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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 7, 2019	2018_767643_0020	010552-18	Complaint

Licensee/Titulaire de permis

The Regional Municipality of Peel
7120 Hurontario Street 6th Floor MISSISSAUGA ON L5W 1N4

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

Sheridan Villa
2460 Truscott Drive MISSISSAUGA ON L5J 3Z8

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

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 19, 20 and 21, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, Medical Director, Physicians, Supervisors of Care (SOC), Program Support Nurse, Enterostomal Therapy (ET) Nurse, Registered Nurses (RN), Registered Practical Nurses (RPN), personal support workers (PSW) and family members.

During the course of the inspection the Inspector conducted observations of provision of care, reviewed resident health records and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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	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 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. (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 each resident set out clear directions to staff and others who provided direct care to the resident.

Complaints were received by the Ministry of Health and Long-Term Care (MOHLTC) from resident #027's substitute decision maker (SDM) related to care for the resident's impaired skin integrity. According to the complaints, resident #027 had areas of impaired skin integrity which were not properly treated.

Review of resident #027's health records revealed they were admitted to the home with identified medical diagnoses. Resident #027 had ongoing identified areas of impaired skin integrity which were being followed by an Enterostomal Therapy (ET) nurse.

Review of resident #027's written plan of care and kardex showed under an identified focus an intervention which indicated resident #027 was to be repositioned every two hours when in bed. Further review of the care plan showed under a second identified focus an intervention indicating resident #027 was to be turned and repositioned every hour. The care plan additionally showed a third identified focus which indicated the resident was to be turned and repositioned every one hour while in bed.

In interviews, PSWs #107 and #114 indicated that they would find instructions for each resident's care in the kardex on the Point of Care (POC) terminals. PSWs #107 and #114 indicated that resident #027 was initially repositioned every two hours while in bed as is required for all residents. PSWs #107 and #114 further indicated that resident #027 had ongoing areas of impaired skin integrity and later was required to be repositioned by staff

every hour while in bed.

In an interview, RN #101 indicated that PSW staff would find instruction for individual resident's care in the kardex and care tasks on their POC terminals. RN #101 further indicated that turning and repositioning would be done at least every two hours for residents and would be a task for PSWs to complete and document in POC. RN #101 indicated that the intervention for turning and positioning had been changed to hourly and should have been changed under each care plan focus to match the rest of the care plan, kardex and tasks.

In an interview, Supervisor of Care (SOC) #112 indicated that a resident's care plan and kardex should not give staff conflicting instructions and could have been edited to provide more clarity for staff. SOC #112 acknowledged that resident #027's written plan of care did not provide staff with clear directions in regards to turning and repositioning. [s. 6. (1) (c)]

2. 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.

Review of resident #027's health records revealed they were admitted to the home with identified medical diagnoses.

Review of resident #027's progress notes showed a note authored on an identified date by RN #101 which indicated the resident had been re-weighed and documented as a specified weight with the previous month's weight specified, representing a loss of of a specified number of kilograms. The progress note indicated that resident #027's weight would start to be recorded on a weekly basis. Review of resident #027's written plan of care showed an entry was created on the above mentioned identified date, instructing staff to weigh the resident weekly on a specified day ongoing.

Review of resident #027's weight history documentation in the electronic documentation system showed the data from the above mentioned identified date, with the next weight documented 13 days later which showed an additional loss of a specified number of kilograms. No documentation was found indicating resident #027 had their weight measured and recorded for the first week following the change in the plan of care to include weekly weight measurement.

In an interview, RN #101 indicated that weights for each resident would be documented

under the weights and vitals tab in the home's electronic documentation system. RN #101 additionally indicated that residents who required more frequent weights would also be documented under the weights and vitals tab or possibly in progress notes. RN #101 indicated that the weight for the above mentioned week would possibly have been completed on an identified date on the resident's shower day, but did not find any documentation that a weight had been completed for that date.

In an interview, SOC #112 indicated that the care plan entry instructing staff to complete weekly weights would also be found in the kardex and tasks for PSW staff to complete. Review of tasks for resident #027 did not show a task indicating staff were to weigh the resident weekly. SOC #112 acknowledged the weight for resident #027 was not recorded weekly as specified in the resident's plan of care. [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 each resident sets out clear directions to staff and others who provide direct care to the resident; and to ensure that the care set out in the is provided to each resident as specified in the plan of care, to be implemented voluntarily.

Issued on this 8th day of January, 2019

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

Original report signed by the inspector.