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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 8, 2022 | 2022_831211_0002 | 020087-21, 000682-22 | Critical Incident System |

### Licensee/Titulaire de permis

Centre d'Accueil Roger Seguin
435 Lemay Street Clarence Creek ON K0A 1N0

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

Centre d'Accueil Roger Seguin
435 Lemay Street Clarence Creek ON K0A 1N0

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

JOELLE TAILLEFER (211)

## 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): February 10, 11, 14, 15, 16, 17, 2022 (onsite) and February 18, 2022 (offsite).**

**During the inspection the following logs were inspected:**
**-Log #000682-22 related to critical incidents, and**
**-Log #020087-21 related to safe and secure home.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, DOC, Coordinator of Quality of Care and Risks Assessment, Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and the Environmental Services Supervisor.**

**During the course of the inspection, the inspectors observed residents and staff interactions, provision of care and resident's environment. Reviewed relevant clinical health records and interviewed staff members.**

**The following Inspection Protocols were used during this inspection:**
**Infection Prevention and Control**
**Medication**
**Safe and Secure Home**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

1.The licensee failed to ensure that the home was a safe and secure environment for a resident when a staff member accidentally hit the resident with a device.

Specifically, the Inspection Protocol “Safe and Secure Home” defined an unsafe environment when any condition, circumstance, or influence surrounding and affecting the resident that may cause physical harm or risk of harm.

A Critical Incident Report indicated a staff member accidentally hit a resident’s body area with a device. The resident’s progress notes indicated that the resident sustained an injury to a body area.

The staff member stated that while they were navigating the device, a piece of the device had been left on top of the device and prevented them from seeing the resident. Inadvertently, a part of the device swung and hit the resident and causing an injury to the resident.

Since a staff member failed to have proper visibility while moving a device, there was actual risk to the resident’s safety. Consequently, the resident was hit by a part of the device and was injured.

Sources: Resident’s health care records and interviews with a staff member, DOC and the Administrator. [s. 5.]

***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 home is a safe and secure environment for its residents, to be implemented voluntarily.***

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**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 has failed to ensure that resident exhibiting altered skin integrity
(i) received a skin assessment by a member to the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and
(iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On a date in 2021, a resident's progress notes indicated that there was a small injury on a resident's body area after the resident was accidentally hit with a device. The next day on two different shifts, the notes indicated that there was a specific injury, and the resident did not complaint of pain.

The DOC validated that the clinical skin and wound assessment instrument designed for skin and wound assessment was not used to assess the size and to describe the injury on the resident's body area. Furthermore, the injury was not assessed weekly to determine when the body area was healed.

As such, there was a potential risk when the resident's injury was not assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound on two different dates in 2021, and at least weekly to determine the healing progress.

Sources: Resident's health care records and interview with the DOC. [s. 50. (2) (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 a resident exhibiting altered skin integrity,
(i) received a skin assessment by a member to the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and
(iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated., to be implemented voluntarily.***

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system**

**Specifically failed to comply with the following:**

**s. 114. (3) The written policies and protocols must be,**
**(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).**
**(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the written policy and procedure regarding medication monitoring at shift change are implemented in accordance with evidence-based practice, and, if there are none, in accordance with prevailing practices.

The licensee's policy titled "Shift Change Monitored Drug Count" indicated that the shift count must be reconciled with the actual amount of drug in the packaging (not just the last blister number or doses). If an individual count is used, the shift count should be reconciled with this as well to account for actual daily use. The procedure was as followed:
1. Record client name, medication name and strength on "Shift Change Monitored Medication Count" form upon receipt of medication.
2. Two staff (leaving and arriving), together:
a. Count the actual quantity of medications remaining
b. Record the date, time, quantity of medication and sign in the appropriate spaces on the "Shift Change Monitored Medication Count" form
c. Confirm actual quantity is the same as the amount recorded on the "Individual Monitored Medication Record" for prn, patchers or injectable.

Specifically, four Registered Nursing Staff did not comply with the licensee's policy when they did not reconcile the actual amount of drug in the packaging at shift change.
Three residents' Medication Administration Records (MAR), for an identified month, indicated that each resident had prescribed medication. These medications needed to be counted and reconciled every shift change.

The Administrator validated that the Shift Change Monitored Medication Count form was not reconciled by two nurses with the actual amount of drug in the packaging related to one of the resident's identified medication on three different dates for four different shifts.

The DOC validated that the Shift Change Monitored Medication Count form was not reconciled by two nurses with the actual amount of drug in the packaging for a second resident on a specified date at the change of shift and a third resident on two different dates for three different shifts changes.

As such, there was a potential risk of not having an accurate reconciliation of residents' drug medication as the "Shift Change Monitoring Medication Count" was not completed for several shifts within three days.

Sources: Review of residents' health care records and their "Shift Change Monitored Medication Count" forms. Review of the licensee's policy "Shift Change Monitored Drug Count". Interviews with the Administrator, DOC and several Registered Nursing Staff. [s. 114. (3) (a)]

***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 the the written policies are implemented in accordance with evidence-based practices and, if there are non, in accordance with prevailing practices, to be implemented voluntarily.***

**Issued on this 9th day of March, 2022**

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

**Original report signed by the inspector.**