually sent to the hospital for an injury.

According to the policy, "Falls Prevention Management Program," policy # RS8B-030, staff were directed to initiate the Falling Leaf Program for four weeks.

The falls prevention and management strategies were reviewed in the written plan of care before and after the fall, the strategies and interventions were not revised. There was no evidence that the Falling Leaf program was initiated after the resident returned from hospital.

Registered Nurse #100 indicated that they would have initiated the Falling Leaf Program for the resident upon return from hospital but was unable to find it for resident #001.

The Resident Care Manager (RCM) acknowledged that the Falling Leaf program had not been initiated for resident #001 upon returning from hospital.

c) A CI was submitted in 2017 to the MOHLTC stating that resident #002 was found sitting on the floor in their room. The resident was eventually sent to the hospital for an injury.

The falls prevention and management strategies were reviewed in the written plan of care before and after the fall, the strategies and interventions were not revised. There was no evidence in the clinical record that the Falling Leaf program was initiated after the resident returned from hospital.

The Resident Care Manager (RCM) acknowledged that the Falling Leaf program had not been initiated for resident #002 upon return from hospital.

The licensee has failed to ensure that the Falls Prevention and Management Program was complied with, specifically that the Falling Leaf Program was initiated upon admission for resident #004 and upon return from hospital for residents #001 and #002.

2. The licensee has failed to ensure that a required plan, policy, protocol, procedure, strategy or system under the Act or Regulation for Pain Management was implemented in accordance with applicable requirements and was complied with.

In accordance with Regulation, s.52 (2), when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A CI was submitted in 2018 to the MOHLTC stating that resident #004 was sent to hospital related to an injury. The resident returned to the home shortly after and was on pain medication.

The clinical record indicated that resident #004 was first identified as having pain in the early morning prior to their hospitalization. Pain medication was given but was ineffective. According to the Electronic Medication Administration Record (E-MAR), there were six times in ten days where pain medication was administered and was documented as being ineffective. When the resident returned from hospital, a Seven Day Pain Assessment was initiated. Upon review of the assessment, there were areas for every shift to describe the resident's pain level and a summary box at the end. There were nine shifts that were left blank on the pain assessment and the summary at the end was also left blank.

Registered Practical Nurse #115 indicated that they were unsure which tool was the clinically appropriate pain assessment tool used when initial interventions were ineffective. They acknowledged that they could only find the seven day pain assessment tool for this resident, and that it was incomplete. They indicated that the seven day pain assessment tool was used to track an individual's pain level for seven days after starting a new pain medication.

The DOC acknowledged that the policy does not provide clear direction of which pain assessment to complete when initial interventions are ineffective.

The licensee has failed to ensure that a required plan, policy, protocol, procedure, strategy or system under the Act or Regulation for 1) Falls Prevention and Management was complied with 2) Pain Management was implemented in accordance with applicable requirements and was complied with.

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 the licensee must 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 (b) is complied with, 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received a skin assessment by a member of the registered nursing staff within 24 hours of admission.

A CI was submitted to the MOHLTC in 2018 stating that resident #004 was sent to hospital related to an injury.

The resident's clinical record showed that the resident was admitted to the home and a couple of days later was sent to hospital, they spent a few days in hospital before returning to the home. A Skin integrity assessment form locked on the day the resident returned from hospital, stated that the resident had altered skin integrity. No other skin assessment form was completed in the first week when the resident was admitted to the home.

Registered Nurse #104 explained that the admission skin assessment was not completed until the resident returned from hospital and that is why it indicated the resident had altered skin integrity.

Registered Nurse #100 acknowledged that a skin assessment should have been completed within 24 hours of admission and a separate skin assessment should be completed when the resident returned from hospital. The RN confirmed that it was not done for resident #004.

The licensee failed to ensure that resident #004 received a skin assessment by a member of the registered nursing staff within 24 hours of admission.

Issued on this 18th day of December, 2018

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

Original report signed by the inspector.