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 10, 2016	2016_287548_0005	O-002898-15	Complaint

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

ALMONTE COUNTRY HAVEN
333 COUNTRY STREET P.O. BOX 250 ALMONTE ON K0A 1A0

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

RUZICA SUBOTIC-HOWELL (548)

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): This inspection was conducted on the following date(s): February 22, 23, 24 and 25, 2016.

During the course of the inspection, the inspector(s) toured resident care areas, reviewed a resident's health care record, reviewed the home's skin and wound program, nutrition and hydration program, reviewed environmental services procedures and housekeeping cleaning procedures, observed residents and reviewed home policies.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSWs), Environmental Support Manager and Housekeeper, RAI Coordinator, Resident Care Coordinator, Food Services, Physiotherapist and Dietitian.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Resident #010 was transferred from another long-term care home and admitted to the home on a specified date in April 2015 with several co-morbidities.

On a specified day in February 2016 during an interview the Power of Attorney (POA) indicated it was brought to the attention of the home that resident #010 required routine blood work to be completed for the management of the resident's co-morbidities.

The home's admission screening process for residents with specific existing co-morbidities indicated lab values are to be obtained and repeated every three months. The home is guided by policy to repeat lab values every three months for the management of specific co-morbidities.

Resident #010's health care record was reviewed, initial blood work was completed on a specified day in April 2015.

On February 25, 2016 RPN #103 indicated lab values are to be completed every three months for those resident's with existing diagnoses or at the discretion of the physician, as necessary.

The Physician's orders were reviewed from specified days in May to October 2015. There is no order for the lab values to be completed other than as per Licensee policy.

A progress note entry dated for a specified day in August 2015 indicated the resident's POA was requesting the results of the most recent blood lab value. The progress note entry indicated blood work was obtained and sent to the lab on a specified day and was scheduled to be completed on a regular basis. The laboratory determined the vials were expired and the blood work was recollected on specified day in August 2015 and processed the following day.

From the review of the health record from April to October 2015 there are two forms dated for a specified day in April 2015 and the other for a specified day in September 2015. RPN#103 indicated the blood work would have been scheduled every three months on specified days in April,July and October 2015 in order to comply with the home's policy for residents screened as high risk. [s. 6. (2)]

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).

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 at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

Resident #010 required assistance for activities of daily living and had a history of compromised skin integrity.

Resident's #010 health care record was reviewed.

A progress note entry dated for a specified day in August 2015 the dietitian indicated that Resident #010's co-morbidities placed the resident at risk for altered skin integrity. In addition, on a specified day in August 2015 the attending physician recorded that the resident was at risk for skin breakdown and infection.

On a specified day in October 2015 a progress note entry indicated the resident was transferred to hospital for a change in health status.

The home follows the Healthy Living, Healthy Skin program, policy HLHS-SW- 3.1 dated January 2012. Home policy: Skin Assessment, HLHS-SW-3.3 dated March 2013. This program indicated that a head to toe assessment including skin, fingernails, toenails, mouth, feet and boney prominences are to be conducted within 24 hours upon return from hospital or longer if at risk for altered skin integrity.

On February 24, 2015 during an interview, the DOC confirmed that the home's procedure is to assess a resident's skin integrity upon return to the home from hospital on the Skin Condition Assessment form.

The resident's health care record was reviewed. There is no record of any assessment conducted on the Skin Condition Assessment form within 24 hours of the resident's return to the home from the hospital. [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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 assessments.

Resident #010 required assistance for activities of daily living and had a history of altered skin integrity.

Resident #010's health care record was reviewed.

A progress note entry dated for a specified day in August 2015 the dietitian indicated that Resident #010's co-morbidities placed the resident at risk for altered skin integrity. In addition, on a specified day in August 2015 the attending physician recorded that the resident was at risk for skin breakdown and infection.

On February 24, 2016 during an interview with inspector #548 Clinical care coordinator (CCC) indicated that any change in the condition and structure of the skin is considered altered skin integrity and requires the use of a clinically appropriate tool specifically designed for skin and wound assessment.

On February 24, 2016 the DOC and CCC both confirmed the form titled: Documentation for Treatments is the clinically appropriate assessment tool to be used for altered skin integrity.

The home follows the Healthy Living, Healthy Skin program, policy HLHS-SW- 3.1 dated January 2012. The home's current procedure for the assessment, monitoring and evaluation of skin integrity includes the recording of findings in the: Skin Condition Assessment form, progress notes, treatment administration record, wound tracker form, wound assessment report, the NCP and Treatment Sheet and a form titled: Documentation for Treatments, HLHS-3.6 (j).

Resident #010's health care record was reviewed.

The Skin Condition Assessment form dated for a specified day in April, 2015 for resident #010 recorded the colour and integrity of a skin assessment for a specific area.

On a specified day in July 2015 the Skin Condition Assessment form for resident #010 indicated that the integrity of the assessed area remained in the same state.

On a specified day in August 2015 a progress note entry indicated that there was a change in skin integrity and there is record of the change describing the area.

On a specified day in August 2015 a progress note entry indicated that there are additional blistering to the specific area.

On a specified day in August 2015 the progress note entry indicated there was drainage from the area.

On a specified day in August 2015 another entry indicated that although changing the dressing to the area was not due, a registered nursing staff observed the wound dressing to be saturated with discharge and changed the dressing.

The following day a progress note entry indicated that the bandage to the area was

saturated with and there were new open wounds. The progress note indicated that the wounds are getting larger and it is recorded that there were bloody areas, sloughing of skin and clear raised bubbles of fluid. Treatment was provided and the resident tolerated the procedure well.

The next day a progress note entry indicated there is a newly developed wound in the vicinity of the existing wound. The area adjacent to the wound was described as odorous and with fluid, characteristics of the wound is recorded. In addition, it is recorded by registered nursing staff the wound appeared "worse" than yesterday. In the progress notes the number of wounds are indicated and treatment was provided.

Several days later a progress note entry on a specified day in August 2015 it is recorded there is significant drainage coming from the wounds with an odor. In addition, it was observed and recorded there are additional small open areas in the vicinity of the original wound. Treatment was provided and pictures were taken.

On a specified day in August 2015 a form titled: NCP and Treatment Sheet- stage 2 Pressure Ulcer described the resident's #010 wound to be stage two ulcer.

A progress note entry on a specified day in August 2015 indicated one wound as having a possible infection. Characteristics of the wound were described and the physician ordered the administration of an antibiotic to treat a diagnosed wound infection.

On a specified day in August 2015 the wounds are described in detail on the Wound Assessment Report.

On a specified day in September 2015 a progress note entries indicated that the wounds were healing with newly developed wound. Treatment was provided.

On a specified day in September 2015 a progress note entry indicated that the resident refused to have the wound dressing changed.

On a specified day in September 2015 a progress note entry indicated the wound dressing was removed and saturated with fluid. The wound is further described as having uneven edges and maceration +++. Treatment was provided and the resident voiced minimal discomfort.

The form titled: NCP and Treatment Sheet-Venous Wound dated for a specified day in

September 2015 indicated there are a total of four areas of compromised skin integrity.

Review of the health care record did not result in finding the clinical appropriate assessment tool. The DOC and CCC confirmed its absence and both indicated that the assessment tool is not being used by registered nursing staff, as required. [s. 50. (2) (b) (i)]

Issued on this 4th day of April, 2016

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

Original report signed by the inspector.