Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Nov 21, 2019	2019_526645_0016	013072-19	Critical Incident System

Licensee/Titulaire de permis

The Rekai Centres
160 Wellesley Street East TORONTO ON M4Y 1J2

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

Sherbourne Place
345 Sherbourne Street TORONTO ON M5A 2S3

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

DEREGE GEDA (645)

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 6, 7 and 8, 2019.

The following critical incident with log# 013072-19 (#2754-000012-19) related to fall prevention and management, was inspected.

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

During the course of the inspection, the inspector performed observations of staff and resident interactions, provision of care, reviewed residents' clinical records, medication administration records (MAR), staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
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	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. 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 residents 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 assessment.

1). A Critical Incident System (CIS) was received by the Ministry of Long Term Care (MLTC), regarding a fall with injury of resident #001. The report indicated that the resident sustained an injury.

The home's policy titled "Skin and Wound Care program Management", revised on August 2019, directed registered staff members to conduct a head to toe and initial skin assessments, when a resident has altered skin conditions and when there is a significant change in health conditions. The policy also directed staff members to initiate weekly wound assessments and take picture of the wounds for follow ups.

Record review of the progress notes indicated that resident #001 had multiple skin breakdowns. Review of the progress notes on an identified date, indicated that the resident had a new onset of skin breakdown. The notes indicated that the initial skin assessment was not completed as the nurse who identified the skin injury, did not have access to the computer system. Further review of the records did not indicate if the initial

skin assessment, weekly skin and head to toe assessments were completed using the home's skin assessment tools. The notes indicated that the wound was healed after several weeks, but there were no skin assessments completed and no documentation regarding the prognosis of the wound was available, throughout the healing process.

Review of the progress notes also indicated that resident #001 had another skin breakdown. Further review of the records did not indicate if there were any initial wound and weekly skin assessments completed; there was no evidence to verify if the skin injury was assessed by a registered dietitian, there were no treatments ordered or administered; there was no records available describing the type, color, size, and drainage type of the wound.

2). Inspector #645 reviewed two additional fall incidents that has caused altered skin injury for residents #002 and #003, to increase the resident sample due to identified noncompliance.
Review of the progress notes on an identified date, indicated that resident #002 had a fall and sustained a skin breakdown. The notes indicated that, few days later, the skin breakdown increased in size. The progress notes also indicated that there was a new onset of skin breakdown on an identified part of the resident's body. Review of the records did not indicate if there were any skin assessments completed following the fall incident and when the new onset of skin injury occurred.

Interviews with RPN #101 and RN (Wound Care Lead) #100 confirmed that there were no skin and head to toe assessments completed after residents #001 and #002 sustained skin breakdown. Both staff members reiterated that it was the expectation of the home to complete a head to toe and skin assessments when a resident has altered skin conditions, initiate treatments and document the findings. The wound care lead indicated that the above identified skin breakdowns were not assessed. They confirmed that there were no treatments initiated for the new onset of skin breakdown for resident #001. They indicated that they would get one of the nurses to complete the assessments and contact the facility physician to obtain treatment orders.

Interview with the RCD indicated that it was the home's expectation that registered staff complete skin assessments using the home's skin assessment tool when a resident has altered skin conditions, initiate treatments and confirmed that the registered staff did not use the assessment tool and document findings as expected. [s. 50. (2) (b) (i)]

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, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.

WN #2: 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 any policy and procedure the home had, instituted or otherwise put in place was complied with.

In accordance with O.Reg 79/10, s. 49, the licensee is required to have, a fall prevention and management program policy and procedure. Confirmation was made that policies and procedures for fall prevention and management program were in place, but they were not complied with.

Record review of the progress notes indicated that resident #001 had a fall and sustained injury.

The home's policy titled "Fall-prevention and Management" last reviewed on January

2019, states that when a resident has fallen, registered staff should complete the following: Fall risk assessment; post fall assessment using Risk Incident Program (RIP); complete head to toe and skin assessment to examine bleeding, bone protrusions, hematomas and fractures; assess pain; complete Head Injury Routine (HIR) if injury to the head is suspected; identify contributing factors, update the plan of care and implement interventions immediately following a fall. Further review of the records did not indicate if a fall risk assessment and head to toe and skin assessments were completed using the home's clinically appropriate assessment tools following the fall incident. Further review of the records did not indicate if head to toe, skin and pain assessment was completed using the tool.

An interview with RPN #100 confirmed that there were no fall risk, head to toe, and skin assessments completed immediately after the fall. RN #100 indicated that they only completed a head to toe assessment few days later after the resident returned from the hospital.

Review of the progress notes on an identified date, indicated that resident #002 had a fall. The note indicated that the resident sustained an injury following the fall and the size of the injury increased few days later. The progress notes also indicated, a week later, a new onset of skin injury was identified following a second fall incident. Review of the records did not indicate if fall risk and head to toe and skin assessments were completed immediately following the fall incident mentioned above.

Interview with RCD confirmed that there was no head to toe, skin and fall risk assessments completed immediately following the fall incidents mentioned above. The RCD reiterated that it is the expectation of the home that registered staff complete head to toe and skin, and post fall risk assessments using the home's clinically acceptable fall assessment tool [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's pain management program to identify and manage pain in residents was implemented in the home.

Review of the home's policy titled "Pain Management Program, #G60" last reviewed on January 2019, directed staff members to provide ongoing pain assessments to optimally control and manage pain and document effectiveness of pain medications. The policy directed staff members to complete pain assessment when a resident is a new admission, when there is a significant change with the resident condition, and when pain is not relieved following the initial pain treatment. The policy also directed staff members to complete "Pain Assessment in Advanced dementia (PAINAD) if a resident has advanced dementia. The home's pain management policy under fall-prevention and management program, also states that when a resident has fallen, registered staff should complete pain assessment using the Risk Incident Program (RIP); complete a thorough assessment to identify gross injuries and extreme pain, and to observe non verbal pain markers such as guarding, facial expressions and tensions.

Record review of the clinical records indicated that the resident had severe intellectual/cognitive impairments secondary to an identified disease condition.

Record review of the progress notes on an identified date, indicated that the resident #001 had a fall and sustained injury. Record review of the progress notes indicated that the next day, the resident was showing non verbal markers of pain such as facial

grimacing, guarding and inability to weight bear and was sent to the hospital. Further review of the records did not indicate if pain assessment (PAINAD) was completed following the fall incident, and after the resident exhibited non verbal markers of pain. There was no documentation available describing the type, severity, quality, onset, duration, and precipitating factors of the pain.

Review of the progress notes on an identified date, indicated that resident #002 had a fall. The notes indicated that the resident sustained an injury following the fall and the size of the injury increased few days later. The progress notes also indicated that, a week later, a new onset of skin injury was identified following a second fall incident. Review of the records did not indicate completion of pain assessment using PAINAD following the fall incidents. The record also did not indicate if pain assessment was completed after the resident sustained a second injury following the second fall incident.

Interviews with RCD confirmed that the registered staff did not complete pain assessments following the fall incident of residents #001 and #002. The RCD indicated that both residents sustained injury following the falls. The RCD indicated that under the home's pain management program, registered staff are expected to complete pain assessments using the home's specified pain assessment tools when a resident exhibits pain and confirmed that the registered staff did not implement the home's pain management program for resident #001 and #002. [s. 48. (1) 4.]

Issued on this 13th day of December, 2019

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

Original report signed by the inspector.