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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 16, 2018	2018_616542_0008	006647-18	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 700 MARKHAM ON L3R 9W2

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

Extendicare Van Daele
39 Van Daele Street SAULT STE. MARIE ON P6B 4V3

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

JENNIFER LAURICELLA (542)

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 10 and 11, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care (ADOC), Registered Nurses and Personal Support Workers.

Throughout the inspection, the inspector reviewed resident health care records and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration
Skin and Wound Care

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	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 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A complaint was submitted to the Director outlining numerous concerns regarding the care of resident #001. The complainant indicated that they felt that the home failed to properly care for resident #001's altered skin integrity.

Inspector #542 completed a health care record review for resident #001. A review of the progress notes revealed that on a specific day in November, 2017, resident #001 was observed with altered skin integrity. A review of the "Skin – Weekly Wound Assessments" located on PointClickCare (PCC) indicated that on the specific day in November, 2017, the area of altered skin integrity had increased. The Inspector was unable to locate any weekly wound assessments that were completed by a member of the registered nursing staff during a 17 day period.

The Inspector reviewed the home's "Skin and Wound Care Program: Wound Care Management" last updated, July, 2016. The document indicated that when a resident was exhibiting any form of altered skin integrity, which may have included but was not limited to skin breakdown, unexplained bruises, pressure ulcers, skin tears and wounds, the resident was to receive a skin assessment by a nurse using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, at least weekly.

Inspector #542 interviewed the Assistant Director of Care (ADOC) and RN #101, who both indicated that they could not locate any weekly wound assessments that were completed during the 17 day time period. Both staff members also verified that an assessment should have been completed. [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 to ensure that the 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident were promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who were to be so notified.

A complaint was submitted to the Director outlining numerous concerns regarding the care of resident #001. The complainant indicated that they felt that the home failed to properly care for resident #001's altered skin integrity and that they were not kept informed of their declining health status.

Inspector #542 completed a health care record review for resident #001. A review of the progress notes revealed that on a specific day in November 2017, resident #001 was observed with altered skin integrity. A review of the "Skin – Weekly Wound

Assessments" located on PointClickCare (PCC) indicated that on a specific day in November 2017, the area of altered skin integrity had increased. A documented progress note from a specific day in December, 2017, indicated that one of the family members for resident #001 was visiting the evening prior and noted that they observed the altered skin integrity and noted to have deteriorated in a number of ways. Inspector was unable to locate any documentation to verify that the family/POA's were made aware of resident #001's deteriorating health condition over a 26 day period.

During a subsequent interview with the complainant, they indicated that when one of the POA's came to visit resident #001 during a day in March, 2018, they observed the resident looking unwell and requested that they be sent to the hospital.

Inspector reviewed the progress notes and found that an entry was documented on a different day in March, 2018, indicating that resident #001 was unwell. On a subsequent day in March, 2018, another progress noted indicated that a note was left in the physician's communication book requesting that resident #001 be seen by the doctor as the resident continued to have a significant decline health. An additional progress note revealed that another staff member found resident #001 to be unwell compared to their previous baseline. Later that evening, a POA for resident #001 visited and requested that they be sent to the hospital for an assessment. Inspector #542 was unable to locate any documentation to support that the POA/family was made aware of resident #001's change of health status over a 7 day period in March, 2018.

Inspector #542 reviewed the home's policy titled, "Wound Care Management" last updated, July 2016. It was documented in the policy that a resident that was exhibiting any form of altered skin integrity, which may include but was not limited to skin breakdown, unexplained bruises, pressure ulcers, skin tears and wounds will discuss treatment options with resident/SDM/family and communicate progress as appropriate. Furthermore, the policy directed staff to document resident/POA/SDM/family communication in the interdisciplinary progress notes. These notes were to include, any involvement in the development and awareness of plan of care related to skin/wound, how long and how often the resident has had a skin breakdown/wound, how skin/wound had been treated in the past and prevention interventions attempted, interventions reflecting choices and preferences, including end of life care, if treatment was refused, whether counselling on alternatives and/or other interventions were offered and any relevant skin/wound education provided to the resident/POA/SDM/family.

Inspector #542 interviewed the ADOC and RN #101; who both verified that they were

unable to locate any documentation to support that the POA/family were notified of resident #001’s deteriorating health status. [s. 107. (5)]

Issued on this 16th day of April, 2018

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

Original report signed by the inspector.