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
Dec 1, 2020	2020_556168_0016	015385-20, 018701-20	Complaint

Licensee/Titulaire de permis

The Corporation of Haldimand County
45 Munsee Street Box 400 Cayuga ON N0A 1E0

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

Grandview Lodge / Dunnville
657 Lock Street West DUNNVILLE ON N1A 1V9

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

LISA VINK (168)

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): October 28, 29, 2020, and November 2, 3, 4, 2020 (on site) and November 5, 9, 17, 18 and 19, 2020 (off site).

This complaint inspection was completed for the following intakes:
015385-20 - related to restorative care, nutritional care and hydration programs, personal care and skin and wound care; and
018701-20 - related to personal care.

PLEASE NOTE: Findings of non-compliance related to LTCHA, 2007, c.8, s. 6 (10) (b), identified in a concurrent Critical Incident System Inspection # 2020_556168_0017, were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the assistant Director of Care (ADOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapy Assistant, the Food Services Manager (FSM), a family member, an advocate and residents.

During the course of the inspection, the inspector toured the home, observed the provision of care, reviewed records including but not limited to: clinical health records, policies and procedures, training records and photographs.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Pain
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

The resident had a decline in their health, was increasingly dependent on staff to meet their care needs and had an area of altered skin integrity.
A review of the care plan did not include the actual needs of the resident related to skin integrity, assistance with care and mobility equipment.
The care plan was not revised when the resident's care needs changed.
Staff who followed the care plan for the specific interventions and care requirements would not have been aware of or provided care according to the actual needs of the resident.

Sources: Clinical record including assessments, progress notes and plan, observations of the resident and interviews with staff.

Please note that a part of this finding of non-compliance was identified during concurrent inspection 2020_556168_0017. [s. 6. (10) (b)]

2. The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Observations of the resident's room included a logo which indicated an aid was used.
The care plan noted the use of the aid as well as the potential for skin breakdown.
i. Observations of the resident identified that the aid was not available to them.
Staff confirmed that the aid was no longer used and that the logo should have been removed.
ii. A review of the clinical record identified that the resident had areas of altered skin

integrity.
The care plan was not revised when the resident developed the area of altered skin integrity which was a change in their care needs.
Staff who followed the care plan for the specific interventions and care requirements would not have been aware of or provided care according to the actual needs of the resident.

Sources: Treatment Administration Records, progress notes and care plan, observations of the resident and interviews with staff.

Please note that a part of this finding of non-compliance was identified during concurrent inspection 2020_556168_0017. [s. 6. (10) (b)]

3. The licensee failed to ensure that a resident's plan of care was revised at any time when the resident's care needs changed.

i. The resident was at nutritional risk.
They were observed at the noon meal by the Registered Dietitian. Following the observation the documented assessment included recommendations to be followed at meal times.
A review of the care plan did not include the recommendations.
ii. According to the Wound - Weekly Observation Tools, the resident current had an area of altered skin integrity and two other areas which had been resolved.
A review of the care plan did not include the concern of actual altered skin integrity.
iii. A review of the progress notes and pain assessments identified that the resident reported or demonstrated signs of pain intermittently.
Documentation included that the physician was consulted regarding the pain and orders were received and implemented.
A review of the care plan did not include a focus statement regarding pain.
Staff who followed the care plan for the specific interventions and care requirements would not have been aware of or provided care according to the actual needs of the resident.

Sources: Progress notes, TARs, Wound - Weekly Observation Tools, Pain assessments, physician's orders and the care plan and interviews with staff. [s. 6. (10) (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 that the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change, 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 two residents who exhibited altered skin integrity, including skin breakdown or pressure areas, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

i. A resident presented with an area of altered skin integrity for which an intervention was provided, according to PSW staff. The record did not include an assessment of the area by registered nursing staff, until two days later when an assessment of the area, utilizing

a clinically appropriate assessment instrument was completed.

ii. According to the progress notes a second resident had redness to an area and a treatment was applied to prevent further skin breakdown.
A review of the clinical record did not include an assessment of the area.

Assessments with a clinically appropriate instrument, provide a consistent process to assist in ongoing planning and evaluation of care needs.

Sources: Progress notes, TARs and Wound - Wound Observation Tools and interviews with staff. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that three residents who exhibited altered skin integrity, including skin breakdown or pressure areas were reassessed at least weekly by a member of the registered nursing staff.

i. A resident had an area of altered skin integrity.
A review of the Wound - Weekly Observation Tools, noted that for a time period of eight weeks the area was assessed four times, by a member of the registered nursing staff and not weekly.
The resident presented with another area of altered skin integrity.
A review of the Wound - Weekly Observation Tools, noted that for a time period of four weeks the area was assessed only three times and not weekly as required.

ii. A second resident had an area of altered skin integrity.
A review of the Wound - Weekly Observation Tools, noted that for a time period of just over five weeks the area was assessed a total of three times and not weekly as required.
Staff identified that they provided treatment to the area, that the area had improved and would have been assessed when the treatment was completed even though an assessment was not documented.

iii. A review of the clinical record noted that a third resident had an area of altered skin integrity.
A review of the Wound - Weekly Observation Tools, noted that for a time period of 12 weeks the area was assessed a total of eight occasions and not weekly as required.
The resident had another area of altered skin integrity.
A review of the TARs identified that the treatment remained active for approximately two months.

A review of the Wound - Weekly Observations Tools, did not include an assessment of the area, by registered nursing staff, during the identified time period.

Staff clarified the expectation of the Skin/Wound Care procedure was for staff to complete the wound assessment tools including characteristics of all area(s) weekly.

Weekly assessments of areas of altered skin integrity assist in the evaluation of the areas and the treatment plan.

Sources: Skin/Wound Care document, progress notes and Wound - Weekly Observation Tools and interviews with staff. [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 residents with altered skin integrity, including skin breakdown or pressure areas, 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 and that areas of altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #3: 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 failed to ensure that any procedure put in place was in accordance with all applicable requirements under the Act and was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 2 the licensee was required to have an interdisciplinary Skin and Wound Care Program and in accordance with O. Reg. 79/10, s. 50 (1), the program was to provide for (2) strategies that included the monitoring of residents and (4) treatments and interventions that included nutritional care.

O. Reg. 79/10, s. 50 (2) identified that "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, within 24 hours of the resident's admission, upon any return of the resident from hospital, and upon any return of the resident from an absence of greater than 24 hours"; and (b) "a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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".

The Skin/Wound Care document, number 03.1.2, with a review date of August 2020, was reviewed.
The document included a procedure which directed registered nursing staff to assess residents identified at risk for altered skin integrity. Residents were to be assessed with a skin assessment or a Braden Scale on return from hospital or leave of absence and staff were to make referrals to the interdisciplinary team members as required, including the Registered Dietitian.

The procedure was not in compliance with the requirements of the regulation when it did not include that a skin assessment was to be completed on return from hospital or leave of absence and afforded staff the option to complete a Braden Scale, which is a risk assessment tool.
The procedure was not in compliance with the requirements of the regulation when it did not provide clear direction for staff that all residents who exhibited altered skin integrity be assessed by a Registered Dietitian.

Progress notes identified that a resident had an area of altered skin integrity.
A new area of altered skin integrity was identified the following month.
There was no documentation in the clinical record that a referral was submitted to the

Registered Dietitian, for the second area of altered skin integrity.

The procedure was not in compliance with the regulation to ensure assessments were completed as required.

Sources: Skin/Wound Care document, clinical health record of a resident and interview with staff. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 3rd day of December, 2020

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

Original report signed by the inspector.