Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Dec 13, 2019	2019_769646_0016	012832-19, 013108-19	Complaint

Licensee/Titulaire de permis

North York General Hospital
4001 Leslie Street NORTH YORK ON M2K 1E1

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

Seniors' Health Centre
2 Buchan Court NORTH YORK ON M2J 5A3

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

IVY LAM (646), SIMAR KAUR (654)

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): October 17, 18, 21, 22, 23, 24, 28, 29, 30, and 31; November 1, 4, 6, 7, 8, 12, 13, and 14, 2019.

The following intakes were completed in this complaint inspection:

Complaint log #012832-19 and CIS log # 013108-19 (CI log #2744-000035-19) related to skin and wound care, infection prevention and control, pain management, and prevention of abuse and neglect.

PLEASE NOTE: A VPC related to LTCHA, 2007, c.8, s.6. (7) was identified in this inspection and has been issued in inspection report #2019_769646_0015, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with with the administrator, interim director of care (DOC), assistant directors of care (ADOCs), nurse practitioner (NP), physiotherapist (PT), resident assessment instrument (RAI) coordinator, social worker (SW), environmental manager (EM), registered nurses (RNs), registered practical nurse (RPN), personal support workers (PSWs), the scheduler, complainant, and residents.

The inspectors conducted observations of staff to resident interactions, conducted observations of residents, reviewed residents' health records, home's investigation notes, staffing schedules, and reviewed relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Pain
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **3 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. 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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to allegations of abuse and neglect towards resident #021. A Critical Incident System (CIS) report was submitted by the home to the MLTC related to the same allegations.

Review of the home's census showed that resident #021 had deceased on an identified date.

Review of resident #021's progress notes on an identified date indicated that the resident had acquired an identified altered skin integrity on an identified part of the resident's body. Review of the resident's assessments did not show that a Skin and Wound Assessment was completed for the above-mentioned altered skin integrity.

During an interview with the home's Skin and Wound Care lead/Registered Practical Nurse (RPN) #104, they reviewed the resident's records and indicated that the resident sustained the above-mentioned altered skin integrity on the identified date. They indicated that the resident should have received a Skin and Wound Assessment when the altered skin integrity was first identified, and the resident did not receive it.

Interview with the Assistant Director of Care (ADOC) #102 indicated that resident #021 should have received a skin assessment by a registered staff, using a Skin and Wound Assessment according to the home's expectation, and this was not done for resident #021. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that resident #021 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, if clinically indicated.

Review of resident #021's progress notes on an identified date indicated that the resident had acquired an identified altered skin integrity on an identified part of the resident's body.

Review of the resident's electronic Treatment Administration Record (eTAR) for an identified period of time indicated a treatment order for weekly skin assessment once a day on an identified day of the week.

Review of the resident's progress notes and an interview with the home's Skin and Wound Care lead/RPN #104 indicated that the resident acquired the above-mentioned altered skin integrity on an identified date, and skin and wound care treatment was initiated. They further mentioned the resident's above-mentioned altered skin integrity had worsened in a three-month period after it was first identified, due to other identified comorbidities.

Review of the resident's skin and wound assessments did not indicate weekly skin and wound assessment on two identified dates during the above-mentioned period for the above-mentioned altered skin integrity.

In a follow-up interview with the Skin and Wound Care lead/RPN #104, they reviewed the resident's eTAR and indicated that it was not signed on one of two identified dates above. However, they did not find a weekly skin and wound assessment for the resident on the above-mentioned dates.

Interviews with ADOC #102 and Skin and Wound Care lead/RPN #104 indicated that the residents exhibiting altered skin integrity, should have been reassessed at least weekly by a member of the registered nursing staff and resident #021 was not reassessed weekly on 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, (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, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #021's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Review of resident #021's Minimum Data Set (MDS) assessment on an identified date indicated an identified altered skin integrity on an identified area of the resident's body. Under the pain section, it indicated that the resident had an identified level of pain few

days a week.

Review of resident's Point of Care (POC) documentation under the pain section for an identified month, it indicated that the resident had a higher identified level pain on six identified dates during identified shifts.

Review of resident #021's progress notes indicated that the resident complained of pain on the movement of an identified part of their body during another identified shift on four dates during the same month, and was being administered an identified pain medication at an identified time.

Review of the resident's electronic medication record (eMAR) indicated on two identified shifts, the resident was administered the same pain medication as needed (PRN).

Further review of the resident's Pain Assessment in Advanced Dementia (PAINAD) Scale documented on an identified date by the registered staff indicated that the resident was at an identified level of pain.

Review of resident #021's pain assessments did not indicate pain assessment during an identified 8-day period.

Review of the home's policy (VII-G-30.30), revised in April 2019, titled Pain and Symptom Management, indicated that the nurse should screen a resident for the presence of pain and complete a pain assessment electronically:
- When resident reports or exhibits signs and symptoms of pain (greater than 4/10 for 24 to 48 hours) following the implementation of pharmacological/ or non-pharmacological interventions.

Interview with the resident's private caregiver #107 and Registered Nurse (RN) #106 indicated that the resident had identified level of pain throughout the day and had a higher level of pain during any movement of their identified part of the body during the above-mentioned period.

In an interview, RN #106 indicated, they had worked on the identified shift in the identified time period with resident #021. The resident was observed in pain during those shifts and was administered scheduled pain medication. The RN further indicated that the home used electronic pain assessment for the residents with ongoing unrelieved pain and they do not recall using the pain assessment tool for resident #021.

Review of the resident's records, and interview with ADOC #102 indicated that when resident #021's pain was not relieved by initial interventions, they should have been assessed using a pain assessment tool during the above-mentioned period. [s. 52. (2)]

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff had monitored symptoms of infection in resident #021 on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Review of resident #021's progress notes on an identified date indicated that the resident had acquired an identified altered skin integrity on an identified part of the resident's body.

Review of a progress note dated six days later, indicated that the resident started receiving an identified medication to be administered at identified times for an identified period due to increased redness and swelling on their above-mentioned area of altered skin integrity. Further review indicated that four days later, resident #021's medication order was changed to a second medication to be administered at identified times for an identified period.

Record review of the home's infection control surveillance record indicated that resident #021 was identified on the record on the date the first medication was ordered.

Review of resident #021's progress notes for the period mentioned above indicated that the resident's signs and symptoms of infection were not monitored on nine day shifts, nine evening shifts, and nine night shifts.

In an interview, RPN #104 indicated after reviewing the resident's progress notes, that staff had failed to monitor and document, sign, and symptoms of infection for the above-mentioned dates.

In an interview with ADOC #102, who is also the infection prevention and control program lead in the home, the ADOC indicated that resident #021's was listed on the surveillance list during the period mentioned above and should have been monitored for symptoms of infection during the day, evening and night shifts, and was not on the above-mentioned shifts. [s. 229. (5) (a)]

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 on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

Issued on this 2nd day of January, 2020

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

Original report signed by the inspector.