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 # / No de registre	Type of Inspection / Genre d'inspection
Feb 22, 2018	2018_536537_0004	019847-17, 020891-17	Complaint

Licensee/Titulaire de permis

Richmond Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

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

Richmond Terrace
89 Rankin Avenue AMHERSTBURG ON N9V 1E7

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

NANCY SINCLAIR (537)

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): February 5 and 7, 2018

The following intakes were inspected regarding an incident of injury to a resident resulting in transfer to hospital and a significant change in status, potential improper care of a resident:
Log #020891-17/IL-526 59-LO
Log #019847/CIS 1149-000023-17

During the course of the inspection, the inspector(s) spoke with the Administrator, one Registered Nurse (RN), one Registered Practical Nurse (RPN), two Personal Support Workers (PSW) and a family member.

The inspector(s) also reviewed the clinical record and plan of care for an identified resident, policies and procedures, and the home's internal investigation notes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Reporting and Complaints
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	Legendé 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. (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 care was provided to the resident as specified in the plan.

A complaint was submitted to the Ministry of Health and Long Term care by a family related to concerns of potential improper and incompetent care of a resident resulting in injury to the resident. The home submitted a corresponding Critical Incident System report of the potential improper and incompetent care provided to the resident.

Review of the written plan of care for the resident included specific focuses and interventions for identified care areas.

The resident was found to have sustained an injury.

Interview was conducted with a Registered Nurse (RN) who stated that the resident was prone to injury and therefore very specific care interventions had been established.

Interviews were conducted with two Personal Support Workers (PSW) who had provided care to the resident around the time the injury was identified, and indicated they were unsure of what the specific interventions for care was on their shift. Both PSW's stated they knew the care interventions implemented following their shifts.

The Administrator stated that following the resident sustaining the injury, the care plan was updated regarding care interventions. The Administrator stated that prior to the implementation of new interventions, it would be expected that the care as outlined in the plan was provided to the resident.

The licensee has failed to ensure that the resident received care as outlined 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 care is provided to the resident as specified in the plan, 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, was reassessed at least weekly by a member of the registered nursing staff.

A resident was noted to have areas of altered skin integrity.

The home's policy titled "Alteration in Skin Integrity Protocol", effective date January 2011, stated in part that reassessment of the alteration in skin integrity should be conducted on a weekly basis to determine effectiveness of the treatment plan.

A Registered Nurse (RN) was interviewed and stated that when a resident was determined to have an area of altered skin integrity, an assessment would be completed by a registered staff member, there would be a treatment protocol determined, and then the area would be reassessed at minimum weekly, utilizing the Weekly Wound Assessment tool found in the Point Click Care (PCC) documentation system. The RN and Inspector #537 reviewed the Weekly Wound Assessments in PCC for the resident and determined that weekly wound assessments were not completed by a member of the registered nursing staff as required for the identified areas of altered skin integrity.

The licensee has failed to ensure that the areas of altered skin integrity were assessed at least weekly by a member of the registered nursing 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 the 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident to a resident for which the resident was taken to a hospital and that results in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

A Critical Incident System (CIS) report submitted by the home indicated that a resident had been transferred to hospital after sustaining an injury with the date of submission being four days following the original injury date.

The Administrator, two PSW's, an RPN, and an RN all indicated the date of the original injury, which was four days before the CIS report was submitted.

The licensee has failed to ensure that the Director was informed of the injury to a resident for which the resident was transferred to hospital, within one business day of the occurrence of the incident. [s. 107. (3) 4.]

Issued on this 22nd day of February, 2018

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

Original report signed by the inspector.