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
Jul 16, 2020	2020_786744_0012	003858-20, 005800-20, 008878-20	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Falconbridge
281 Falconbridge Road SUDBURY ON P3A 5K4

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

STEVEN NACCARATO (744), HILARY ROCK (765)

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): July 6-10, 2020.

The following intakes were inspected during this complaint inspection:

-One complaint was submitted to the Director regarding unexplained altered skin integrity; and
-Two complaints were submitted to the Director regarding screening and accommodations during COVID-19.

Critical Incident System inspection #2020_786744_0013 and Follow-up inspection #2020_786744_0014 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Physiotherapist, Dietitian, Kinesiologist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The Inspectors conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures, internal investigation notes, staff work schedules, observed resident rooms, observed resident common areas, and observed the delivery of resident care and services, including resident-staff interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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 a resident exhibiting altered skin integrity is assessed by a Registered Dietitian.

A complaint was submitted to the Director, regarding unexplained altered skin integrity on resident #003. The complainant stated that they had visited resident #003 and discovered a large area of altered skin integrity on the resident. When the complainant questioned the altered skin integrity, the staff were unsure how the altered skin integrity was acquired.

A review of the home's policy titled, "Skin and Wound Program: Wound Care Management" last updated December 2019, indicated that a resident exhibiting any form of altered skin integrity will be assessed by a Registered Dietitian.

Inspector #744 reviewed resident #003's electronic health care records on Point Click Care (PCC) and did not identify that the Registered Dietitian was notified of resident #003's altered skin integrity.

In an interview with Inspector #744, RN #107 stated that it was their responsibility to notify the Registered Dietitian but that they had failed to do so.

Inspector #744 interviewed Registered Dietitian (RD) #110, who stated that they did not receive a referral from registered staff to assess the altered skin integrity. The RD further indicated that assessments of altered skin integrity were necessary, as it allows them to identify concerns with the resident.

Inspector #744 interviewed the DOC who confirmed that the registered staff should have sent a referral to the RD in regards to resident #003's altered skin integrity, but this did not occur. [s. 50. (2) (b) (iii)]

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 is assessed by a Registered Dietitian, to be implemented voluntarily.

WN #2: 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was submitted to the Director, regarding unexplained altered skin integrity on resident #003. Please refer to WN #1 for additional details.

A review of the home's policy titled, "Skin and Wound Program: Wound Care Management" last updated December 2019, indicated that the home will follow all regulatory directives related to skin and wound care management, including prompt notification of family/SDM.

Inspector #744 interviewed RPN #102, #119 and RN #107. The registered staff stated in separate interviews that after a discovery of altered skin integrity, the registered staff who assessed the resident was to notify the enacted SDM immediately and document the communication in Point Click Care (PCC).

Inspector #744 reviewed resident #003's electronic health care records on PCC and did not identify that the enacted SDM of resident #003 was contacted by RN #107 after their assessment of resident #003's altered skin integrity.

In an interview with Inspector #744, RN #107 stated that the complainant was the enacted SDM for resident #003 and they should have been informed of resident #003's altered skin integrity after the Impaired Skin Integrity Assessment was completed.

Inspector #744 interviewed the DOC who confirmed that the complainant should have been contacted following RN #107's assessment of resident #003's altered skin integrity, but this did not occur. [s. 6. (5)]

2. The licensee has failed to ensure that the outcomes of the care set out in the plan of care are documented.

A complaint was submitted to the Director, regarding unexplained altered skin integrity on resident #003. Please refer to WN #1 for additional details.

A review of the home's policy titled, "Skin and Wound Program: Wound Care Management" last updated December 2019, indicated that nurses were to promptly assess all residents exhibiting altered skin integrity on initial discovery and to use the "Impaired Skin Integrity Assessment" tool to document skin impairments. The policy also indicated that staff were to document all skin breakdown in the interdisciplinary progress notes.

A review of the home's internal investigation notes indicated that during a shift on a specified date, Registered Practical Nurse (RPN) #120 observed altered skin integrity on the resident. The investigation notes further indicated that RPN #120 had forgotten to record this assessment in the progress notes.

Inspector #744 reviewed resident #003's electronic health care records on Point Click Care (PCC) and did not identify a progress note or an assessment of resident #003's altered skin integrity from RPN #120.

Inspector #744 interviewed RPN #102, #116, #119 and Registered Nurse (RN) #107. The registered staff stated in separate interviews that altered skin integrity must be assessed and documented in PCC, using the appropriate assessment tool, upon the initial discovery of the altered skin integrity.

Inspector #744 interviewed the Director of Care (DOC) who confirmed that RPN #120 did not assess and document resident #003's altered skin integrity using a clinically appropriate assessment tool. [s. 6. (9) 2.]

Issued on this 29th day of July, 2020

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

Original report signed by the inspector.