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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 22, 2013	2013_179103_0063	O-002038-13	Complaint

Licensee/Titulaire de permis

COUNTY OF LENNOX AND ADDINGTON
97 Thomas Street East, NAPANEE, ON, K7R-4B9

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

THE JOHN M. PARROTT CENTRE
309 BRIDGE STREET WEST, NAPANEE, ON, K7R-2G4

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

DARLENE MURPHY (103)

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): November 19-21, 2013

During the course of the inspection, the inspector(s) spoke with a Personal support worker, a Registered Nurse, the RAI supervisor, the Assistant Manager of Nursing and the Manager of Nursing.

During the course of the inspection, the inspector(s) reviewed resident health care records including wound care recommendations made by the Nurse Practitioner, and the home's policy on skin and wound care management.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 comply with O. Reg 79/10, s. 50 (2)(b)(iii) whereby residents exhibiting altered skin integrity were not assessed by a registered dietitian who is a member of the staff of the home.

Resident #1 was admitted to the home on an identified date and was assessed as a high nutritional risk.

The dietitian ordered protein powder three times a day on an identified date to "maintain good skin condition". The resident developed an open wound shortly after admission and later developed additional open areas.

Three dietary quarterly summaries were provided by the home, all hand dated to correspond to the applicable months. All of the summaries contained identical information including a reference to "a stage 2 skin ulcer". There were no documented assessments by the dietitian to indicate any changes were made to the resident plan of care relating to nutrition and hydration for wound healing.

Resident #3 has been assessed as a high nutritional risk. The dietitian ordered protein powder for this resident on an identified date, but there was no documented assessment by the dietitian to indicate the reason for the intervention. The most recent dietary summary indicated the resident had a stage two skin ulcer. Resident #3's plan of care in effect at the time of this inspection indicated the resident has a stage three wound. A registered nurse was able to confirm the information on the plan of care is accurate.

The Manager of Nursing was interviewed and stated the dietitian currently reviews the summary of the daily progress notes to identify all nutritional related issues. [s. 50. (2) (b) (iii)]

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 all resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are assessed by a registered dietitian, 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. (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).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 6(1)(c) whereby the resident plan of care failed to provide clear directions to staff and others who provide care to the resident.

On an identified date, Resident #1 was ordered to start a supplement. The order was discontinued ten days later. The resident plan of care in effect five months later still indicated the resident was to receive the supplement three times a day. The plan of care failed to provide clear directions to staff.

Dietary quarterly summaries hand dated and completed after the supplement was discontinued all indicated the resident was to receive the supplement three times a day. [s. 6. (1) (c)]

WN #3: 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 :

1. The licensee has failed to comply with O. Reg 79/10, s. 8(1) whereby policies related to wound and skin care are not in accordance with all applicable requirements under the Act and is not complied with.

The home's Skin and Wound Care Management policy #04-07-05 does not comply with legislated requirements. O. Reg 79/10, s. 50 (1)(b)(iii) states a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds is assessed by a registered dietitian.

The home's policy under procedure states, "a dietary review will be requested to assess increased dietary requirements associated with pressure related skin impairments." The policy fails to include the need for assessment by a registered dietitian for skin breakdown, skin tears and wounds that are not the result of pressure. [s. 8. (1)]

Issued on this 22nd day of November, 2013

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