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 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 apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 28, 2017 | 2017_251512_0001 | 012195-16, 030855-16, 031211-16, 031279-16 | Complaint |

## Licensee/Titulaire de permis

PROVIDENCE HEALTHCARE
3276 St. Clair Avenue East TORONTO ON M1L 1W1

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

PROVIDENCE HEALTHCARE
3276 ST. CLAIR AVENUE EAST SCARBOROUGH ON M1L 1W1

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

TILDA HUI (512), ADAM DICKEY (643)

## 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 20, 21, 22, 23, 28, 29, 30, 2016 and January 4, 5, 9, and 10, 2017.**

**The following complaint intakes were inspected at this inspection:**
**1) #012195-16 related to improper care**
**2) #030855-16 related to plan of care and dealing with complaints**
**3) #031211-16 related to duty to protect and residents' rights**
**4) #031279-16 related to skin and wound**
**5) #031189-16 related to abuse**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Manager (RCM), Activation and Program Manager, Activation Assistant, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Assistants (RAs), Family Members, Power of Attorney (POA) and Substitute Decision Maker (SDM).**

**During the course of the inspection, the inspectors conducted observation in home and residents' areas, review of the home's staff training records, staff schedules, meeting minutes, relevant policies and procedures, and residents' health records.**

**The following Inspection Protocols were used during this inspection:**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**
**Reporting and Complaints**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **5 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

This inspection was initiated related to complaints made to the Ministry of Health and Long-term Care (MOHLTC) regarding improper care concerns of resident #001.

In an interview with resident #001's identified family member, he/she stated that the staff had not been correctly providing oral care.

Record review of resident #001's plan of care revealed that staff were to provide mouth care to the resident every two hours. The plan further stated specified interventions were used for resident #001. The plan of care also stated that resident #001's oral care was only to be provided by the family member at his/her request.

Interviews with RA #101, and RA # 103 revealed that staff had been providing oral care to resident #001 improperly. RA #101 further stated that staff would provide resident

#001 oral care every two hours.

In an Interview with the Director of Care (DOC), he/she confirmed that the written plan of care for resident #001 gave conflicting directions to the staff for providing oral care. He/she confirmed that resident #001's written plan of care did not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

This inspection was initiated related to complaints made to the MOHLTC regarding skin and wound concerns of resident #001.

Review of resident #001's plan of care with an identified date, indicated the resident had an altered skin integrity. The resident was assessed by the home's Enterostomal Therapy (ET) Nurse Consultant who recommended that the resident be using an identified protective device to offload pressure, and that the pressure relief air mattress's setting to be at a specified setting when resident was in bed for maximum therapeutic support. The ET Nurse's recommendation were care planned and implemented eight weeks prior to the plan of care's date.

Interview with the resident's family member indicated the resident did not have the protective device in place at times when he/she was in bed and that during two occasions in the past few months when the resident was transferred to the hospital for assessment and/or treatment, the resident was sent without the protective device in place. The family member also indicated that the resident's pressure relief mattress on his/her bed was not set at the specified setting. The family member believed that the two above mentioned observations contributed to the resident's worsening skin integrity and overall deteriorated ill health.

The resident was transferred to hospital prior to the inspection and was not available for observation/interview. The resident was reported to have deceased in the hospital during the inspection.

Interview with Resident Assistant (RA) #103 indicated the resident would not have the protective device in place when in bed as the RA used alternative method for the resident while in bed. RA #103 indicated that when sending residents out to hospital, the

protective device was usually not sent with them. The RA also stated that the resident's pressure relief mattress would often be set at a different setting than the plan of care, and that the RA had been shown how to set the pressure at educational in-services provided by the home and he/she knew what to do. Interview with RN #110 indicated he/she as the charge nurse, did not know the setting of the pressure relief mattress as RAs knew what to do and registered nursing staff were supposed to go around and check the setting daily to ensure they were set appropriately. Interview with RA #111 stated he/she did not have anything to do with the air mattress setting, and that the setting was to be done by the RPN even though RAs had been trained how to do the setting. Interview with RPN # 105 stated RAs were supposed to do the residents' air mattresses pressure setting and then RPN would check daily and document on the electronic Medication Administration Record (MAR). RPN #105 indicated the air mattress pressure setting should be at the specified setting. Interview with RPN #106 stated he/she never had to check the air mattress pressure setting as it was always fine when he/she came to work. RPN #106 also stated that the resident always had his/her protective device on even when in bed at night.

Interview with the DOC confirmed there was a lack of collaboration among the nursing staff as to the implementation of alteration to skin integrity prevention strategies recommended by the ET Nurse including the use of protective device for the resident at all times and the setting at a specified setting for the pressure relief air mattress while the resident was in bed. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care related to daily dressing change was provided to the resident as specified in the plan.

This inspection was initiated related to complaints made to the MOHLTC regarding skin and wound concerns of resident #001.

Review of resident #001's plan of care with an identified date indicated the resident had an altered skin integrity. The resident was assessed by the home's ET Nurse Consultant. Orders from the attending physician for the resident 's dressing directed the staff to change the dressing daily.

Review of the resident's electronic MAR for daily dressing change for two identified months, revealed 12 dates were not signed off to indicate that the daily dressing change was performed. Review of the registered staffing schedules for the above mentioned period indicated RPN #106 was on duty for those dates while the resident was at the

home at the unit where RPN #106 worked the day shift. The daily dressing change was to be performed on the day shift.

Interview with RPN #106 admitted that the daily dressing change was not conducted by him/her for the above mentioned dates. RPN #106 indicated he/she was too busy on those days and he/she delegated the dressing change to the evening staff who had agreed to do them. RPN #106 stated he/she was not sure if the evening staff had actually did the dressing changes on those dates.

Interview with RPN #105 stated he/she always signed the eMAR whenever a dressing change on residents had been conducted. If there were no signature on the eMAR, it can be assumed that the dressing change was not done. Interview with the DOC and the Administrator confirmed that the daily dressing change were not conducted for the resident, and that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

***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 written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident, that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, and that the care set out in the plan of care related to daily dressing change was provided to the resident as specified in the plan, to be implemented voluntarily.***

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**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 related to complaints made to the MOHLTC regarding skin and wound concerns of resident #001.

Review of resident #001's plan of care with an identified date indicated the resident had an altered skin integrity. Review of the resident's list of weekly skin and wound assessment revealed the weekly skin assessments were not conducted for nine days over a period of four months.

Interview with RPN #105, and RN # 110 indicated weekly wound assessment was supposed to be conducted on the resident every Monday. The charge nurse of the unit would conduct wound rounds on Sunday and made a list of the residents who would require the weekly wound assessment. The RPN on duty on Monday would then conduct the wound assessments and submit a report to the nursing management staff. Interview with RPN #106 stated that he/she was aware that the wound rounds were conducted every Sunday, and the list would be left for the wound care nurse. RPN #106 indicated the wound assessments would always be completed by the full time person and he/she being the part time would never have to do it.

Interview with the DOC and the Administrator confirmed that the weekly wound assessments were not conducted for the resident for the above mentioned dates. [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 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, to be implemented voluntarily.***

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**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 has failed to ensure that the home's policy instituted or otherwise put in place related to safe lifting and transferring was complied with.

This inspection was initiated related to complaints made to the MOHLTC regarding skin and wound concerns of resident #001.

The home's policy titled Safe Lifting and Transferring, with no policy number, last revised date of August 2016 was reviewed. In the policy section, item #5 stated that: for each resident requiring transfer or repositioning using a mechanical lift, at least two caregivers must attend to operate the mechanical lift and removal of sling once transferred.

Interview with the resident's identified family member revealed that on several occasions, the resident was observed to be sitting on top of a transfer sling after being transferred from the bed to the wheelchair. The family member indicated the resident was sitting with the straps of the transfer sling under his/her leg which could have caused indentation on his/her skin resulting in discomfort.

The resident was transferred to hospital prior to the inspection and was not available for observation/interview. The resident was reported to have deceased in the hospital during the inspection.

Interview with RA #103 indicated sometimes the sling would be left under the resident after the resident was transferred from the bed to the chair. Interview with RN #110 stated it was the home's practice to leave the sling under the resident after transfer as it would be difficult to move the resident to place the sling under the resident for the next transfer. However staff would put a sheet under the resident separating the resident's skin from the sling. And staff would check to ensure that the straps were not lying directly under the resident's skin. Interview with RPN #106 indicated the resident always sat on the sling after transfer as it was easier to put the resident back in bed after. RPN #106 stated that RAs would put a soaker pad and a pillow case behind the resident and on his/her buttock for protection, and that RAs had a way to make sure that the straps on the sling were not under the resident.

Interview with RN #110 and the DOC confirmed that the home's policy on removal of the transfer slings from under the resident once transfer was completed was not complied with by the home's staff. [s. 8. (1) (a),s. 8. (1) (b)]

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Record review of an identified Critical Incident System report revealed that on an identified date, resident #001's identified medical device had been displaced accidentally during care which required him/her to be sent to hospital.

In an interview RA #101 stated that he/she was attempting to reposition resident #001 when the resident moved, which caused the medical device to become displaced. RA#101 stated that he/she was alone when repositioning resident #001 at the time when the medical device became displaced.

Review of resident #001's plan of care revealed that he/she required assistance with bed mobility. The plan stated that two staff members were required to turn him/her from side to side and to assist with pulling resident #001 up in bed.

Interviews with RA #103, RPN #105 and RPN #106 revealed that resident #001 required the assistance of two staff members when being repositioned in bed. RPN #106 further stated that two staff members were always present when giving resident #001 care.

In an interview with the DOC, he/she stated that by repositioning resident #001 without assistance of another staff member, RA #101 had not used safe positioning techniques when assisting resident #001 on the incident date. The DOC confirmed that staff did not use safe transferring and positioning techniques when assisting resident #001. [s. 36.]

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff**

**Specifically failed to comply with the following:**

**s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:**
**2. Skin and wound care. O. Reg. 79/10, s. 221 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all direct care staff are provided training in skin and wound care.

This inspection was initiated during the recent Risk Focused Resident Quality Inspection (RQI) related to complaints made to the MOHLTC regarding skin and wound concerns for resident #001.

Interview with RPN #106 revealed that the RPN did not receive skin and wound training for 2016.

Review of the home's training record indicated for 2016, 79 per cent of the home's direct care staff completed the skin and wound program training provided by the home.

Interview with the DOC and the Administrator confirmed that 21 per cent of the home's direct care staff did not receive skin and wound training in 2016 including RPN #106. [s. 221. (1) 2.]

**Issued on this 28th day of February, 2017**

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

**Original report signed by the inspector.**