Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
Oct 1, 2019	2019_643111_0017	020981-18, 025104-18, 027966-18, 032367-18, 032524-18, 014618-19	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Winbourne Park
1020 Westney Road North AJAX ON L1T 4K6

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

LYNDA BROWN (111)

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): August 23, 26 to 29, 2019

There were concurrent complaints and a critical incident inspection completed during this inspection as follows:
-Log #032367-18 for critical incident (CIR) related to a fall with injury.
-Log # 020981-18, 032524-18 for complaints related to skin and wound care, plan of care and medications.
-Log #025104-18, 014618-19, 027966-18 for complaints related to falls, plan of care, complaints, pain, missing personal items.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Clinical Manager, Resident Services Coordinator (RSC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers(PSW), residents, families, Wound Care Champion (WCC) and the Registered Dietitian (RD).

During the course of the inspection, the inspector reviewed health care records of resident, observed residents, observed medication administration, reviewed complaints and reviewed the following policies: skin and wound, complaints, missing clothing and personal items, falls prevention and medication administration.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
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 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee failed to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place, any policy, the licensee is required to ensure that the policy is complied with.

In accordance to O.Reg. 79/10, s.48(1) Every licensee of a long-term care home shall ensure that the following programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Review of the "Fall Prevention and Injury Reduction" policy (CARE5-010.05) , last reviewed March 31, 2019 indicated under procedure, the following additional communication and documentation is required: for those residents who have a Substitute Decision Maker (SDM), the SDM is notified. All falls are communicated to the Physician/Nurse Practitioner (NP). Urgent communication is required with the physician/NP when a medical intervention requires an immediate change.

There were two complaints received (by the home and the Director) from the family of resident #001, regarding the resident sustaining a fall with injury on a specified date that was not reported to the SDM for a period of time. The family also indicated they were not aware of any other falls the resident had sustained.

Review of the progress notes for resident #001 related to falls, indicated the resident sustained a number of falls over a specified period of time. On a specified date and time,

RN #101 indicated the resident sustained an unwitnessed fall and sustaining injuries to specified areas. Later the same day, the resident was assessed by the NP, who ordered a specified diagnostic test. The physician assessed the resident the following day and ordered another specified diagnostic test. The SDM was informed at this time of the fall. On another specified date and time, RN #101 indicated the resident sustained an unwitnessed fall with no injuries and the progress notes did not indicate the SDM was notified of the fall. On another specified date and time, RN #106 indicated the resident sustained an unwitnessed fall with no injuries. Later the same day, the resident complained of pain to a specified area, the physician was notified and ordered a specified diagnostic test. There was no indication in the progress notes the SDM was notified of the fall. On another specified date and time, a nursing student indicated the resident had sustained an unwitnessed fall with no injuries and the progress notes had no indication the SDM was notified.

During an interview with RN #101, they indicated when a resident has fallen, they are to document in the progress notes of any pain/injury, if there is suspected injury, they would contact the physician and the SDM. The RN indicated they recalled the fall that occurred with resident #001 that occurred on a specified date and only noted specified marks to a specified area at that time. The RN indicated they requested the oncoming day shift to notify the physician and family of the fall. The RN confirmed they were working when the resident sustained another fall on specified date and could not recall if they notified the SDM.

During an interview with RN #106, they indicated when a resident has fallen, they would assess the resident for any pain or injuries, document the incident and notify the SDM and physician. The RN confirmed that they had documented a fall with resident #001 on a specified date and the SDM was not informed of the fall.

The Inspector was unable to interview the nursing student as they were no longer in the home.

During an interview with the DOC, they indicated when a resident sustains a fall, the registered staff are to assess the resident for any pain or injury, if injury or pain, they are to transfer the resident to the hospital. The DOC indicated if there is a suspected injury, the physician and family are to be notified immediately. The DOC indicated if there was no injury and the fall occurs during a specified time, and the SDM is agreeable, the staff can wait to notify the SDM later the same day.

The licensee failed to ensure that their falls policy was complied with, as resident #001 sustained a fall with an injury on a specified date and the SDM was not informed of the fall until the following day. The SDM was also not informed of a number of other falls that occurred, on specified dates, as per the home's policy.

2. In accordance with O.Reg. 79/10, s. 100, every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101 of O.Reg. 79/10.

In accordance with LTCHA, 2007, c.8, s.21, every licensee shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

Review of the licensee's "Complaint Management" policy (ADMIN3-010.01) reviewed March 31, 2019, indicated:
1.Under documentation: a complaint management program binder is maintained. The binder contains the following information: copy of the client services response (CSR) forms, including the archived completed CSR forms; written complaints and follow up documentation.
2.Under verbal concerns, complaints: if concerns cannot be resolved immediately at point of service, the individual who is first aware of the concern will initiate the CSR form. A copy of the form will be forwarded to the Executive Director. Where the complaint alleges harm or risk of harm to one or more residents, an investigation shall commence immediately. The concern will be responded to within 24-48 hours (2 business days). The person who raised the concern will be informed of the actions being taken to resolve the concern. The CSR form will be completed in full and all actions taken during the investigation will be documented. The CSR form is then filed in the complaints management binder. Upon completion of an investigation of the concerns, a response will be provided to indicate what had been done to resolve the complaint, or if the complaint is found to be unfounded, an explanation will be provided regarding this finding.

A complaint was received by the Director from the family of resident #001, indicating they had submitted ongoing written complaints to the home related to the resident missing personal items, that were not resolved.

Review of the home's complaint management program binder indicated that there was no documented evidence of any written complaints received from the family of resident

#001.

Review of the progress notes for resident #001 indicated on a specified date, there was a note indicating the family reported the resident was missing personal items and were unable to locate the items.

Review of complaints submitted to the former DOC, indicated there were ongoing written complaints from the SDM of resident #001 that were received on specified dates and were not immediately resolved. Those complaints were not documented in the homes complaints binder, as per the policy and were related to missing personal items. The last written complaint that was received by the home on a specified date, the family was not provided a response to their complaint.

During an interview with the current DOC, they confirmed that none of the written complaints received by the former DOC were included in the home's complaint management procedure binder, as per the complaints policy, to indicate an investigation was commenced immediately, the concern was responded to within 2 business days, the person who raised the concern was informed of the actions being taken to resolve the concern, no CSR form was completed in full and all actions taken during the investigation were documented. A response was also not provided to indicate what had been done to resolve the complaint, or if the complaint was determined to be founded or unfounded.

3. In accordance with O.Reg. 79/10, s.114(2), every licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

A complaint was received by the Director from the family of resident #002, regarding a medication incident that occurred on a specified date.

Review of the licensee's "Prescriber's Medication Orders" policy (MEDI-CL-ONT-039) reviewed October 1, 2018 indicated that orders must be recorded immediately on the Prescriber Order Form. Ensure the order is written with the digital Pen assigned to that particular unit. With the digital pen, write the order within the order boxes. Once all orders have been written, return the digital pen to the cradle. All orders written will be sent to the pharmacy.

Review of the progress notes for resident #002 indicated on a specified date, the resident

went to an appointment and returned a new prescription. RPN #114 confirmed the resident returned to the home with a new prescription.

Review of the physician orders for resident #002 indicated the new prescription, provided on a specified date, was not transcribed onto the Physician's Order form until three days later.

Review of the eMAR for resident #002 for a specified month, indicated the resident was previously prescribed the specified medication but at a lower dose. The medication was discontinued and the newer dose was not administered until three days later.

The Inspector was unable to interview RPN #114 as they no longer worked in the home.

During an interview with the DOC, they indicated the medication incident involving resident #002, occurred prior to them starting in the home. The DOC indicated there was no documented medication incident report for this incident. The DOC indicated their expectation would be that the RPN should have transcribed the new prescription onto the physician's order form, so the pharmacy would be aware of the change in dosage and also recorded onto the eMAR.

The licensee failed to ensure that a new medication order was transcribed as per the licensee's policy to ensure the drug was administered to resident #002, in accordance wit

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 falls prevention, transcribing of orders and complaints policy that was instituted or otherwise put in place, is complied with, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure that a 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.

A complaint was received by the family of resident #001, indicating the resident developed an alteration in skin integrity to a specified area.

The practice in the home for the clinically appropriate assessment tool included, when the resident has a new wound, there is a checklist under the procedure which includes: classify wound (i.e. pressure) and registered nursing staff are to use the Initial Wound Assessment-Treatment Observation Record (TOR).

Review of the progress notes for resident #001 indicated on a specified date, RPN #108 documented the resident had an alteration in skin integrity noted to a specified area. Approximately two weeks later, the resident was sent to hospital (unrelated) and returned the following day. A number of days later, RPN #102 indicated the resident had an alteration in skin integrity to a specified area and a specified treatment was applied.

Review of the skin assessments for resident #001 indicated there was no documented

initial wound assessment (TOR) completed on a specified date, when the alteration in skin integrity was first discovered. A head to toe assessment was completed by RPN #111 when the resident returned from hospital, but the area of skin impairment was left blank (no indication of the any alteration in skin integrity).

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infections as required.

Review of the physician/NP orders for resident #001 for a specified period, had no indication of orders related to treatments for the alteration in skin integrity to resident #001.

Review of resident #001 electronic Treatment Administration Record (eTAR) for a specified period, had no treatments identified related to the alteration in skin integrity to a specified area.

3. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was 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 were implemented.

The practice in the home for a resident exhibiting altered skin integrity, including pressure ulcers, is to have a referral completed to the Registered Dietitian and a Nutritional/Hydration Risk Identification assessment completed to determine nutritional risk and any further changes required.

Review of the Nutritional/Hydration Risk Identification assessments (completed by the RD) indicated the only assessment Tool completed for resident #001, during a specified period, was completed a month later, which indicated the resident was a nutritional risk and the area that indicated the presence of altered skin integrity, was left blank. There were no further changes noted and there was no indication of a referral completed.

Review of the written plan of care for resident #001 related to skin care, had no indication the plan of care was updated to indicate the presence of an alteration in skin integrity to a specified area or interventions to manage the same.

4. The licensee has failed to ensure that a resident 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.

The practice in the home for the weekly wound assessments included the use of the "Ongoing Weekly Wound Assessment (TOR)".

Review of the assessments for resident #001 indicated there were no ongoing weekly wound assessment (TOR) completed.

During an interview with RPN #108, they confirmed they documented on a specified date, regarding the change in skin for resident #001 and would have passed onto the next shift for follow up. The RPN confirmed no other actions were taken.

During an interview with RPN #102, they confirmed they were working when resident #001 returned from hospital and asked the next shift to complete the skin assessment. The RPN indicated they are supposed to complete the skin assessment for resident's upon return from hospital. The RPN did not recall documenting that they noted an alteration in skin integrity on a specified date and confirmed they did not take any other actions, as per the skin and wound care policy.

During an interview with RPN #111, they indicated when a resident develops an alteration in skin integrity, an electronic head to toe skin assessment is to be completed, then a TOR, then they update the eTAR with any treatment, inform the physician, the wound care champion, the family and complete a referral to the RD. The RPN confirmed they were to complete a head to toe skin assessment whenever a resident returned from hospital. The RPN confirmed they completed the head to toe assessment of resident #001 upon return from hospital and indicating there was no evidence of an alteration in skin integrity noted on that date, despite having the altered skin integrity in place and no other actions were taken.

During an interview with the DOC, they indicated the home has a medical directive for skin care that staff are to follow for any alteration in skin integrity. The DOC confirmed there were no medical directives for wound care completed for resident #001. The DOC confirmed there was no weekly wound assessments completed for resident #001, despite the resident developing an alteration in skin integrity to a specified area, on a specified date, no eTAR was completed and no indication the physician or RD were notified. The DOC confirmed their skin and wound care policy was not followed and

should have been.

The licensee failed to ensure that when resident #001 exhibited altered skin integrity, the resident was assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument, received immediate treatments and interventions to promote healing, was assessed by a registered dietitian and was reassessed at least weekly.

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, 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; received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infections as required; was 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 were implemented and was reassessed at least weekly, by a member of the registered nursing staff, if clinically indicated, 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. (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 :

The licensee has failed to ensure that the plan of care was provided to the resident as specified in the plan, related to nail care.

There were three complaints received by the family of resident #002 (two written to the home and the third to the Director). The complaints indicated resident #002 did not have proper nail care provided, as per the written plan of care.

Review of the written plan of care for resident #002 related to nail care, indicated the resident was to have their nails (fingernails and toes) cut on bath days and the nurse to ensure that the PSW cleans the resident's nails every evening shift.

Observation of resident #002 by the Inspector on two separate dates, indicated the resident`s finger nails were trimmed, but dirt was noted under the finger nails.

During an interview with PSW #109, they indicated they were familiar with resident #002, had provided the resident with their care and indicated the resident required total assistance with nail care. The PSW indicated the residents finger and toe nails were to be trimmed by the PSW on bath days and was not aware that the residents finger nails were soiled.

During an interview with RPN #110, they indicated they were familiar with resident #002, indicated the resident was to have their finger and toe nails trimmed on bath days and was not aware that they were to be checking the resident`s fingernails to ensure the PSWs kept them clean an free of dirt.

During an interview with the DOC, they indicated the family of resident #002 had ongoing complaints in the home related to hygiene and grooming. The DOC was not aware that the resident`s nails were not being kept free of dirt.

The licensee failed to ensure that resident #/002 received fingernail care, including keeping their nails clean (free of dirt) as indicated in the written plan of care.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee failed to ensure the Director was informed no later than one business day, followed by the report, an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

A critical incident report (CIR) was submitted to the Director on a specified date, for a fall incident that resulted in transfer to hospital and a significant change in condition. The CIR indicated on a specified date and time, resident #003 had sustained a fall with an injury, was transferred to hospital and diagnosed with an injury to a specified area the same day. The CIR indicated that no after hours call was placed to the Director on that date.

During an interview with the Administrator, they indicated the CIR was completed by the former Administrator.

The licensee failed to ensure the Director was informed of a fall incident for which resident #003 was taken to hospital and resulting in an injury to a specified area. The Director was not informed of the fall until 13 business days after the incident occurred.

Issued on this 1st day of October, 2019

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

Original report signed by the inspector.