

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

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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
Jul 17, 2019	2019_749653_0016	016535-17, 024927- 17, 026124-17, 029440-17, 032642-18	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON
L4W 0E4

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

Elginwood
182 Yorkland Street RICHMOND HILL ON L4S 2M9

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

ROMELA VILLASPIR (653), DIANE BROWN (110), JOVAIRIA AWAN (648)

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): June 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, and July 2, 3, 2019.

The following complaint intakes were inspected during this inspection:

Log #(s):

016535-17, related to bathing and personal support services;

024927-17, related to the residents' bill of rights, nutrition and hydration, snacks, and plan of care;

026124-17, 029440-17, related to allegation of abuse, skin and wound care, continence care, and personal support services;

032642-18, related to withholding approval for admission.

During the course of the inspection, the inspector(s) conducted observations of resident care provision, staff and resident interactions, reviewed clinical health records, staff training records, staffing schedules, staff employment records, the home's complaints and Critical Incidents (CI) binder, and internal investigation records.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Private Caregiver (PC), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Wound Care Champion RPN (WCC RPN), Registered Dietitian (RD), Agency Registered Staff, Central Local Health Integration Network Care Coordinator (CLHIN CC), Central Local Health Integration Network Supervisor (CLHIN Supervisor), Associate Director of Care (ADOC), Director of Care (DOC), and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:

Admission and Discharge

Continence Care and Bowel Management

Dignity, Choice and Privacy

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

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

- 5 WN(s)**
- 3 VPC(s)**
- 0 CO(s)**
- 0 DR(s)**
- 0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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 had failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The Ministry of Long-Term Care (MLTC) received a complaint related to the care resident #024 was receiving in the home.

During an interview, the complainant stated to Inspector #653 that resident #024 recently sustained a new area of skin breakdown.

An interview with Personal Support Worker (PSW) #109 indicated on an identified date and time, they noted a new area of skin breakdown while providing care to resident #024. The PSW stated they had documented on Point of Care (POC) and reported it to the Wound Care Champion (WCC) Registered Practical Nurse (RPN).

An interview with the WCC RPN indicated on an identified date and time, PSW #109

reported to them that resident #024 had a new area of skin breakdown, and the WCC RPN subsequently left a note in the doctor's book. When asked by the inspector if the WCC RPN assessed the resident's skin, the WCC RPN indicated they did not and that the procedure was for the assigned registered staff to carry out the skin assessment. An interview with RPN #115 who was the assigned registered staff, indicated PSW #109 informed them they had reported to the WCC RPN that resident #024 had a new area of skin breakdown. RPN #115 further indicated when they had spoken to the WCC RPN, they were told resident #024 had a new skin breakdown and they noted it in the doctor's book. The RPN indicated they thought everything was taken care of by the WCC RPN, including the skin assessment so RPN #115 did not carry out a skin assessment on resident #024.

A record review of resident #024's assessments on Point Click Care (PCC) did not identify a skin assessment was completed on the identified date, after the skin breakdown was first noted.

An interview with the Director of Care (DOC) indicated when PSW #109 first identified the skin breakdown and reported it to the registered staff, the expectation was for the registered staff to do a proper skin assessment of the skin breakdown. The DOC acknowledged in this case, resident #024 did not receive a skin assessment by the registered staff using a clinically appropriate assessment instrument specifically designed for skin and wound assessment when the skin breakdown was first noted. [s. 50. (2) (b) (i)]

2. The licensee had failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

An interview with PSW #109 indicated on an identified date and time, they noted a new area of skin breakdown while providing care to resident #024. The PSW stated they had documented on POC and reported it to the WCC RPN.

An interview with the WCC RPN indicated on an identified date and time, PSW #109 reported to them that resident #024 had a new area of skin breakdown, and the WCC RPN subsequently left a note in the doctor's book. An interview with RPN #115 who was the assigned registered staff, indicated PSW #109 informed them they had reported to the WCC RPN that resident #024 had a new area of skin breakdown. RPN #115 further indicated when they had spoken to the WCC RPN, they were told resident #024 had a

new skin breakdown and they noted it in the doctor's book. Separate interviews with the WCC RPN and RPN #115 indicated they did not check and see the skin breakdown after they were made aware of it. Both registered staff further acknowledged that immediate treatment and interventions were not provided after being made aware of the new skin breakdown.

A review of the physician's digiorder form indicated the WCC RPN received a telephone order for treatments, from the attending physician the following day after the new area of skin breakdown was first noted.

A review of resident #024's electronic Treatment Administration Record (eTAR) indicated the resident received the first dose of the identified medication the following day, and three shifts after the skin breakdown was first noted.

During an interview, the DOC acknowledged the above mentioned information and that resident #024 did not receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required. [s. 50. (2) (b) (ii)]

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, and receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee had failed to ensure that each resident who was incontinent had an individualized plan as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A review of resident #024's assessment and written plan of care indicated they required an identified type of assistance for continence care and bowel management. The written plan of care did not specify the frequency and interval of the care that had to be provided.

Separate interviews with PSWs #109, #111, and RPN #115 acknowledged that resident #024 did not have an individualized plan as part of their plan of care to promote and manage bowel and bladder continence, as their plan of care did not specify the frequency and interval of the care that had to be provided.

During an interview, the DOC indicated that the home's identified program was individualized based on the resident's condition and diagnosis, and that the frequency and interval of the identified care would be specified in the plan of care. The DOC reviewed resident #024's written plan of care and acknowledged they did not have an individualized plan as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented. [s. 51. (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 each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident's Substitute Decision-Maker (SDM) was notified of the results of the alleged abuse investigation immediately upon the completion.

The MLTC received a complaint related to the care resident #024 was receiving in the home. During a follow-up call by the Centralized Intake, Assessment, and Triage Team (CIATT), the complainant indicated on an identified date, resident #024 sustained an injury from unknown cause.

The home called the MLTC after hours infoline and subsequently submitted a CIR for an allegation of abuse. Report #17531 indicated the resident presented with an area of altered skin integrity. The CIR indicated the attending physician ordered a diagnostic test to be done in the home, and the resident was transferred to the hospital thereafter.

During an interview, the complainant stated to Inspector #653 that the resident's SDM was not notified of the results of the home's investigation related to resident #024's injury they had sustained from an identified date.

A review of the home's investigation notes, resident #024's progress notes, and an interview with the DOC did not identify that the resident's SDM was notified of the results of the alleged abuse investigation immediately upon the completion. [s. 97. (2)]

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 resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation, to be implemented voluntarily.

**WN #4: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident's SDM had been given an opportunity to participate fully in the development and implementation of the plan of care.

The MLTC received a complaint related to the care resident #024 was receiving in the home.

During an interview, the complainant stated to Inspector #653 that resident #024 recently sustained a new area of skin breakdown. The complainant indicated that the family was not informed of the new skin breakdown and they only found out about it when they visited the resident and had seen it themselves.

An interview with PSW #109 indicated on an identified date and time, they noted a new area of skin breakdown while providing care to resident #024. The PSW stated they had documented on POC and reported it to the WCC RPN.

An interview with the WCC RPN indicated on an identified date and time, PSW #109 reported to them that resident #024 had a new area of skin breakdown. An interview with RPN #115 who was the assigned registered staff, indicated PSW #109 informed them they had reported to the WCC RPN that resident #024 had a new area of skin breakdown. Separate interviews with the WCC RPN and RPN #115 and a review of resident #024's progress notes did not identify that the resident's SDM was notified of the new skin breakdown when it was first noted. RPN #115 further indicated that the family was upset about not being informed of the new area of skin breakdown.

During an interview, the DOC acknowledged that the resident's SDM had not been given an opportunity to participate fully in the development and implementation of resident #024's plan of care when they were not notified of the new skin breakdown. The DOC further indicated the home's expectation was for the registered staff to notify the SDM immediately when a new skin breakdown is first noted. [s. 6. (5)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,

(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).

(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).

(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,

(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).

(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).

(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).

(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee had failed to comply with s. 44 (7) of the Long-Term Care Homes Act (LTCHA) whereby the licensee refused the application of applicant #001 for reasons other than provided for in the LTCHA.

The MLTC received a complaint related to the home withholding approval for admission of applicant #001.

At the time of the inspection, applicant #001 remained in their personal home.

An interview with the Central Local Health Integration Network (CLHIN) Care Coordinator (CC) indicated applicant #001 applied to Elginwood Long-Term Care (LTC) for private accommodation and was rejected by the home.

A review of the CLHIN assessment indicated the applicant had responsive behaviours, and required an identified care provision.

A review of the home's letter addressed to applicant #001 from the DOC of Elginwood indicated the home was unable to approve the application based on the information provided to them through the CLHIN, and that the home's nursing staff lacked the nursing expertise to meet their care requirements.

During an interview, the DOC reviewed the letter with Inspector #653, and indicated applicant #001 had been refused admission due to their responsive behaviours, and at that time the staff lacked the nursing expertise to meet their care requirements. When asked by the inspector what care requirements as it related to responsive behaviours, that the home's staff lacked the nursing expertise necessary to meet the applicant's care requirements, the DOC indicated they had so many residents with responsive behaviours that were on one on one staff monitoring at that time and the home thought applicant #001 would need one on one staff monitoring and constant redirection due to their responsive behaviours. The DOC further indicated it was the responsive behaviours that the home were not able to manage because they already had many residents on one on one staff monitoring. When asked by the inspector if the home had a responsive behaviours program at the time, the DOC indicated it was not fully implemented but they had resources available such as external Behavioural Support Ontario (BSO), Leap of Faith Together (LOFT), and internal Dementia Observational System (DOS) monitoring.

The DOC could not demonstrate to the inspector that the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements as indicated in the written notice to the applicant. The DOC acknowledged that the licensee had failed to comply with s. 44 (7) of the LTCHA, whereby the licensee refused the application of applicant #001 for reasons other than provided for in the LTCHA. [s. 44. (7)]

2. The licensee had failed to ensure that when withholding approval for admission, the licensee shall give a written notice setting out the ground or grounds on which the licensee is withholding approval; a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justify the decision to withhold approval; and contact information for the Director.

A review of the home's letter addressed to applicant #001 from the DOC of Elginwood

indicated the home was unable to approve the application based on the information provided to them through the CLHIN, and that the home's nursing staff lacked the nursing expertise to meet their care requirements.

During an interview, the DOC reviewed the letter with Inspector #653, and acknowledged that the letter did not include sufficient details as required, for withholding approval for admission, and that the letter did not provide a detailed explanation of the supporting facts, as they related to the home's staff lacking nursing expertise necessary to meet the applicant's care requirements, and an explanation of how the supporting facts justified the decision to withhold approval. [s. 44. (9)]

Issued on this 18th day of July, 2019

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

Original report signed by the inspector.