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 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
May 24, 2019	2019_683126_0007	008031-19	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 Starwood
114 Starwood Road NEPEAN ON K2G 3N5

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

LINDA HARKINS (126)

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): April 16, 17, 18, 23, 24, 25, 26, 29, 2019

During this inspection the following complaint was inspected:
Log # 008031 related to care and services

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associated Director of Care (ADOC), two Physicians, the Registered Dietitian (RD), the Skin and Wound Care Nurse, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW) and several family members.
During the course of this inspection, the Inspector reviewed the resident health care record, the licensee skin and wound care program and documentation provided by the informant.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 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	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. 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 policies related to skin and wound are complied with:

In accordance with O. Reg 79/10. R.48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 2. A skin and wound program to promote skin integrity, prevent the development of wounds and pressures ulcers and provide effective skin and wound care interventions.

The licensee does have a Skin and Wound Program that was last updated February 2017. As part of their Skin and Wound Program they have the following policy:

The Policy "Wound Care Management", RC-23-01-02, last updated February 2017, 2019, page 3, requires the following:
Page 4:
"Documentation: 3. Complete the Bates-Jensen Assessment if condition is worsening or not improving as expected, but a minimum every 7 days."

1.The licensee has failed to ensure that resident #001's weekly skin assessments of the wounds were documented on the Bates-Jensen Assessment Tool (BJAT) for a specific period in 2019.

Resident #001 health care record was reviewed. In the Treatment Administration Record (TAR), it was noted that the dressing to the wounds were done twice a week. For a specific period in 2019, it was noted that the dressings were changed but no documentation was found related to the completion of the BJAT.

Discussion held with DOC #111, who indicated that in a discussion with RPN #101, they have noted that the weekly BJAT assessments were not completed for that period.

Discussions held with several nurses who changed resident #001's dressing indicated that the expectation is to sign the TAR and that a weekly assessment was to be completed and documented.

The nursing staff did not complete the BJAT as per the Wound Care Management policy requirements. [s. 8. (1) (a),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 to ensure weekly skin assessment is completed as per skin and wound policy, to be implemented voluntarily.

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,
(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 #001 who was exhibiting altered skin integrity received a skin assessment by the registered nursing staff upon the return from the hospital.

Resident #001 health care record was reviewed.

Resident #001 was know to have altered skin integrity and required dressings changes twice a week. The resident was sent to the hospital on a specific date related to a change in condition. No documentation was found related to a skin assessment done upon the return from the hospital. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that resident #001 who was exhibiting altered skin integrity for a specific period was assessed by the Registered Dietitian (RD).

Resident #001 health care record was reviewed and it was noted that the Nutrition - Priority Screen v3 assessment dated a specific date was completed by RD #108 and indicated the followings:
Section A. High Nutrition/Hydration Risk check all that apply: Indicators #15. Altered skin integrity (skin breakdown, wounds, delayed wound healing, history of wounds) and under Section B. Moderate Nutrition/Hydration Risk, Indicators #7. Compromised skin integrity (skin tears, abrasions, excoriation, rashes) does not identified that resident #001 has altered skin integrity.
Under Section C.
Low Nutrition/Hydration Risk, Indicator #7 indicates that resident #001's skin is intact.

Discussion held with Registered Dietitian (RD) #108 on April 23, 2019 who indicated that they were aware that resident #001 had altered skin integrity. The RD indicated that at the beginning of a specific month, the nurses on resident #001's unit, requested that resident #001 intake be assess to ensure that resident's intake was appropriate. The resident was assessed by RD #108 a few days later and it was documented in the progress notes, to change the diet texture in an attempt to improve intake.

RD #108 reviewed the resident health care record with Inspector #126 and could not find any documentation indicating that resident #001 was assessed related to the altered skin integrity for that specific period. [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 resident who exhibit altered skin integrity receives a skin assessment upon any return from the hospital and is assess by the Registered Dietitian, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #001 was prescribed two medications that were to be adminitered on a daily basis via a specific route.

It was noted in resident #001's Medication Administration Records (MARs) that the two medications were not administered for a specific period.

Interview held with Registered Nurse (RN) #103 and Registered Practical Nurses (RPNs) #104 and #105, indicated that they recalled that the equipment for administering the medications was broken for a few days and that a company was contacted for repair. They could not recalled contacting the physician or the pharmacist regarding the two medications not being administered on those days.

Resident #001's health care record was reviewed and no documentation was found that nursing staff contacted the physician or the pharmacy informing them that the resident was not being administered the two medications.

Discussions held with Pharmacist #109 and Physician #102 who indicated that they were not informed that the resident was not administered the two medications for that period.

The licensee has failed to ensure that the two medications prescribed to resident #001 were administered in accordance with the direction for that specific period. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #001 health care record was reviewed.

It was documents in the care plan that resident #001 was to have a bath twice a week and under another section it was documented that the resident was to have a shower twice a week.

Discussion held with several Personal Support Workers (PSWs) who indicated that resident #001 was having a shower twice a week not a bath.

It was documented in the progress notes, written by Registered Practical Nurse (RPN) #104 on a specific date, that resident #001 had a bath on that day as per schedule. Discussion held with RPN #104, indicated that it was a documentation error as the resident only received showers not baths.

The licensee has failed to ensure that the written plan of care of resident #001 set out clear directions to ensure the resident received a shower twice a week not a bath. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the Substitute Decision Makers (SDM) has been

given an opportunity to fully participate in the development and the implementation of the plan of care of resident #001 related to altered skin integrity and pain management.

Resident #001 had dressings changes for a specific period.

Resident #001's SDM indicated that they were not aware of all the details of the resident's altered skin impairment until a specific date when a discussion occurred with physician #100.

Resident #001's health care record was reviewed for the period of a specific period.

Discussion held with Physician #102, indicated that an assessment was done on a specific date and the result was not shared with the family. Physician #102 stated that they did not informed the SDMs of the finding of the assessment and that the nurse was to follow up with the family.

Discussion held with Physician #100, indicated that they were reassigned resident #001 on a specific day in 2019. Physician #100 indicated that there was a discussion on that day with one of the SDM regarding the severity of the wound and the treatment.

The SDM expressed concerns related to the pain management of resident #001 and that that resident was not a regular dose of pain medication. The SDM indicated that they were not aware that the pain medications were changed as needed and that the resident's pain was assessed on an ongoing basis.

The Medication Administration Record (MARs) were reviewed and it was noted that there were several changes in the dosage and type of pain medications between February to April 2019.

It is noted in the progress notes, that the resident SDM contacted the nurse as they were concerns about the resident's pain. The SDM was informed that a note was left for Physician # 102 to reassess the resident. Physician #102 reassessed the resident the day prior and increased the pain medication. The SDM was not aware of this increased.

No other documentation was found in the resident health care record, that the SDMs were notified of the pain management interventions (assessment, change in medications and frequency).

The SDM's were not given an opportunity to fully participate in the development and the implementation of the plan of care. [s. 6. (5)]

Issued on this 28th day of May, 2019

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

Original report signed by the inspector.