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Original Public Report

Report Issue Date: July 20, 2023	
Inspection Number: 2023-1003-0003	
Inspection Type: Complaint	
Licensee: King Nursing Home Limited	
Long Term Care Home and City: King Nursing Home, Bolton	
Lead Inspector Daniela Lupu (758)	**Inspector Digital Signature**

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 10-14, 2023

The following intake(s) were inspected:

- Intake #00088755, related to resident care and allegations of neglect

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care - Involvement of resident

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care related to oral and nail care.

Rationale and Summary

i) A resident needed assistance from staff with their oral care.

The resident had a history of refusing oral care, despite specific interventions provided.

In approximately a five-month period, there was no documentation that the resident's SDM was informed about the resident's refusal of oral care, or any concerns related to the resident's oral care.

An RPN said the resident's SDM was not notified about the resident's refusal of oral care, as required.

ii) A resident had an area of concern on one of their nails.

On multiple occasions over a 10-month period, it was documented that the resident's affected nail was deteriorating.

During a medical visit, the resident's SDM discovered the condition of the resident's nails.

An RPN and an RN said the resident's SDM should have been informed about the changes in the resident's nail condition when they first started.

Not involving the resident's SDM in the development and implementation of the resident's plan of care related to oral and nail care, may have contributed to the delay in appropriate interventions being implemented.

Sources: a resident's clinical health records, and interviews with PSWs, an RPN, an RN and the DOC.
[758]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee failed to ensure that interventions and actions taken with respect to a resident's care and pain and the resident's responses to these interventions were documented.

Rationale and Summary

A**.** A resident needed assistance from staff to complete their oral care. Staff were to document in the Point of Care (POC) three times daily if the level of assistance changed and if the oral care was provided or refused.

The resident refused frequently oral care despite staff providing specific strategies.

In a three-month period, there was no documentation related to the resident's oral care provision and refusal or actions taken when the resident refused oral care and their response to the interventions provided.

The DOC said all care and interventions provided to the resident should have been documented.

Sources: a resident's clinical health records, and interviews with PSWs, RPNs, an RN, and the DOC.

B. A resident had an area of concern on one of their nails.

i) The resident's nail was to be monitored twice daily and assessed weekly using the skin and wound evaluation assessment. Staff were to document the description of the nail including colour and size of the affected area, any changes in the nail condition and the evaluation of the nail condition by comparing the previous assessments.

Through approximately one-year, multiple skin and wound assessments of the resident's nail did not document the required details of the nail condition.

An RPN said the weekly evaluation of the resident's nail condition was difficult when a detailed description of the nail was not documented as required.

ii) Multiple PSWs noted that a resident had pain when they attempted to provide nail care to the affected nails. They said that if pain was observed, it should be documented in the POC and reported to the registered staff.

In approximately a 10-month period, there was no documentation in POC to indicate that resident had pain related to their nails.

iii) A resident's skin and wound assessment documented that the resident had pain during treatment and as needed pain medication was administered.

There was no documentation of the pain level, the dose of the pain medication administered and the evaluation of this intervention.

By not documenting interventions and actions taken with respect to the resident's oral care, nail care and pain and the resident's responses to these interventions, staff members may have not been aware of the resident's concerns, and it may have delayed the implementation of appropriate actions.

Additionally, gaps in the documentation of care would make it difficult to evaluate the interventions provided.

Sources: a resident's clinical health records, and interviews with PSWs, RPNs, an RN, and the DOC. [758]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee failed to ensure that a resident's areas of concerns related to their nails were assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

A resident had areas of concern related to their nails.

There were no skin and wound assessments completed for the affected areas to indicate when changes started, a description of the affected nails, the location, interventions in place and an evaluation of these interventions.

By not assessing a resident's affected nails, registered nursing staff may have not been aware of changes in the resident's nails condition and appropriate interventions could not be initiated in a timely manner.

Sources: a resident's clinical records, and interviews with an RN, an RPN, the DOC and other staff. [758]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The licensee has failed to ensure that a resident received immediate interventions to promote healing of their affected nails.

Rationale and Summary

A resident had an area of concern on one of their nails and staff were to monitor for changes in the nail condition.

In approximately a six-month period, the resident’s nail condition gradually deteriorated.

Despite these changes, no immediate actions were taken to promote healing of the affected nail. A specialized referral was not completed, the physician was not notified and actions to promote healing were not initiated until after the resident’s SDM brought the concern to the home.

By not providing immediate interventions to promote healing when changes in the resident’s nails condition were noted, it resulted in a deterioration in the condition of the resident’s nail.

Sources: a resident's clinical records, and interviews with PSWs, RNs, the DOC and other staff. [758]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

The licensee has failed to ensure that a verbal complaint alleging risk of harm to a resident was immediately investigated.

Rationale and Summary

A verbal complaint alleging risk of harm of a resident was received by the home.

The DOC said the complaint was not immediately investigated.

The investigation was not initiated until six days later, after two subsequent complaints alleging neglect related to the same concerns were received by the home.

By not investigating the initial complaint related to a resident’s care, it delayed the process for identifying the concerns and actions taken to resolve them.

Sources: a resident’s clinical records, the home’s complaints management policy, the home’s investigation notes, and interviews with the DOC and other staff. [758]