Ontario

Ministry of Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère des Soins de longue durée

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2021	2021_857129_0008	006792-21	Complaint

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way Thorold ON L2V 4T7

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

Gilmore Lodge
50 Gilmore Road Fort Erie ON L2A 2M1

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

PHYLLIS HILTZ-BONTJE (129)

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): November 5, 8, 9, 10, 15, 16, 17, 18, 19, 2021.

The following intake was inspected 006792-21 related to: end of life care, bathing, nutritional care, skin and wound care, use of medications, physiotherapy services and information provided to Substitute Decision Maker.

During the course of the inspection, the inspector(s) spoke with residents, resident's family members, Personal Support Workers, Covid-19 Screener, Registered Nurses, Nutrition/Environmental Manager, RAI Coordinator, Physiotherapist, Physician, Director of Resident Care and the Administrator.

During the course of the inspection the Inspector observed resident care and resident's environments, reviewed electronic and paper clinical records, reviewed Licensee's policies related to Skin and Wound and Palliative Care as well as toured the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 failed to ensure that a resident's care plan was based on an identified assessment.

The above noted assessment was completed by staff in 2021, and provided information about the resident's health condition.

Registered Nurse (RN) #105 indicated they had taken no action to adjust the resident's care plan after completing the assessment.

A review of the electronic care plan confirmed the document did not contain a care focus or interventions related to the health condition of the resident and the information identified in the assessment.

Resident #001 was at minimal risk that the care provided to them may not be based on their identified needs when staff failed to ensure the plan of care was based on the identified assessment.

Sources: An identified assessment, electronic care plan and an interview with RN #105. [s. 6. (2)]

2. The licensee failed to ensure that a resident's Substitute Decision Maker (SDM) participated fully in the development and implementation of their plan of care.

The resident's SDM was not allowed to participate fully in the development and implementation of the resident's plan of care when the condition of the resident and the

resident's prognosis were not fully explained to them.

A specific assessment was completed by RN #105, which provided information about the resident’s health condition.

During an interview with RN #105 it was identified that there was no evidence in the clinical record to indicate that the outcome of the assessment and the possible implications for care were discussed with the resident or the resident's SDM. RN #105 indicated they were unable to recall if they discussed the outcome of the assessment with the SDM.

RN #105 and the resident's Physician confirmed that a conversation was held with the resident's SDM which was followed by the Physician writing a specific order for the care of the resident. During an interview with the Physician they indicated they did not recall the conversation they had with the SDM and if they fully explained their prognosis for the resident.

The DRC confirmed a care conference was not held with the resident or their SDM about the change in the condition of the resident while the resident was in the home.

After the resident was discharged from the home, a team meeting was held at the request of the family to discuss the care of the resident. Documentation made in the clinical record following the team meeting indicated the family communicated that no one told them about the prognosis of the resident and that they were not clinical and required clarification of the care the resident received.

The resident was at minimal risk when staff failed to ensure their SDM was given the opportunity to participate in the development and implementation of their plan of care.

Sources: A specific assessment, clinical notes made by registered staff and the Administrator, Physician orders and interviews with RN #105, the DRC and the resident’s Physician. [s. 6. (5)]

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 and ensuring the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of the resident as well as ensuring the resident's Substitute Decision Maker is given the opportunity to participate fully in the development and implementation of the plan of care, 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 failed to ensure that skin assessments, using a clinically appropriate assessment instrument were completed when staff identified two residents had wounds.

i) Registered staff documented in the clinical record that a resident showed an area of skin breakdown on their lower body.

A review of the computerized clinical record indicated a wound assessment had not been completed.

Twelve days later it was reported to staff that the previously identified area of skin breakdown had worsened.

The DRC confirmed that an assessment of the area of skin breakdown had not been completed when the area was first identified.

The resident was placed at risk for poor wound healing when staff failed to complete a wound assessment when it was identified the resident had a wound.

Sources: the resident’s electronic progress notes made on two identified dates, the assessment tab in the resident's electronic clinical record and an interview with the DRC.

ii) A clinical note made by registered staff, indicated a resident had an area of skin breakdown on their upper body.

During an interview, the DRC, and staff #104 reviewed the resident’s computerized clinical record and confirmed a skin assessment had not been completed when staff identified the resident had an area of skin breakdown.

The resident was placed at risk of poor wound healing when staff failed to complete a skin assessment when it was identified the resident had a wound.

Sources: Clinical notes, the resident’s electronic assessments file and interviews with staff #104 and the DRC.[s. 50. (2) (b) (i)]

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 and ensuring that a 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 assessments, to be implemented voluntarily.

Issued on this 2nd day of December, 2021

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

Original report signed by the inspector.