Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: March 24, 2023	
Inspection Number: 2023-1571-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: The Corporation of the County of Prince Edward	
Long Term Care Home and City: H.J. McFarland Memorial Home, Picton	
Lead Inspector Heath Heffernan (622)	**Inspector Digital Signature** Heath Heffernan Digitally signed by Heath Heffernan Date: 2023.04.05 13:30:49 -04'00'
Additional Inspector(s) Ashley Bernard-Demers (740787)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
January 30, 31, 2023 and February 2, 3, 7-9, 13-17, 2023.

The following intake(s) were inspected:
• Complaint Intake: #00013633 related to resident care and services and a fall of a resident with injury, for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition.
• Critical Incident Intake: #00014371 related to alleged improper care of a resident and skin and wound care.

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Housekeeping, Laundry, and Maintenance Services
Infection Prevention and Control

Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

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

The licensee has failed to ensure that there was a written plan of care for a resident, that set out the planned care for the use of a specific assistive device.

Rationale and Summary
Review of the risk management documentation on point click care indicated that a resident was using a specific assistive device when they fell.

There was no documentation on the resident's plan of care to support the use of the specific assistive device.

On January 31, 2023, Inspector #622 observed that the resident was using the specific assistive device.

On January 31, 2023, a Personal Support Worker (PSW) stated that the specific assistive device was being used for the resident.

Inspector #622 spoke with the Director of Care (DOC) who stated that the resident should not have the specific assistive device and removed it.

By using the specific assistive device when it was not part of the plan of care, placed the resident at risk for injury.

Sources: observation of the resident's care and services, review of the care plan and interview of the

DOC and other staff.
[622]

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of oral care set out in a resident's plan of care has been documented.

Rationale and Summary
A review of the point of care (POC) documentation and the progress notes related to oral care completion indicated that there was no documentation for a resident's oral care completion for a 38-day period.

A review of the daily report sheets indicated that there were 32 dates during a 37-day period, that documentation was missing for the resident's oral care on either the day shift, evening shift or both.

During separate interviews on February 8, 2023, two Personal Support Workers (PSWs), and a Registered Practical Nurse (RPN) stated that the resident received oral care at least twice daily, however staff missed documenting the care.

Sources: review of the progress notes, the POC documentation, interview with a PSW and other staff.
[622]

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.

The licensee has failed to ensure that the outcomes of the care set out in a resident's physiotherapy plan of care was documented.

Rationale and Summary
A review of the physiotherapy plan of care including the care plan and progress notes on point click care indicated that the resident was to perform a specific intervention five times per week, if tolerated.

A review of the Physiotherapy Resident Log and the Therapy Quick Entry indicated that during a 25-day period, the resident's specific intervention was documented as spending zero minutes on nine dates out of 25 business days. There was no documentation to explain the outcome of why the resident did not complete the specific intervention according to the physiotherapy plan of care.

During an interview on February 13, 2023, the Physiotherapist Assistant (PTA) stated that the resident's physiotherapy plan of care included a specific intervention five times per week, if tolerated. If the resident did not perform the specific intervention, they would document a zero on the Physiotherapy Resident Log for the number of minutes spent on the intervention and not the reason the care had not been delivered.

As a result, the outcome to the physiotherapy plan of care related to the specific intervention for the resident was not documented on nine out of 25 dates which would make assessment of the plans efficacy difficult.

Sources: review of the progress notes, Physiotherapy Resident Log, Therapy Quick Entry, interview of the PTA and other staff.
[622]

WRITTEN NOTIFICATION: Accommodation services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

The licensee has failed to ensure that an assistive device was maintained in a safe condition and in a good state of repair.

Rationale and Summary
On January 31, 2023, Inspector #622 observed that a resident was using an assistive device which was in disrepair.

A review of the maintenance records and the maintenance request forms indicated that there was no documentation of the assistive device being in disrepair.

During an interview on February 16, 2023, Environmental Services Supervisor stated that there were schedules and procedures in place for routine, preventive, and remedial maintenance. However, they

were not aware of the assistive device needing repair.

The use of an assistive device being in a state of disrepair, placed the resident at risk of injury.

Sources: observation of the resident's environment, review of maintenance records, and interview with the Environmental Services Supervisor and other staff.
[622]

WRITTEN NOTIFICATION: Provision in plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 35 (2) 4.

The licensee has failed to ensure that when a resident's plan of care included the use of a restraint, the restraint was ordered or approved by the physician, registered nurse in the extended class or other person provided for in the regulations.

Rationale and Summary
During the inspection, Inspector #622 made multiple observations of a resident using a specific restraint.

A review of the falls prevention care plan on point click care indicated that staff were to ensure that the resident used the specific restraint.

A review of the resident's physician's orders and progress notes indicated that there was no documented physician or registered nurse in the extended class order or approval for the resident to be restrained using the specific restraint.

By placing a resident in a physical restraint without a physician or registered nurse in the extended class order or approval places the resident at risk of injury.

Sources: observation of resident restraint, review of the progress notes, care plan, physician orders.
[622]

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b)

The licensee has failed to ensure that a resident who exhibited altered skin integrity received a weekly 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.

Rationale and Summary
A review of the progress notes indicated that a resident was assessed as having altered skin integrity.

A review of the progress notes and the assessments on point click care indicated that there were no weekly wound assessments documented for the resident.

During an interview on February 14, 2023, the Assistant Director of Care (ADOC), reviewed the documentation on the progress notes and the assessments on point click care. The ADOC stated that they had not completed the weekly wound assessments for the resident's altered skin integrity.

By not completing weekly wound assessments for a resident with altered skin integrity does not allow the registered staff to assess for change and places the resident's wound at risk for decline. There was no impact to the resident as their altered skin integrity healed.

Sources: review of the progress notes, assessments on point click care and interview with the ADOC. [622]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee has failed to ensure that a resident who was incontinent, had an individualized plan as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

Rationale and Summary
A review of a resident's plan of care including the care plan and kardex related to continence care, indicated that the resident was incontinent of both bowel and bladder. The plan of care did not include how often the resident was to receive continence care.

During separate interviews, Inspector #622 interviewed two Personal Support Workers (PSWs) who indicated different directions for when the resident was to receive continence care.

By not having an individualized continence care and bowel management plan of care, staff were not always aware of how often the continence care was to be provided, which increased the risk that the care would be missed.

Sources: review of the care plan, kardex, and interview with PSWs and other staff.
[622]

WRITTEN NOTIFICATION: Maintenance services

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)

The licensee has failed to comply with the procedure that was developed and implemented to ensure that a resident's assistive device was kept in good repair.

In accordance with O. Reg. s 11. (1) (b), the licensee is required to ensure that there is a procedure in place to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair.

Specifically, the Preventative Maintenance Program Policy #V-C-10.00 dated January 2023, indicated that procedure was as follows: A work requisition system was in place for all team members to use when reporting required repairs, and malfunctioning of any equipment or building systems to the Environmental Services Supervisor or designate to initiate the necessary repairs.

Rationale and Summary
On January 31, 2023, Inspector #622 observed that a resident's assistive device was in disrepair.

A review of the preventative maintenance work requisitions for January 2023, indicated that there were no requisitions submitted related to the resident's assistive device.

During an interview on February 16, 2023, the Environmental Services Supervisor stated that they had not been informed that the resident's assistive device was in disrepair.

During an interview on February 16, 2023, a Personal Support Worker (PSW) stated that they were

aware of the preventative maintenance procedure, and that they had not submitted a work requisition or notified the Environmental Services Supervisor or their designates about the resident's assistive device being in disrepair.

By not following the licensee's Preventative Maintenance Program Policy #V-C-10.00, the resident was placed at risk for injury.

Sources: observation of the resident's assistive device, review of the licensee's Preventative Maintenance Program Policy #V-C-10.00, the preventative maintenance work requisitions, and interview of a PSW and other staff.
[622]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 6.

The licensee has failed to ensure that when a resident was restrained, all assessment, reassessment, and monitoring including the resident's response to the restraint, was documented.

Rationale and Summary
During the inspection, Inspector #622 observed a resident using a restraint.

A review of the tasks documentation on point of care (POC) related to the resident's restraint indicated that there was no documentation for the assessment, reassessment, monitoring, and the resident's response to the restraint being used.

A review of the treatment administration record (TAR) indicated that there was no documentation that the resident was being reassessed, and the effectiveness of the restraining evaluated by a registered staff member, physician, NP at least every eight hours 8 hours while in the restraint.

A review of the progress notes indicated that there was no documentation related to assessment, reassessment, monitoring, and resident response to the restraint being used.

During separate interviews, a Registered Practical Nurse (RPN) and a Personal Support Worker (PSW) stated that the resident was being reassessed hourly while in their restraint. The assessments would be

documented on the POC by the PSW staff and on the TAR by the registered staff. The RPN stated that the resident would be assessed by registered staff for their safety, the fit, application, condition of the restraint and how the resident was responding. The PSW and RPN stated that the assessments had not been documented for the resident's restraint on either the TAR by the registered staff or the POC by the PSWs.

By not documenting the assessment, reassessment, and monitoring, including the resident's response to a restraint makes follow-up analysis difficult and can increase risk of injury to the resident.

Sources: observation of the resident's restraint, review of the progress notes, TAR, the POC and interview of the PSW and other staff.
[622]