Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Aug 25, 2020	2020_745690_0014	011744-20, 013023-20, 013737-20	Critical Incident System

Licensee/Titulaire de permis

Board of Management for the District of Parry Sound West
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

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

Belvedere Heights
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

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

TRACY MUCHMAKER (690)

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): August 11-14, 2020.

The Following intakes were inspected upon during this Critical Incident System inspection:
-Two Logs, which were related to critical incidents that the home submitted to the Director related to incidents of alleged abuse of a resident,
-One log, which was a critical incident that the home submitted to the Director related to an incident of Improper/Incompetent treatment of a resident that results in harm or risk of harm.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident (CI) report was submitted to the Director for an allegation of staff to resident neglect that occurred on an identified date. The CI report indicated that resident #001 had requested assistance with an adhesive dressing. Registered Nurse (RN) #102, used tape to secure the adhesive dressing and did not change it. The CI report indicated that the following morning, the resident was calling for assistance, was distraught and indicated to staff that RN #102 was abrupt with them, and “couldn’t be bothered” to change the dressing.

Inspector #690 reviewed the electronic progress notes on Gold Care and identified a progress note that indicated that Registered Practical Nurse (RPN) #106, was made aware that resident #001 was requesting assistance with their adhesive dressing. RPN #106 attended to the resident and noted that the edges of the adhesive dressing where the tape was applied was soiled and the skin was reddened.

A review of the electronic care plan for an identified activity of daily living indicated that no tape was to be used if the adhesive dressing had lost adhesion and that staff were to change the dressing. The care plan entry was dated prior to the time of the incident.

In an interview with RPN #106, they indicated that they were made aware that resident #001 was requesting assistance with the adhesive dressing and that they were upset. RPN #106 attended to the resident and found that the resident was distraught, that tape had been used around the adhesive dressing and that the skin around the dressing was red and excoriated. RPN #106 further indicated that it was in the resident’s care plan not to use tape as it had caused skin breakdown in the past. RPN #106 indicated that if the resident’s dressing had lost adhesion or the resident requested that it be changed, that staff were to change it.

In an interview with RN #102, they indicated that they were notified that resident #001 was requesting assistance with an adhesive dressing and that they assessed it. RN #102 indicated that they knew the resident was to receive a shower the following day and the dressing was due to be changed after the shower, therefore they used tape to address the issue. RN #102, further indicated that it had been past practice to use tape if the dressing had lost adhesion and they were not aware of the entry in the care plan to not use tape.

In an interview with the Director of Care (DOC), they indicated that resident #001’s adhesive dressing frequently came loose and that in the past, staff would use tape to re-

enforce it until it was due to be changed. The DOC further indicated that the resident would often become anxious about the dressing and at the request of the resident's Substitute Decision Maker (SDM), staff were not to use tape and to change it. The DOC indicated that the care plan was updated to reflect the request and that it was the expectation that staff provide care to the resident as specified in the plan of care. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 26th day of August, 2020

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

Original report signed by the inspector.