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 # / Registre no	Type of Inspection / Genre d'inspection
Nov 30, 2016	2016_417178_0020	007059-16, 019005-16, 027182-16	Critical Incident System

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 WEST END VILLA
2179 ELMIRA DRIVE OTTAWA ON K2C 3S1

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 8, 9, 10, 14, 15, 2016.

This inspection concerned critical incident intakes #007059-16, #019005-16, and #027182-16, all of which involved resident to resident altercations resulting in injuries.

During the course of the inspection, the inspector(s) spoke with Director of Care, Nurse Practitioner, registered practical nurses (RPNs), personal support workers (PSWs), and residents.

During the course of the inspection, the inspector also observed residents and resident care, reviewed residents' health records, and reviewed home policies and records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident

under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Resident #007 was known to be cognitively impaired and exhibited responsive behaviours.

Interview with RPN #S103 on Nov 9, 2016 revealed that on an identified date, resident #007 sustained a laceration as a result of a resident to resident altercation.

Review of resident #007's progress notes confirmed that on an identified date, the resident was found bleeding profusely from an identified wound, thought to be caused by a resident to resident altercation. Progress notes indicated that pressure was applied to the wound to stop the bleeding. The resident's health record was reviewed and documentation of assessments of the wound could be found in the form of progress notes for only the first three days following the incident. Review of the resident's electronic Treatment Administration Record indicated that the wound was treated for 14 days after the incident, however no documentation was present describing assessment of the wound, other than the progress notes on the first three days after the resident sustained the wound. Review of resident #007's health record revealed no documentation of weekly assessment of the resident's wound after these three days. No documentation is present indicating when the wound healed.

During an interview with the home's wound care nurse on November 10, 2016, she stated that when a resident has impaired skin integrity, it is to be assessed weekly using the weekly impaired skin integrity assessment tool on the home's documentation software, Point Click Care (PCC), and the assessment would be documented on that form. The wound care nurse stated that some staff document the weekly wound reassessments on the resident's progress notes, but they should be documenting the assessments on the weekly impaired skin integrity assessment tool since it is difficult to find assessments documented in the progress notes. The wound care nurse reviewed resident #007's assessments and progress notes on PCC and confirmed that there is no documentation present documenting weekly wound assessments of resident #007's wound. [s. 30. (2)]

2. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

This non compliance concerns Critical Incident intake #027182-16, regarding a resident to resident altercation resulting in injury.

Resident #006 is known to be cognitively impaired and requires extensive assistance for activities of daily living.

Review of an identified Critical Incident Report indicated that on an identified date, resident #006 sustained a laceration as a result of a resident to resident altercation. Pressure was applied to stop the bleeding, and resident #006 was sent to hospital for assessment and returned to the home the same day.

The inspector reviewed resident #006's health record, including assessment records, treatment records and progress notes. Notes were found describing the wound as clean and dry on the day of the incident and the next day, after which time there is no further documentation describing assessment or treatment of the wound. No documentation is present to indicate when the laceration healed.

During an interview with the home's wound care nurse on November 10, 2016, she confirmed that no documentation is present on resident #006's health record documenting the assessment, care or healing of the resident's wound other than on the day of the incident and once day later. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, 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,
(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, received 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.

Resident #007 was known to be cognitively impaired and exhibited responsive behaviours.

Interview with RPN #103 on Nov 9, 2016 revealed that on an identified date, resident #007 sustained a laceration as a result of a resident to resident altercation. RPN #103 stated that the resident's laceration was not assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. RPN #103 stated that staff uses the initial wound care assessment tool located under the Assessments tab on the home's electronic record system, Point Click Care (PCC), to assess any new ulcers or skin tears, but that she would not normally use the assessment tool to assess a new laceration.

Review of resident #007's progress notes confirmed that on an identified date, the resident was found bleeding profusely from a laceration, thought to be caused by a resident to resident altercation. Progress notes indicated that pressure was applied to

stop the bleeding. The progress notes do not contain an assessment of the resident's wound other than stating the site of the laceration. Review of resident #007's assessments on PCC reveal no wound assessments of the identified laceration.

During an interview on November 10, 2016, the home's wound care nurse stated that staff is expected to assess any new impaired skin integrity, including a laceration, using a skin integrity assessment tool located on PCC, and she confirmed that this assessment was not completed for resident #007 after he/she sustained the laceration on an identified date. [s. 50. (2) (b) (i)]

2. This non compliance is related to Critical Incident intake #007059-16, which concerns a resident to resident altercation resulting in injury.

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

Resident #002 is known to be cognitively impaired and exhibits verbally responsive behaviours.

Review of an identified Critical Incident Report indicated that on an identified date, resident #002 sustained multiple scratches after an altercation with resident #001.

The inspector reviewed the resident #002's assessment records and progress notes and was unable to find any documentation to indicate that the resident was assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment after he/she sustained the scratches.

During an interview on November 10, 2016, the home's wound care nurse indicated that when a resident exhibits any new impaired skin integrity, including scratches, the expectation is that the resident is to be assessed by registered staff using a skin integrity assessment tool located on home's electronic record system, PCC. The wound care nurse reviewed resident #002's record, and confirmed that this assessment was not done after resident #002 sustained scratches on an identified date. [s. 50. (2) (b) (i)]

3. This non compliance is related to Critical Incident intake #019005-16, concerning a resident to resident altercation resulting in injury.

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

Resident #004 is cognitively impaired, and is known to have fragile skin which is easily compromised.

Review of an identified Critical Incident Report indicated that on an identified date, resident #004 sustained a skin tear to an identified site as a result of a resident to resident altercation.

The inspector reviewed the resident's assessment records and progress notes and was unable to find any documentation to indicate that the resident was assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment after he/she sustained the skin tear.

During an interview on November 10, 2016, the home's wound care nurse indicated that when a resident exhibits any new impaired skin integrity, including skin tears, the expectation is that the resident will be assessed by registered staff using a skin integrity assessment tool located on the home's electronic records software, PCC. The wound care nurse reviewed resident #004's record, and confirmed that this assessment was not done for resident #004 after he/she sustained a skin tear on an identified date. [s. 50. (2) (b) (i)]

4. This non compliance is related to Critical Incident intake #027182-16, concerning a resident to resident altercation resulting in injury.

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

Resident #006 is known to be cognitively impaired and requires extensive assistance for activities of daily living.

Review of an identified Critical Incident Report indicated that on an identified date,

resident #006 sustained a laceration as a result of a resident to resident altercation.

The inspector reviewed the resident's assessment records and progress notes and was unable to find any documentation to indicate that the resident was assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment after he/she sustained the laceration on an identified date.

During an interview on November 10, 2016, the home's wound care nurse indicated that when a resident exhibits any new impaired skin integrity, including lacerations, the expectation is that the resident will be assessed by registered staff using a skin integrity assessment tool located on the home's electronic records software, PCC. The wound care nurse reviewed resident #006's record, and confirmed that this assessment was not done for resident #006 after he/she sustained a laceration on an identified date. [s. 50. (2) (b) (i)]

5. This non compliance is related to Critical Incident intake #019005-16, concerning a resident to resident altercation resulting in injury.

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin tears, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #004 is cognitively impaired, and is known to have fragile skin which is easily compromised.

Review of an identified Critical Incident Report indicated that on an identified date, resident #004 sustained a skin tear to an identified site as a result of a resident to resident altercation.

The inspector reviewed the resident's assessment records, progress notes, and treatment administration record and was unable to find any documentation of weekly assessments of the resident's identified skin tear. The resident's progress notes contain an entry on the day of the altercation describing the size and location of the skin tear, and the immediate treatment provided. A progress note three days later states that the dressing was changed, and describes the wound as having no sign of infection or redness or discharge. The resident's treatment record indicates that the dressing to the skin tear was changed twice weekly beginning the day after the altercation, and continuing for 12 weeks, however no documentation is present describing weekly

assessments of the resident's identified skin tear during that 12 week period.

During an interview on November 10, 2016, the home's wound care nurse indicated that when a resident exhibits any impaired skin integrity, including skin tears, the resident is to be reassessed weekly by registered staff, using the Weekly Skin Assessment Tool located under the Assessments tab in PCC, and the assessment is to be documented on that form. The wound care nurse stated that sometimes the staff document the weekly wound reassessment on the progress notes, but they should be documenting on the Weekly Impaired Skin Integrity Assessment tool as it is difficult to find assessments documented in the progress notes. The wound care nurse reviewed resident #004's assessments and progress notes on PCC and confirmed that there is no documentation present on the resident's assessments tab or progress notes to indicate that weekly reassessments were conducted on the resident's identified skin tear sustained on an identified date. [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
-the resident exhibiting altered skin integrity, including skin tears, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

Issued on this 14th day of December, 2016

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

Original report signed by the inspector.