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
Feb 6, 2020	2020_549107_0001	024080-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Telfer Place
245 Grand River Street North PARIS ON N3L 3V8

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

MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 29, 30, 31, 2020

The following intakes were completed in this Critical Incident System Inspection:
Log #024080-19, CIS#2742-000028-19 related to a fall with injury

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care, Associate Director of Care, Acting Director of Care, Registered Nurses, Registered Practical Nurses, and Personal Support Workers

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

During the course of this inspection, Non-Compliances were issued.
- **3 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 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

A. The licensee failed to ensure that resident #001, who was at risk of altered skin integrity, received a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

The home's policy, "Care 12-010.01 LTC – Procedure Steps: Prevention of Skin Breakdown", directed staff to complete a skin assessment using the "Head to Toe Assessment" after every return from hospital.

During interview with Registered Nurses (RN) #106 and #107, they stated that all head to toe skin assessments would be completed on the Point Click Care (PCC) documentation system within the progress notes or under the "Assessment" tab. They confirmed that the assessment was to be completed within 24 hours after returning to the Long-Term Care Home.

Documentation under the "Assessment" tab in Point Click Care did not include a skin assessment for the resident within 24 hours of re-admission to the home. Documentation in the resident's progress notes included a head to toe skin assessment, however the assessment was not completed within 24 hours after the resident's return from hospital. The resident was identified to have new areas of skin impairment on the skin assessment that was completed two days after the resident's return from hospital.

B. The licensee failed to ensure that resident #004, who was at risk for skin breakdown, received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

Resident #004 was at risk for skin breakdown as identified in their plan of care. The resident was transferred to hospital and a skin assessment was not documented as completed after the resident's return to the home.

The licensee's policy, "Care12-)10.01 LTC-Procedure Steps: Prevention of Skin Breakdown", directed staff to complete a Head to Toe Assessment for all residents upon return from hospital.

Registered Nurse #104 reviewed the resident's clinical health record with Inspector #107 and confirmed that a skin assessment by a member of the registered nursing staff was not completed when the resident returned from hospital. [s. 50. (2) (a) (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 with O.Reg. 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 failed to ensure that staff involved in the different aspects of care collaborated with each other in the assessment of resident #001 so that their assessments were integrated, consistent with, and complemented each other.

Safe Lift and Transfer (SALT) assessments identified that resident #001 was cognitively and physically able to participate in transfers. The Falls Risk Assessment and the resident's Cognitive Performance Score on the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment identified that the resident had severe cognitive impairment.

During interview with Inspector #107, RN #107 confirmed that the resident was able to communicate with staff. During interview with PSW #105, the PSW stated that the resident was cognitively and physically able to participate in activities of daily living.

Inspector #107 spoke with the resident and the resident was able to communicate with the Inspector.

Information on the SALT assessment, Falls Risk Assessment, and statements by RN #107 and PSW #105, were not consistent and did not complement each other related to resident #001's level of cognition. [s. 6. (4) (a)]

2. The licensee failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan related to falls prevention and

management.

The plan of care for resident #001 identified the resident was at risk of falling and directed staff to place the resident's call bell within reach of the resident.

On a specified date, resident #001 was observed sleeping in their room. The resident's call bell was positioned out of reach of the resident. Registered Nurse #103 observed the resident with Inspector #107 and confirmed that the call bell was not placed within the resident's reach.

On a specified date PSW #105 also confirmed that resident #001 would not be able to access the call bell in the location it was placed.

The plan of care was not provided to resident #001 as specified in their plan related to falls prevention and management. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

On a specified date, a treatment cart was located in the charting room across from the nursing station. Inspector #107 was able to enter the charting room and access the treatment cart without staff noticing. Inspector #107 identified a medication, labeled with resident #002's name, sitting on-top of the treatment cart. Inspector #107 was able to remove the medication without staff being aware of it. RPN #109 was notified and stated that the door to the treatment room was to be kept locked when unsupervised.

On a specified date, the charting room was again left unlocked and unsupervised, and the same medication was observed on-top of the treatment cart. RN#106 was notified that the medication was accessible. The RN stated that the medication should not have been stored on-top of the treatment cart and was to be kept in a locked medication cart and stored in the medication room. The RN moved the medication to the medication storage room. [s. 129. (1) (a) (ii)]

Issued on this 6th day of February, 2020

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

Original report signed by the inspector.