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
Jun 27, 2018	2018_565647_0017	010896-18	Complaint

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Roberta Place
503 Essa Road BARRIE ON L4N 9E4

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

JENNIFER BROWN (647)

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): June 5 - 8, 2018.

The following complaint was inspected related to responsive behaviours and skin and wound care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Residents, and Substitute Decision Makers.

During the course of the inspection, the inspector conducted observation in resident home areas, observation of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 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, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

The Director received a written complaint in 2017, from the substitute decision maker (SDM) of resident #015. The complainant stated that resident #015 had not been treated related to an area of altered skin integrity, had been sent to hospital which led to a detrimental outcome.

A review of the progress notes indicated that in 2016, resident #015 had been found in their room, and complaining of feeling unwell. A further review of the progress notes indicated that resident #015 had been assessed by the registered staff and concluded that the resident required a further assessment at the hospital and therefore, called an ambulance.

A review of the ambulance call report, indicated that they assessed resident #015 and identified an area of altered skin integrity. The ambulance call report further acknowledged that they asked the staff about the area of altered skin integrity and staff were unaware of any area of altered skin integrity.

A review of the emergency room report, indicated that resident #015 had been assessed by physician #109. Physician #109 documented on the identified hospital physician consultation note that resident #015 had been diagnosed with an identified infection and the area of altered skin integrity.

Further review of the emergency room report indicated that resident #015 had been admitted to hospital. They were further assessed by physician #110 who documented that upon examination, resident #015 had an area of altered skin integrity and had presented to the hospital with an identified infection. Physician #110 documented that the infection could have potentially been the introduction of bacteria that way.

The Inspector reviewed the resident's health care record specific to progress notes for a one month period prior to being admitted to hospital, and identified that there was no documentation related to an area of altered skin integrity for resident #015. A review of the plan of care for resident #015 that had been current during the indicated time frame identified they did not have any area of altered skin integrity. Review of the Personal Support Worker (PSW) care documentation for resident #015 during the identified period of time, related to skin integrity, indicated that PSW #106 documented there was an area of altered skin integrity.

During an interview with PSW #106, they acknowledged providing care for resident #015, however did not recall documenting an observed area of altered skin integrity. PSW #106 further indicated that they are unable to recall if they had reported this to any registered staff.

Interview with Registered Practical Nurse (RPN) #103 who had worked on the identified date, indicated that PSW #106 had not reported anything to them relating to an area of altered skin integrity for resident #015, and was further unaware that resident #015 had an area of altered skin integrity.

Attempts had been made to contact Registered Nurse (RN) #107 and #108, as these registered staff had worked on the day of resident #015's transfer to hospital. The Inspector was unable to reach them.

During an interview with the Administrator, they indicated that the home was unaware that resident #015 had an area of altered skin integrity, and had subsequently not initiated treatment and interventions to reduce or relieve pain, promote healing, and

prevent infection. [s. 50. (2) (b) (ii)]

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, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, to be implemented voluntarily.

WN #2: 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 the care set out in the plan of care was provided to the resident as specified in the plan.

The Director had received a written complaint, from the SDM of resident #015. The complainant stated that they requested to be notified if resident #015 refused a specific activity of daily living. The complainant further indicated that they had not been notified on numerous occasions that resident #015 had refused the specific activity of daily living.

A review of the PSW documentation regarding the specific activity of daily living provided to resident #015 dated for a 30 day period of time, indicated that they refused the specific activity of daily living 67 percent of the time.

A record review of the plan of care for resident #015 indicated that the SDM was to be informed of all refusals for the specific activity of daily living.

A record review of the progress notes for the 30 day period of time identified above, indicated a progress note entry for each of the above mentioned refusals and further documentation on the strategies and interventions used to encourage resident #015, however there had not been any documentation relating to contacting the SDM regarding the refusals.

In an interview with RPN #103, they indicated that if a resident refused the specific activity of daily living, the registered staff would document in the progress notes, the actions taken related to the refusal. The RPN further indicated that if the family had been notified it would have been documented in the progress notes.

The Administrator indicated to the Inspector that the registered staff members had been required to contact the SDM of resident #015 after each refusal of the specific activity of daily living. The Administrator confirmed that resident #015's plan of care was not followed relating to contacting the SDM after all refusals during the above mentioned time frame. [s. 6. (7)]

Issued on this 27th day of June, 2018

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

Original report signed by the inspector.