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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 8, 2019	2018_769646_0023	002905-18, 024980-18	Complaint

Licensee/Titulaire de permis

City of Toronto
55 John Street Metro Hall, 11th Floor TORONTO ON M5V 3C6

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

Kipling Acres
2233 Kipling Avenue ETOBICOKE ON M9W 4L3

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

IVY LAM (646)

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): December 14, 17, 18, 19, 20, 21, 27, 28, 2018, January 2, 3, 4, 7, 8, 10, 11, 14, 15, 16, 2019.

The following complaints were inspected:

- Log #002905-18 related to the home's skin and wound program, and
- Log # 024980-18 related to withholding of approval for admission.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, O. Reg. 79/10, s. 50. (2) (b) (iv), identified in a concurrent inspection #2018_769646_0023 (Log # 002905-18) was issued in this report.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6(4)(a), was identified in this inspection and has been issued in Critical Incident System (CIS) Inspection Report #2018_780699_0012 (Log # 014147-18, CIS M545-000026-18), which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Managers (NM), Skin and Wound Lead, Medical Director, Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Care Assistants (PCA), Registered Dietitian (RD), Physiotherapists (PT), family members and residents.

During the course of the inspection, the inspectors observed resident care, observed staff to resident interactions and provision of care, reviewed resident health records, schedules, staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of skin condition, including altered skin integrity and foot conditions.

This inspection was initiated to inspect on a complaint intake, where the home received a written complaint on an identified date alleging improper care of resident #001. The complaint alleged that during the resident's stay in the home, the resident had an area of altered skin integrity, and the family was not made aware. The family also had concerns with the resident's wound care where they had another identified area of altered skin integrity that had no dressing on it. Resident #001 no longer resided in the home at the time of this inspection.

Review of resident #001's head to toe skin assessment on admission indicated that the resident was admitted on an identified date, with an identified area of altered skin integrity. Review of the resident's progress note on their admission date showed that the resident's skin assessment was done, and two identified areas of altered skin integrity were noted on resident #001's body.

Review of the resident's care plan showed that no other care plan related to the assessment of the resident's skin condition and altered skin integrity from admission was created until two weeks after the resident's admission date.

Interview with RN #102 who worked regularly on the floor and had worked with this resident indicated that the care plan should have been done based on the assessment to indicate the resident is at risk for altered skin integrity and had areas of altered skin integrity.

Interviews with the skin and wound lead/NM #114 and the DON confirmed that the resident's care plan should have been done to include the resident's altered skin integrity from admission, so that PCAs would be aware and registered staff could be aware to monitor and complete weekly skin assessments, and it was not completed. The care plan was not done following the admission skin assessment, when the resident was identified with altered skin integrity. [s. 26. (3) 15.]

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 a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident's skin condition, including altered skin integrity and foot conditions, 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, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

This inspection was initiated to inspect a Critical Incident System (CIS) report submitted by the home on an identified date, related to an incident of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

From the critical incident report, the family had reported to the home on an identified date about alterations to skin integrity on identified areas of resident #007's body. The resident had alleged that a staff was rough during transfer during the resident's bathing care. Resident #007 no longer resided in the home at the time of the inspection.

The inspection did not identify findings of abuse. The finding below is related to skin and wound care.

Review of the home's incident note on an identified date showed that the resident was observed with identified areas of altered skin integrity on identified areas of the resident's body. Review of the resident's head to toe skin assessment dated the abovementioned identified date showed that the resident had identified areas of altered skin integrity on two identified areas of the resident's body.

The home was unable to find the Weekly Altered Skin Integrity Assessment form for the resident, for the incident reported on the abovementioned date.

Interviews with RN #127 indicated that resident #007's family member had approached the RN to follow up on how resident #007 received the identified areas of altered skin integrity on identified areas of the resident's body. The RN stated they completed the incident report and the head to toe assessment, but did not recall if they had done the weekly altered skin integrity assessments regarding the identified alterations of skin integrity for resident #007.

Interview with NM #114 who initiated the home's investigation of the incident and prepared the CIS report indicated that the head to toe assessment and incident report was completed for resident #007, but was unable to find the weekly altered skin integrity assessments after the initial assessment of the alterations of skin integrity.

Interview with the DON indicated that if a resident was observed with the abovementioned identified alterations of skin integrity, the staff are expected to monitor the alterations of skin integrity for any changes. Weekly skin assessments of the identified alterations of skin integrity should have been done for resident #007, and it was not done. [s. 50. (2) (b) (iv)]

2. This inspection was initiated to inspect on a complaint intake, where the home received a written complaint on an identified date alleging improper care of resident

#001. The complaint alleged that during the resident's stay in the home, the resident had an area of altered skin integrity, and the family was not made aware. The family also had concerns with the resident's wound care where they had another identified area of altered skin integrity that had no dressing on it. Resident #001 no longer resided in the home at the time of this inspection.

Review of resident #001's head to toe skin assessment on admission indicated that the resident was admitted on an identified date, with an identified area of altered skin integrity. Review of the resident's progress note on their admission date showed that the resident's skin assessment was done, and two identified areas of altered skin integrity were noted on resident #001's body.

Review of the resident's clinical chart showed that no other skin assessment was documented for the resident's identified area of altered skin integrity fifteen days after the admission assessment, where the resident had been found with an identified alteration of skin integrity on admission. A head to toe skin assessment was completed for the resident on an identified date fifteen days after the admission assessment, and one weekly skin assessment was completed after this identified date.

Interviews with NM #114 and the DON indicated that resident #001 should have had a weekly skin assessment completed when the resident was identified with altered skin integrity on admission, and the weekly skin assessment was not completed until 20 days after the resident was admitted to the home. [s. 50. (2) (b) (iv)]

3. This inspection was initiated for resident #005 as part of the sample expansion when a non-compliance was found regarding skin and wound care for resident #001.

Review of resident #005's current care plan showed the resident had an identified area of altered skin integrity on an identified date.

Review of weekly skin assessments for resident #005 showed that there was an assessment completed on the abovementioned date for the identified alteration to skin integrity, but no other skin assessments were completed until 43 days after the abovementioned assessment.

Interview with RPN #103 stated that resident #005 continues to have an identified ongoing area of altered skin integrity, and that weekly assessments should be completed for the resident. RPN #103 showed inspector the resident's weekly ulcer/wound

assessment record binder, and weekly skin assessments were not done until 43 days after the abovementioned assessment was completed.

Interview with NM #114/Skin and wound lead and the DON stated that they would expect weekly skin assessments to be done for resident #005 following the first identified date until the area of altered skin integrity was healed, and that this had not been done. [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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that, if the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care.

An inspection was initiated to inspect on a complaint that was received by the MOHLTC, related to alleged wrongful bed refusal for applicant #002.

Review of the home's written notice sent to applicant #002, titled Withholding Approval of Admission for resident #002 on an identified date indicated that the behaviours outlined in the assessments provided by the Local Health Integration Network (LHIN), posed too great a risk to the residents and staff, specifically surrounding inappropriate sexual activity towards others. The written notice further cited O. Reg. 79/10, s. 54., where, "Every licensee of a long-term care home shall ensure that steps are taken to minimize risk of altercations and potentially harmful interactions between and among residents". The written notice further detailed that applicant #002's documented behaviours required a nursing complement and interventions that surpassed the home's ability to provide safe nursing care or to mitigate the risks associated with the behaviour, resulting in declining the application.

Review of the home's assessment of the application showed that the Director of Nursing Care (DON), Administrator, and the Medical Director had considered and discussed applicant #002's identified condition and requirements of care. Interviews with the DON and the Medical Director indicated that based on the assessment, the resident would continue to need identified resources and the home would not be able to provide the nursing complement to meet this applicant's needs. The home further indicated that in order to ensure residents' safety, the home declined applicant #002's application.

Interview with the DON indicated that the written notice included the resident's identified behaviours which posed too great a risk to residents and staff, and required a nursing complement and interventions that surpass the home's ability to provide safe nursing care, but did not include the abovementioned details from the home's assessment. The DON indicated that a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care, was not included on the written notice sent to applicant #002. [s. 44. (9) (b)]

Issued on this 20th day of February, 2019

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

Original report signed by the inspector.