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**

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 16, 2016 | 2016_417178_0019 | 013518-16 | Resident Quality Inspection |

### Licensee/Titulaire de permis

DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC
2121 ARGENTIA ROAD SUITE 301 MISSISSAUGA ON L5N 2X4

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

PERTH COMMUNITY CARE CENTRE
101 CHRISTIE LAKE ROAD R. R. #4 PERTH ON K7H 3C6

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

SUSAN LUI (178), PAULA MACDONALD (138)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): October 31, November 1, 2, 3, 4, 2016.**

**Critical Incident intake #021933-16, regarding a fracture of unknown cause, was inspected concurrently with this RQI.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care, Director of Resident Services, Registered Dietitian, Activity Coordinator, Maintenance Supervisor, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), residents, family members of residents.**

**During the course of the inspection, the inspectors also observed residents and resident care, reviewed resident health records, reviewed home records, including policies and procedures and staff training records.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Residents' Council**
**Safe and Secure Home**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **4 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 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 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.

Resident #018 has a history of numerous identified medical diagnoses, and was identified as being at risk for skin breakdown.

Review of resident #018's quarterly head to toe skin assessment completed on an identified date, indicated that the resident had two areas of impaired skin integrity. Reviews of the resident's medical record revealed no documentation of a wound assessment of these areas, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Interviews with registered staff #102, #103 and #107 on November 3, 2016, confirmed that when a resident has impaired skin integrity, the resident's wound is to be assessed by registered staff using the home's electronic skin assessment tool called Wound Tracker. On November 3, 2016, registered staff #102 confirmed that no wound assessments had been conducted for resident #018 using Wound Tracker.

Interview with the home's Director of Resident Care (DRC) on November 3, 2016, confirmed that it is the home's policy to assess any open areas or wounds using the home's electronic skin assessment tool Wound Tracker, and that resident #018's impaired skin integrity documented on his/her quarterly head to toe skin assessment should have been assessed and documented using the home’s electronic skin assessment tool, Wound Tracker. [s. 50. (2) (b) (i)]

***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 ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

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

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident # 010 was identified as being incontinent of urine, and requires assistance for toileting.

Review of resident # 010's admission note indicated that on admission the resident was identified as being incontinent of urine and wore incontinence products for bladder and occasional bowel incontinence.

Review of the resident's record produced no record of a continence assessment which included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, or which was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Interview on Nov 4, 2016 with registered staff #102 revealed that on admission a resident's continence is assessed by completing a three day voiding record for the resident, and the registered staff will include this record when they assess the resident using the Initial Continence Assessment tool. This initial continence assessment is kept on the resident's chart. Staff #102 confirmed that the Initial Continence Assessment tool on resident #010's chart had not been completed. Resident #018's Initial Continence Assessment tool was blank, apart from the word "daily", which had been written beside the question "use of products".

The Initial Continence Assessment is a tool which prompts the user to answer questions regarding the resident's urinary history, focusing on incontinence problems, pharmacology, functional ability, cognitive ability, medical status, type of incontinence, and voiding pattern.

Interview with the home's Director of Resident Care (DRC) and Director of Resident Services (DRS) on November 4, 2016 confirmed that the initial continence assessment is to be used on admission to assess any resident who has challenges with continence. The DRC confirmed that although a plan of care was in place to address resident #010's continence needs, the initial continence assessment was not completed for the resident. [s. 51. (2) (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 the resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.***

---

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

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

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,**
**i. kept closed and locked,**
**ii.equipped with a door access control system that is kept on at all times, and**
**iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,**
**A. is connected to the resident-staff communication and response system, or**
**B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.**
**O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**
**3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.**
**4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee failed to comply with section 9.(1)(1)(i) of the regulation in that the licensee failed to ensure that all doors leading to stairways and outside the home other than doors leading to secure outside areas that precluded exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked.

On October 31, 2016, Inspector #138 conducted a tour of the home and noted during the tour that the right side door of a set of double doors labelled A1 on first floor Hart unit was found unlocked. The Inspector was able to open this door and enter the stairwell. An alarm sounded when the door was opened and the Inspector was able to cancel the alarm.

On November 4, 2016, the Inspector and the Maintenance Coordinator went to the same set of doors. Again, the Inspector pushed on the same door but this time observed that it was locked and secured. The Maintenance Coordinator proceeded to unlock the door then opened and closed the door. The Inspector once again pushed on the door and this time the door pushed opened into the stairwell. The Maintenance Coordinator stated that this should not happen as the door should lock when closed.

The Maintenance Coordinator inspected the door and completed adjustments in an attempt to rectify the door from not locking properly. The Inspector tested the door several times once the adjustments were made and observed that the door was locked each time. [s. 9. (1)]

---

**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 61. Family Council assistant**

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

**s. 61. (1) If the Family Council so requests, the licensee shall appoint a Family Council assistant who is acceptable to that Council to assist the Family Council. 2007, c. 8, s. 61. (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the licensee appointed an assistant to the Family Council to assist the Council and who is acceptable to the Council.

Interview with a representative from the Family Council on November 3, 2016 revealed that the home has not provided an assistant to the council, to attend monthly meetings and act as a liaison between the home and the Family Council. The Family Council representative stated that the council had an assistant in the past, but for approximately the past year they have not had an assistant to attend monthly meetings and act as a liaison with the home.

Review of the Family Council meeting minutes revealed entries in October 2016 and May 2016 regarding the need for a home appointed assistant to Family Council to act as a liaison between the home and the council.

Interview with the Administrator on November 4, 2016 revealed that the home is not currently providing an assistant to Family Council, mainly because the Family Council has not made it clear what duties they want this assistant to assume, which the Administrator states makes it difficult to choose an assistant. [s. 61. (1)]

---

**Issued on this 17th day of November, 2016**

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

**Original report signed by the inspector.**