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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Feb 13, 2015	2015_332575_0003	S-000503-14, S-000553-14	Complaint

Licensee/Titulaire de permis

VALLEY EAST LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

ELIZABETH CENTRE
2100 Main Street Val Caron ON P3N 1S7

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

LINDSAY DYRDA (575)

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): February 5 and 6, 2015

The following logs were inspected:
S-000503-14
S-000553-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care (Co-DOC), Restorative Care Staff, Wound Care Lead, Staff Educator, Registered Staff, Personal Support Workers (PSW), Family Members, and Residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Reporting and Complaints
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 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. (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 resident #003 as specified in the plan.

Inspector #575 was informed that resident #003's dressing was overdue to be changed. The inspector reviewed the resident's TAR and progress notes. The TAR indicated the resident was to receive a dressing change every 3 days. The inspector noted that the dressing was last changed 5 days before. The dressing was due to be changed approximately 2 days before, and on this day the signature was missing on the TAR to indicate that the dressing was changed and there were no progress notes to support the dressing was changed. The home's policy titled 'Medication Management System - Treatment Administration Record (TAR)' indicated that failure to sign for a treatment indicated that the treatment was not given. Progress notes indicated that the dressing was changed more than 3 days after the previous dressing change. [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 ensuring that the care set out in the plan of care is provided to resident #003 as specified in the plan, 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 the home's policy 'Medication Management

System - Treatment Administration Record (TAR)' is complied with.

Inspector #575 was advised that some resident's dressings were not being changed as ordered. The inspector reviewed the home's policy titled 'Medication Management System - Treatment Administration Record (TAR)' last revised 10/07/2013. The policy indicated that all treatments administered shall be documented on the resident's TAR and that registered staff will document the administration of the treatment on the TAR by signing the designated section. The policy further indicated that failure to sign for a treatment indicated that the treatment was not given. If registered staff are unable to administer the treatment as ordered, they are to keep with the legend provided on the TAR and make a notation in the progress notes including actions taken and further follow up actions to be taken.

The inspector conducted an audit of 3 resident's TARs for a period of 3 months and noted that signatures were missing for all 3 residents.

Specifically, for resident #002, care was to be done twice per week. One month, 2/9 signatures were missing and in another month, 2/9 signatures were missing. The TAR also indicated that registered staff were to sign that weekly documentation was completed. One month 1/5 signatures were missing.

Additionally, the inspector noted that on two occasions the staff member signed that the resident was sleeping and did not provide for a progress note indicating actions taken or follow up to be completed; and on another occasion the resident's TAR indicated that the weekly documentation was completed, however the inspector noted that there was no assessment completed in the progress notes.

For resident #003, care was to be done every 3 days. One month, 2/10 signatures were missing and in another month, 1/10 signatures were missing. The TAR also indicated that registered staff were to sign that weekly documentation was completed twice daily every week. One month, 1/8 signatures were missing and in another month, 2/10 signatures were missing.

Additionally, the inspector noted that on two occasions the staff member signed 'other/see nurses notes' and did not provide for a progress note indicating actions taken or follow up to be completed; and on four occasions the resident's TAR indicated that the weekly documentation was completed, however the inspector noted that there was no assessment completed in the progress notes.

For resident #004, care was to be done twice per day. One month, 5/62 signatures were missing and in another month 6/62 signatures were missing.

Additionally, the inspector noted the following: on five occasion's the staff member signed either 'hold/see nurses notes', 'sleeping', or 'other/see nurses notes' and did not provide for progress notes indicating actions taken or follow up to be completed.

This non-compliance related to the home's policy 'Medication Management System - Treatment Administration Record (TAR)' was previously issued during an inspection conducted in 2014 with similar findings. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that home's policy 'Resident Rights, Care and Services - Concerns and Complaints Management' is complied with.

A complainant indicated to the inspector that the home had been notified of their concerns several times verbally and one time written to staff member #104 and the Administrator. The inspector reviewed the home's complaint log and noted that there was no record regarding the complainant's concern. The complainant further indicated that they did not receive a response back from the home.

With permission from the complainant, the inspector interviewed the Administrator. The Administrator told the inspector that they did not receive a written concern, however they told the inspector that a concern was verbally brought forward and they dealt with it immediately. The Administrator further indicated that they did not look at the concern as a complaint because the issue was not discussed in detail with the complainant. The Administrator further indicated that if they had received a written concern, it would have been forwarded to the MOHLTC.

The inspector then interviewed staff member #104. The staff member told the inspector that they did not receive a written concern. They indicated they they did not have a record of the concern/complaints and that if it was in writing they would normally keep the concern/complaint and respond back to the complainant. The staff member told the inspector that they did receive verbal concerns at least twice. Once the verbal concern came forward, the home dealt with it as required.

The home's policy titled 'Resident Rights, Care and Services - Concerns and Complaints Management' revised 11/06/2014 was reviewed by the inspector. The policy indicated

that any staff member receiving a verbal concern or complaint will:

1.) Listen closely to concern expressed;
2.) Empathize with the complainant;
3.) Acknowledge the concern, apologize for the inconvenience;
4.) Respond by starting investigation and identifying possible solutions; and
5.) Follow-up by solving situation if possible. Log concern and investigations and actions taken on Resident Rights, Care and Services- Concern and Complaint form (1). Inform the supervisor of the concern.

The policy further indicated that the department supervisor would notify the complainant that they have received the concern and check that it is resolved and/or that they will be investigating further.

Although the Administrator did not consider the complainant's concern a 'complaint', the policy indicated the above steps to be completed for any concern or complaint. The policy did not provide for a description of a concern or a complaint. [s. 8. (1) (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 ensuring that the home's policies 'Medication Management System - Treatment Administration Record (TAR)' and 'Resident Rights, Care and Services - Concerns and Complaints Management' are complied with, to be implemented voluntarily.

WN #3: 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 resident #002 exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Inspector #575 reviewed resident #002's health care record and determined the resident had altered skin integrity. The resident was sent to hospital in the morning and returned to the home later that day.

The inspector reviewed the home's policy titled 'Resident Rights, Care and Services - Skin and Wound Care - Program' effective 09/16/2013. The policy indicated that Registered staff will ensure that all residents receive a head to toe skin assessment (on Point Click Care (PCC) under assessments) upon any return from hospital. The

inspector noted that a head to toe assessment was not completed when the resident returned from hospital. The most recent head to toe assessment was dated over 3 years previously. During an interview, staff member #107 told the inspector that 'upon any return from hospital' meant any 'admission' to hospital and that the resident was not required to have an assessment after their return from hospital as they were not admitted.

The inspector noted that the policy and the legislation indicate that a skin assessment is to be completed upon any return from hospital and does not specify only if the resident is admitted. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that resident #002 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #575 reviewed resident #002's health care record. The inspector noted that the resident's TAR indicated staff are to complete weekly documentation of all skin and wounds. The inspector reviewed the home's policy titled 'Resident Rights, Care and Services - Required Programs - Skin and Wound Care - Program' effective 09/16/2013. The policy indicated that Registered staff will complete a wound progress note, weekly, if altered skin integrity is a wound or complete a skin progress note, weekly, if altered skin integrity is other than a wound. During an interview, staff member #104 told the inspector that staff should be completing a wound progress note weekly for resident #002.

The inspector reviewed the resident's progress notes for a period of 3 months. The inspector noted that the weekly assessments were not consistent and some wound notes were included under eMAR and daily progress notes instead of wound progress notes.

The inspector reviewed the flow sheets and progress notes with staff member #104. The staff member told the inspector that it was 'a mess'. The staff member also told the inspector that if it was not documented, then it was not done. They agreed with the inspector that assessment notes were missing. [s. 50. (2) (b) (iv)]

3. The licensee has failed to ensure that resident #004 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The inspector reviewed the home's policy titled 'Resident Rights, Care and Services - Required Programs - Skin and Wound Care - Program' effective 09/16/2013. The policy indicated that Registered staff will complete a wound progress note, weekly, if altered skin integrity is a wound or complete a skin progress note, weekly, if altered skin integrity is other than a wound.

The inspector reviewed the resident's wound progress notes for a period of 3 months. The inspector noted that the weekly assessments were not consistent and some wound notes were indicated under daily progress notes instead of wound progress notes. [s. 50. (2) (b) (iv)]

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 ensuring that residents exhibiting altered skin integrity receive a skin assessment by a member of the registered nursing staff upon any return from hospital and that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

Issued on this 13th day of February, 2015

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

Original report signed by the inspector.