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
Nov 4, 2019	2019_777731_0030	018204-19, 018215-19	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Berkshire Care Centre
350 Dougall Avenue WINDSOR ON N9A 4P4

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

KRISTEN MURRAY (731), INA REYNOLDS (524)

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 15, 16, 17, and 18, 2019.

The following Complaint intakes were completed within this inspection:

Complaint Log #018215-19 / IL-70415-LO related to skin and wound, continence care, laundry services and the prevention of abuse and neglect

Complaint Log #018204-19 / IL-70388-LO related to nutrition and hydration, and the prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Registered Dietitian (RD), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), an Activity/Restorative Aide, a Laundry Aide, and residents.

The inspectors also observed resident rooms and common areas, observed meal service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 a resident that exhibited altered skin integrity received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

The Ministry of Long-Term Care (MOLTC) received an anonymous complaint related to a number of care concerns regarding resident #002, including continence care concerns. When Inspector #115 spoke with the complainant, they brought forward an additional concern involving an area of altered skin integrity on a specified body part of resident #002.

In a clinical record review for resident #002, the progress notes for the resident identified that on a specific date, resident #002 returned to the home with specified symptoms of altered skin integrity noted to a certain body part. On the same day, a skin and wound referral was made for resident #002 related to the specified symptoms of altered skin integrity, and a number of days later, another skin and wound referral was made related to specific symptoms of altered skin integrity present to specified areas of their body. According to the progress notes and assessments for resident #002, the areas of concern on the specified body part were assessed by the Wound Care Nurse (WCN) #115 four days after the initial referral was made, and identified that the appearance of resident #002's specified areas of altered skin integrity had deteriorated upon their return

to the home.

A review of resident #002's electronic Treatment Administration Record (eTAR) for September 2019, identified that four days after they returned to the home, an order was created to monitor the specified area along with a number of specified interventions for altered skin integrity. The eTAR further indicated that five days after the resident returned to the home, an order was created to apply a specified medical treatment to the area of altered skin integrity.

In an interview with Registered Practical Nurse (RPN) #107, when asked if resident #002 returned to the home on a specified date with areas of altered skin integrity identified, RPN #107 stated there were areas of altered skin integrity noted on a specified area of the resident's body when they returned, including a new area on that specified area of the body. When asked the process in the home upon identifying areas of altered skin integrity, RPN #107 stated that a head to toe assessment was to be completed, a referral was to be completed for the WCN, the Nurse Practitioner (NP) or Physician would be contacted, and the resident would be provided an immediate treatment, which would go in the eTAR. RPN #107 further stated that resident #002 should have been treated right away.

In an interview with Director of Care (DOC) #105 when asked what the expectation was in terms of assessing, referring and treating a resident upon return to the home for areas of altered skin integrity, DOC #105 stated that once the resident comes back to the home, if the Nurse identifies any areas of altered skin integrity, they are to follow the protocol. DOC #105 further stated that if the WCN is not available, the wound needs to be referred to the NP or Physician. DOC #105 stated that after resident #002 returned to the home on the specified date, either the WCN should have seen resident #002 before the date they completed the assessment, or if unavailable, the nurse on the unit should have contacted the NP or Physician to treat the areas of altered skin integrity.

A review of the home's policy titled "Skin Risk Assessment and Head-To-Toe Skin Assessment" number RCS G-35-05 last revised July 29, 2019, stated in part that head to toe skin assessments will be conducted by a member of the registered staff under the following circumstances: Upon return to the home, and at any other time as clinically indicated. The policy stated, "The registered staff assess and documents the assessments including changes to the Plan of Care as required and initiates appropriate interventions". The policy further indicated that "A referral is then initiated by the Reg. staff to the home's Wound Care Lead for their follow-up assessment, Registered Staff will

document the Wound Assessment in the residents' records following the protocol under "Skin and Wound" tab in PCC, and other notifications will include: SDM, Physician, NP, may include Physiotherapist and other members of the Interdisciplinary Team".

The licensee failed to ensure that when resident #002 exhibited altered skin integrity, they received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required. [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 a 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, as required, 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).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of casual factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required. The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

The Ministry of Long-Term Care (MOLTC) received an anonymous complaint related to a number of care concerns regarding resident #002, including continence care concerns.

In a clinical record review for resident #002, there were no documented continence assessments in PointClickCare (PCC), under the assessments tab, for the resident. A review of resident #002's paper chart identified that there were no documented continence assessments in the paper chart, for the resident. A review of the MDS assessments for resident #002 identified that on a specific date, the resident was identified as incontinent and an intervention was used for incontinence. The MDS assessments further indicated that on another specific date, the resident was identified as incontinent, and two interventions were used for incontinence.

In an interview with Registered Practical Nurse (RPN) #114, when asked how a resident's continence status was determined on admission, RPN #114 stated that a continence assessment was completed to determine what interventions the resident may need. When asked how often continence assessments were completed after admission, RPN #114 stated quarterly and at any health status change. When asked where the assessments were documented, RPN #114 identified that they were documented under the assessment tab in PCC and they previously used to be documented in the resident's chart as a paper copy. When asked if resident #002 had a continence assessment completed on admission, RPN #114 looked in the resident's chart on PCC and in the resident's paper chart, and stated they did not see one.

In an interview with Director of Care (DOC) #105 when asked where continence assessments should be documented, DOC #105 stated they should be in the assessments tab on PCC. When asked how often the continence assessments should be completed, DOC #105 stated they should be done upon admission, quarterly, and for any significant change in health status. When asked if resident #002 had a continence assessment completed at any point in time, DOC #105 stated they could not find an

assessment for resident #002 and it should be documented in PCC.

A review of the home's policy titled "Bowel/Bladder Assessment – Continence Assessment", last revised March 2018, stated that "Screening resident for continence level occurs on admission and quarterly using the RAI-MDS assessment, and resident voiding and bowel patterns are assessed on admission using the voiding record". The policy further stated that "Resident will have an assessment completed as per the Long Term Care Homes Act (LTCHA) and regulation". [s. 51. (2) (a)]

2. In a clinical record review for resident #002, the plan of care, including the kardex identified that the resident was incontinent, and interventions specific to the resident's needs were identified.

In an interview with Personal Support Worker (PSW) #113, when asked the continence status of resident #002, PSW #113 stated that the resident had a number of specific interventions in place, different than one of the interventions identified in the resident's plan of care. When asked if the resident's care needs related to their continence status had recently changed, PSW #113 stated that a specific intervention had recently changed.

In an interview with Registered Practical Nurse (RPN) #114, when asked if there is a process in place in the home to change the intervention for a resident, RPN #114 stated that staff would assess the resident and may need to change the interventions based on the assessment. When asked the continence status of resident #002, RPN #114 stated that the resident had a specific intervention in place. When asked if the resident's care needs related to their continence status had recently changed, RPN #114 stated that they had one intervention in place, but then changed to a different intervention.

In an interview with Director of Care (DOC) #105 when asked which interventions were used for resident #002, DOC #105 stated the resident had one intervention in place during a certain time of the day and a different specific intervention in place during a different time of the day. When asked if this was reflected in resident #002's plan of care, DOC #105 stated the plan of care stated one specific intervention was to be used for the resident and the plan of care may not have been updated.

The licensee failed to ensure that resident #002 received a continence assessment that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence and failed to ensure that that resident #002 had

an individualized plan to promote and manage bowel and bladder continence that was implemented. [s. 51. (2) (b)]

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, 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, and each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

The Ministry of Long-Term Care (MOLTC) received an anonymous complaint related to a number of care concerns regarding resident #002, including continence care concerns. When Inspector #115 spoke with the complainant, they brought forward an additional concern involving an area of altered skin integrity on a specified body part of resident #002.

In a clinical record review for resident #002, the progress notes for the resident identified that on a specific date, resident #002 returned to the home with specified symptoms of altered skin integrity noted to a certain body part. On the same day, a skin and wound referral was made for resident #002 related to the specified symptoms of altered skin integrity, and a number of days later, another skin and wound referral was made related to specific symptoms of altered skin integrity present to specified areas of their body.

In a clinical record review for resident #002, the assessments identified that the day the resident returned to the home, a Head to Toe Skin Scan was conducted and identified a symptom on specified areas of the resident's body. Four days after resident #002 returned to the home, four specified areas of the resident's body were assessed by the Wound Care Nurse (WCN) #115 and three of those areas were identified as deteriorated, while one was identified as a new area. Five days after resident #002 returned to the home, a Head to Toe Skin Scan was completed for the resident and indicated that there were no areas of altered skin integrity on the resident. Eleven days after the resident returned to the home, the four specified areas of the resident's body were assessed by the WCN #115 and the areas were identified as improving and monitoring with areas of altered skin integrity present.

In an interview with Registered Practical Nurse (RPN) #107, when asked what the expectation was in terms of completing a skin assessment for new areas of altered skin integrity, RPN #107 stated they would complete the electronic Treatment Administration Record (eTAR) for the treatment, complete the referral to the WCN, write a note in the Physician book, complete a referral to the RD, would change the care plan, and a skin assessment would be completed. When asked if resident #002 had areas of altered skin integrity, RPN #107 stated they had areas on a specified area of the body, where a treatment was applied. When asked how long the resident has had areas of altered skin integrity on the specified area, RPN #107 stated a specified amount of time. When asked if resident #002 had any new areas of altered skin integrity when they returned to the home on a specified date, RPN #107 stated resident #002 had a new area of altered skin integrity on a specified area of their body when they returned to the home.

In an interview with Director of Care (DOC) #105 when asked what the expectation was in terms of completing a skin assessment for new areas of altered skin integrity, DOC #105 stated that an assessment was to be done at the time the areas were identified and a referral completed to the WCN. DOC #105 further stated a dietary referral would be completed, the care plan updated, and they should cover the area, as well as get an order in the eTAR for monitoring. When asked if the assessment completed for resident #002 on a specified date, was consistent with and complemented the assessments completed on a number of other specified dates, DOC #105 stated the assessment on that specified date was not consistent with the other assessments for resident #002 related to the altered skin integrity of a specified area of their body.

A review of the home's policy titled "Skin Risk Assessment and Head-To-Toe Skin Assessment" number RCS G-35-05 last revised July 29, 2019, stated in part that head to toe skin assessments will be conducted by a member of the registered staff under the following circumstances: Upon return to the home, and at any other time as clinically indicated. The policy stated, "The registered staff assess and documents the assessments including changes to the Plan of Care as required and initiates appropriate interventions". The policy further indicated that "A referral is then initiated by the Reg. staff to the home's Wound Care Lead for their follow-up assessment, Registered Staff will document the Wound Assessment in the residents' records following the protocol under "Skin and Wound" tab in PCC, and other notifications will include: SDM, Physician, NP, may include Physiotherapist and other members of the Interdisciplinary Team".

The licensee failed to ensure that the staff and others involved in the different aspects of care of resident #002 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

Issued on this 5th day of November, 2019

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

Original report signed by the inspector.