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
Jan 14, 2019	2018_530726_0009	020994-18, 024465-18, 024806-18, 026658-18	Complaint

Licensee/Titulaire de permis

Villa Colombo Seniors Centre (Vaughan) Inc.
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

Villa Colombo Seniors Centre (Vaughan)
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

REBECCA LEUNG (726)

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 13, 14, 15, 19, 20, 21, 22, 26, 27, 28, December 3, 4, 2018, and off-site on December 6, 11, 12, 13, 14, 17, 18, 19, 20, 24, 2018

The following Complaint intakes were inspected during this inspection:

Log #020994-18: related to skin and wound care, plan of care, pain management, fall prevention and management, medication management system, and dealing with complaints

Log #024465-18: related to prevention of abuse and neglect, licensee must investigate, respond and act

Log #024806-18: related to prevention of abuse and neglect, nutrition care and hydration, skin and wound care, and plan of care

Log #026658-18: related to licensee to forward complaints, Residents' Bill of Rights, additional training for direct care staff, and skin and wound care

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (Administrative), Infection Prevention and Control/Continuous Quality Improvement/Skin and Wound Program Lead, Clinical Manager, Physician, Occupational Therapist, Physiotherapist, Assistive Devices Program Authorizer/Occupational Therapist, Wound Care Nurse, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Agency Staff, residents, family member and substitute decision-maker (SDM).

During the course of the inspection, the inspector observed staff to resident interactions, reviewed resident's health records, relevant policies and procedures, and manufacturer's clinical user manual.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Falls Prevention
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care
Training and Orientation

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Ministry of Health and Long Term Care (MOHLTC) received complaints in regards to resident #015's plan of care specifically related to an identified altered skin integrity to an identified body part within a specified range of time.

In an interview, the SDM stated they had concerns with the staff not informing them regarding an identified altered skin integrity to an identified body part of resident #015 that had healed in 2017 as informed by the home's staff, and the worsening of the identified altered skin integrity after resident #015 was re-admitted to the home from the hospital on an identified date. The SDM felt that they were not given the opportunity to participate fully in the development and implementation of resident #015's plan of care specifically related to the care of the identified altered skin integrity. The SDM stated they only became aware of the deterioration of the identified altered skin integrity when resident #015 was admitted to the hospital with specified diagnoses and significant complications on an identified date. The SDM stated that the home's clinical coordinator

called on an identified date and apologized that nobody had informed the SDM that the identified altered skin integrity was getting worse, and said they were going to check with the nurses and call the SDM back, but they never did.

Review of clinical record for an identified date indicated RPN #153 had documented an identified altered skin integrity was observed to an identified body part of resident #015. Review of registered dietitian's (RD #149) assessment note for an identified date indicated resident #015 was referred due to the identified altered skin integrity. Review of resident #015's specified assessment on an identified date, indicated that two identified altered skin integrity areas were observed on two different identified body parts. Review of the Nurse Practitioner's note for an identified date, indicated that resident #015 presented with an identified altered skin integrity and a specific treatment was prescribed. Review of resident #015's clinical records indicated no documentation was found related to the SDM being informed by the staff regarding the above mentioned identified altered skin integrity observed on the identified body parts and the treatment provided.

Review of resident #015's clinical record, indicated an order for a specified treatment was started on an identified date and continued for an extended period of time until the order was discontinued on an identified date. Review of resident #015's clinical records indicated no documentation was found related to the SDM being informed by the staff regarding the above mentioned identified altered skin integrity observed and the treatment provided.

Review of clinical records indicated that resident #015 was admitted to the hospital on an identified date for a specific diagnosis and received specified treatment, and an identified altered skin integrity was noted the second day after resident #015 was admitted to the hospital.

Review of a specified assessment and the clinical note written by RN #100, indicated the identified altered skin integrity was getting worse, a note was left in MD binder and communicated with team through report. Further review of the clinical record indicated resident #015 was then assessed by a specialty nurse on an identified date for the worsened altered skin integrity and recommendations were provided. There was no documentation found related to the SDM being informed by the staff regarding the worsening of the above mentioned identified altered skin integrity, and the assessment completed by the specialty nurse and the recommendations provided.

Review of clinical record for an identified date, RPN #140 stated that orders were received for investigations and initiation of an oral medication. The SDM was notified and was "OK" with the orders. Review of clinical record for a specified date, RPN #140 stated that resident #015 continued the treatment for the identified altered skin integrity and received new orders from the physician, and the SDM was notified. However, in a telephone interview, the SDM denied being informed by RPN #140 for the above mentioned information on the identified dates.

Review of clinical record for a specified date, the occupational therapist (OT #154) stated referral received to see resident #015 and assess their mobility device due to the identified altered skin integrity. OT #154 recommended resident #015 to use a specific mobility device as personal assistance services device (PASD). OT #154 indicated that they had informed the SDM the recommendation and the SDM agreed. The SDM was also informed about the Assistive Device Program (ADP) authorizer would come to perform an assessment for resident #015. In a telephone interview, OT #154 confirmed that they had called the SDM on an identified date to discuss the recommendations with the rationales for resident #015 as documented. However, in a telephone interview, the SDM denied being informed by OT #154 regarding the recommendations with rationales for resident #015 to use a specific mobility device as a PASD for a specific therapeutic function. The SDM stated they had requested the physiotherapist to assess resident #015 for a new regular mobility device long time ago. The SDM recalled the phone conversation with OT #154 was only about purchasing a new regular mobility device for resident #015.

Review of clinical record for a specified date, the Clinical Coordinator stated they had a conversation with the SDM regarding resident #015's identified altered skin integrity and how it progressed. The Clinical Coordinator advised the SDM that the identified altered skin integrity was inherited from hospital and had worsened shortly after. The SDM was aware that it was inherited. The specialty nurse assessed resident and treatment was started. The SDM was informed that resident #015 was offered a specific intervention and resident #015 was not compliant with the treatment plan.

Review of clinical record for a specified date, indicated the attending physician (MD #136) called the SDM and discussed resident #015's clinical history. In particular, the SDM felt that they were not made aware by nursing that the identified altered skin integrity was a serious concern. MD #136 advised the SDM that the staff had followed the home's protocol that once the identified altered skin integrity progressed to the specific stage, a specialty nurse saw the resident and made appropriate

recommendations. The SDM stated that the nurses were very good at informing them of resident's other concerns, however, with regard to the identified altered skin integrity, the SDM did not feel that they were informed. The SDM questioned whether the identified altered skin integrity had in fact started at the hospital. MD #136 reviewed the clinical notes and confirmed that the identified altered skin integrity was found on resident #015's return from hospital.

Review of clinical record for a specified date, the administrator (#103) stated that the SDM acknowledged resident #015 was re-admitted from the hospital with the inherited identified altered skin integrity, however, it was the home's responsibility for treatment thereafter; and the SDM was never informed of status of the identified altered skin integrity nor its progression. Administrator agreed, however, they provided the SDM a verbal timeline from an identified date as well as resident's refusal to comply with the treatment plan and the expected challenges. The SDM acknowledged resident had been non-compliant to the treatment plan. Administrator #103 apologized for SDM's concern for lack of communication and advised they would further discuss with the physician and had the specialty nurse visits weekly.

In an interview, Administrator #103 stated that during the care conference on an identified date, they admitted that they could not confirm the reason why the deterioration of the identified altered skin integrity was not communicated to the family, as the staff was having ongoing verbal communications with the family. However, the verbal communications were not documented on file. They had apologized to the family during the meeting.

In summary, before the identified date, there was no strong evidence available to support that the staff had informed the SDM regarding resident #015:

- developed an identified altered skin integrity to an identified body part in the specified range of time,

- had an ongoing identified altered skin integrity to an identified body requiring treatment for a specified period of time,

- had a deterioration of the identified altered skin integrity to the identified body part as indicated in the specified assessment completed on an identified date, and

- was assessed by the specialty nurse for the identified altered skin integrity to an

identified body part on an identified date and recommendations for treatment were provided.

The home has failed to ensure that the SDM and family were given the opportunity to participate fully in the development and implementation of the resident #015's plan of care specifically related to the identified altered skin integrity. [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The intake notes indicated the SDM reported a laboratory test was scheduled for resident #015 and it did not happen. The SDM had concerns as to why the laboratory test was documented completed but it was not done. The SDM stated that resident #015 was later transferred to hospital as per physician's direction for specified clinical conditions on an identified date. Resident #015 had the laboratory test done in hospital and received treatment. Resident #015 was discharged back to the home with a script of specific supplements.

Review of physician order for an identified date, indicated an order was written by the physician for a set of specific laboratory tests.

Review of clinical record for an identified date, no documentation was found related to the scheduled specific laboratory tests not being completed for resident #015.

Review of clinical record for a specified date, the attending physician (MD #136) noted the specific laboratory tests ordered were not done and resident #015 appeared unwell. MD #136 indicated as there was no laboratory test results to clearly define a specific clinical condition, they would need to rely on a specified assessment from nursing. MD #136 spoke with the SDM and obtained consent for transferring resident out to emergency room (ER) for assessment.

Review of clinical record for a specified date written by RPN #140, indicated that the SDM called and was very upset that they were not notified that the specific laboratory tests were not done on the identified date due to the laboratory technician was unable to obtain the specimen for resident #015.

In an interview, RPN #140 stated they were aware that resident #015 had specific laboratory tests scheduled on an identified date and the laboratory technician was unable

to obtain the specimen for the resident. The practice in the home was that the laboratory technician would usually write a note on the upper top corner of the laboratory requisition. The nurses would then reschedule the laboratory tests on the next scheduled day in the same week unless it was urgent. RPN #140 did not know how the laboratory tests got missed later and stated it was the nurses' responsibility to ensure the laboratory tests would be done in the next possible day.

In a telephone interview, RPN #141, who had worked on the identified shift on an identified date, stated that they could not recall what had happened to resident #015's scheduled laboratory tests in that shift. RPN #141 reviewed their documentation and called the inspector again later to confirm the same information.

In a telephone interview, MD #136 stated that the specific laboratory tests was ordered on an identified date for resident #015, but the laboratory technician was unable to get the specimen from the resident on the scheduled date. On the identified date, resident #015 presented to be unwell, MD #136 was concerned with a specific clinical condition, and the challenge with treating an acutely ill resident in the home. MD #136 indicated that given the goal of care of resident, even if the specific laboratory tests were done as scheduled, they were unsure when the laboratory results would be available for review; therefore, they would not change their decision to transfer resident #015 to the ER for assessment.

In an interview, the Director of Care (DOC #133) acknowledged that the laboratory technician could not obtain the specimen for resident #015 on the specified date, and the registered staff did not reschedule the specific laboratory tests on the next scheduled day in the same week, as a result, the specific laboratory tests were missed. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On an identified date, the inspector met with the SDM. The SDM stated when they visited resident #015 in the evening on an identified date, the staff informed them that the resident had a specific investigation done on that day. The SDM called the charge nurse on-duty in the evening. The charge nurse told them that the specific investigation was ordered by the doctor on an identified date, and another order was received on a later date for discontinuing the specific investigation. The charge nurse could not tell the SDM why the specific investigation was done for resident #015 on the identified date. The SDM stated that they had discussed with the attending physician (MD #136) on many

dates that the SDM did not want any investigation or treatment other than the specified investigation and treatment consented by the SDM. The SDM indicated that they did not give any consent for the specific investigation to be done for resident #015. The SDM informed the inspector that they had already complained the issue to the Director of Care followed by sending a written complaint to the administrator via email.

Review of physician orders for an identified date, the specific investigation was ordered for specified reason. A note with an identified date written beside the order indicated that resident #015's family member was "notified of today's orders…OK with them".

Review of clinical record for a specified date, RPN #141 stated the SDM informed that they did not want the investigations ordered including the specific investigation and the specialist consultation done for resident #015. RPN #141 indicated that they called the on-call physician and received an order to discontinue the investigations including the specific investigation and specialist consultation, which were originally ordered on the specified date.

Review of clinical record indicated no documentation was found regarding the specific investigation done for resident #015 on the identified day.

In an interview, RPN #141 stated on an identified date, after obtaining the order from the on-call physician to cancel the specific investigation for resident #015 as requested by the SDM, they found out the requisition for the specific investigation had already been faxed to the external service provider and the original copy of the requisition was kept in a folder. RPN #141 wrote on the requisition "POA refused to have the test done, please discard", then placed the requisition back in the folder. RPN #141 indicated that the requisition used to go to the DOC's office for processing. They were unsure if the process had changed, they decided to just leave the requisition in the folder.

As there was no documentation on file to confirm that the specific investigation was actually done for resident #015 on an identified date, RPN #141 called the external service provider later and confirmed that the specific investigation was done on that day and documented the information on file.

In an interview, DOC #133 stated that RPN #141 got the orders to cancel the investigations including the specific investigation, but they did not fax the cancellation request to the external service provider. As a result, the external service provider came and did the specific investigation for resident #015 as per requisition faxed. [s. 6. (7)]

4. The licensee has failed to ensure that the resident was assessed and the plan of care reviewed and revised at least six months and at any other time when the care set out in the plan had not been effective.

In an interview, the SDM was concerned with the worsening of the identified altered skin integrity which occurred after resident #015 returned to the home from the hospital on an identified date. Resident #015 was admitted to the hospital about two and a half months later with specified diagnoses and significant complications related to the deterioration of the identified altered skin integrity.

Review of a specified assessment completed on an identified date, showed that resident #015 was identified with specific functional issues.

a. Review of a specified referral summary for an identified date, resident #015 was referred for assessment after re-admission to the home. The physiotherapist (PT #121) indicated that resident #015 could tolerate sitting on their mobility device.

During the review of specified clinical record within an identified range of time, the inspector found multiple entries of documentation by the registered staff related to resident #015 refusing to be transferred from the mobility device to bed and stayed sitting in the mobility device for prolonged period of time sometimes.

Review of resident #015's care plan (completed by staff on an identified date) under the focus related to the identified altered skin integrity, the specific interventions included "turn and reposition every two hours". No direction was provided to direct care staff in regard to how resident #015 could be repositioned when they were sitting in the regular mobility device.

In an interview, PSW #147 stated before resident #015 became confined to bed, they were sitting in the mobility device for prolonged period of time almost every day, and they were using a regular mobility device without a specific therapeutic function. Resident #015 did not want to stay in bed, they always wanted to stay sitting in the mobility device. When the staff encouraged resident #015 to go back to bed, they would refuse.

In an interview, RPN #140 stated after resident #015 was re-admitted on an identified date, they were very confused. Resident #015 wanted to get up from bed. Sometimes, resident #015 would stay sitting in a regular chair in their room for a specified period of

time, however, there were days that the staff could not get them to bed. RPN #140 stated resident #015 did not receive a mobility device with a specific therapeutic function before they were admitted to the hospital on an identified date.

Review of a specified referral summary for an identified date, indicated PT #121 implemented new interventions for support, and confirmed the specific therapeutic device on the mobility device was in proper condition, and indicated the plan to coordinate with the OT on recommendation related to the mobility device.

Review of a specified clinical record for an identified date, Occupation Therapist (OT) #154 stated referral was received to see resident #015 and assess their mobility device due to the identified altered skin integrity. OT #154 recommended resident #015 to use a mobility device with a specific therapeutic function as personal assistance services device (PASD). OT #154 stated they had discussed their recommendation with the SDM and the SDM agreed. No other alternative or temporary intervention was recommended by OT #154 before the mobility device with the specific therapeutic function was available for trial by resident #015.

In an interview, PT #121 stated they were not aware that OT #154 had recommended resident #015 to have a mobility device with the specific therapeutic function and it was the OT's responsibility to follow up with the vendor and Assistive Device Program (ADP) authorizer regarding the ADP assessment and to arrange the delivery of the loaner mobility device with the specific therapeutic function for the resident to have a trial.

In a telephone interview, OT #154 stated they usually did not follow up with their referral after it was sent to the vendor. They expected the vendor to forward their referral to the ADP authorizer to perform the assessment for the resident, and arrange the delivery of the loaner mobility device with the specific therapeutic function to the resident in the home. They would then be asked to assess the resident and the mobility device if needed.

In a telephone interview, OT #156 (ADP authorizer) stated they received a referral from the vendor on an identified date. They contacted the SDM and obtained consent, then conducted the ADP assessment for resident #015 on an identified date. OT #156 recommended a mobility device with the specific therapeutic function for resident #015 and sent the information to the vendor. OT #156 later found out that the vendor had delivered a loaner mobility device without the specific therapeutic function to resident #015. The correct loaner mobility device with the specific therapeutic function was not

delivered to resident #015 until an identified date, by that time, resident #015 had become confined to bed due to the worsened identified altered skin integrity. The family then cancelled the trial for loaner mobility device. OT #156 indicated that the usual delivery time for a loaner mobility device could be up to four weeks, the PT or OT in the home could have implemented other temporary strategies until the loaner mobility device with the specific therapeutic function became available to resident #015 for trial.

In summary, the interdisciplinary team failed to reassess resident #015 and consider implementing other strategies when the identified altered skin integrity started to deteriorate, and resident #015 often preferred to stay sitting in mobility device for prolonged period of time, but the loaner mobility device with the specific therapeutic function was not yet available.

b. Review of resident #015's current care plan (completed on an identified date) under the focus for the identified altered skin integrity, one of the strategies was repositioning every half hour.

The inspector conducted repeated observations of resident #015 in their room on a number of identified dates at various times of the day and evening. Resident was observed repeatedly lying in an identified position in bed and appeared to be calm and comfortable.

In the interviews, PSW #142, #143 and #147 stated that they had been trying to reposition resident #015 every half hour. However, resident #015 did not like to lie on the specified position most of the time, and they were able to reposition themselves back to the identified position that they preferred.

In the interviews, RPN #140 and #155 indicated that they were aware that resident #015 preferred to stay lying in the identified position that they preferred sometimes, but the staff would always encourage resident #015 to lie on the specified position. RPN #140 stated they had not reviewed the strategy or discussed the challenge with the interdisciplinary team.

The team failed to reassess resident #015 when the strategy of repositioning resident #015 every half hour had not been effective. [s. 6. (10) (c)]

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, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that the resident is assessed and the plan of care reviewed and revised at least six months and at any other time when the care set out in the plan has not been effective, 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 :

1. The licensee has failed to ensure that a resident exhibiting identified 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 was specifically designed for skin and wound assessment.

In the Ontario Regulation 79/10, section 50 (3), "identified altered skin integrity" means potential or actual disruption of epidermal or dermal tissue.

In an interview, the Skin and Wound Program Lead (#150) clarified that the home had a specified assessment template for head-to-toe assessment and it was usually completed for new admissions and re-admissions, and another specified assessment template would be completed for skin openings, the staff were expected to complete this specified assessment whenever they changed the dressing for the residents.

Review of a clinical record for an identified date written by RPN #153 indicated an identified altered skin integrity was observed on an identified body part of resident #015. Review of registered dietitian's (RD #149) assessment note for an identified date, indicated resident #015 was referred due to the identified altered skin integrity.

Review of resident #015's clinical records indicated the specified assessment was not completed for the above mentioned identified altered skin integrity on the identified date or before resident #015 was admitted to the hospital on an identified date with a specified clinical condition. No further documentation was found related to the progression or healing of the above mentioned identified altered skin integrity to the identified body part for resident #015.

In an interview, RN (#151) stated that the registered staff shared the responsibilities for completing the specified assessments for the residents.

In an interview, the Skin and Wound Program Lead (#150) confirmed the specified assessment was not completed for the identified altered skin integrity to the identified body part for resident #015 by RPN #153 on the identified date. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting identified altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

Review of clinical record for an identified date written by RPN #153, indicated that a dressing was noted on an identified altered skin integrity on the day resident #015 returned to the home from the hospital on an identified date. Review of resident #015's

specified assessment for an identified date, indicated an identified altered skin integrity was observed on an identified body part.

The RD was receiving referrals within a specified range of time, and was reviewing the plan and making recommendations. Referrals to the RD related to the resident #015's identified altered skin integrity and other skin issues were sent on a number of identified dates. The RD assessed the resident and adjusted the plan accordingly.

Review of resident #015's specified assessment for an identified date completed by RN #100 indicated a worsening of the identified altered skin integrity. Reviewed of a clinical record for an identified date written by RN #100, indicated the identified altered skin integrity was getting worse, treatment was done as per order, resident #015 tolerated the procedure well, note left in MD binder and communicated with team through report.

Review of a specified referral note for an identified date documented on the day after the above mentioned specified assessment was completed by RN #100, indicated resident #015 was referred to RD #149 for specified issues that was not related to the worsening of the identified altered skin integrity.

Review of resident #015's clinical records did not indicate a referral to the registered dietitian was initiated on (or after) the above mentioned specified assessment was completed by RN #100 for resident #015, and documented the deterioration of the identified altered skin integrity; or after the specialty nurse assessed resident #015 on an identified date.

Review of clinical records, resident #015 was admitted to the hospital for a specified period of time and was diagnosed with specific clinical conditions. Review of a specified referral note documented on the date resident #015 returned to the home, RD #149 stated resident was referred due to return from hospital with the worsened identified altered skin integrity.

In an interview, RD #149 stated that the nurses did not refer to them again when resident #015's identified altered skin integrity to the identified body part started to get worse. They relied on the nurses to refer to them when the identified altered skin integrity started to deteriorate. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that a resident exhibiting identified 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.

Review of resident #015's specified assessment for an identified date, indicated that identified altered skin integrity was observed on two identified body parts.

Review of the Nurse Practitioner's note for an identified date, indicated that resident #015 presented with an identified altered skin integrity to an identified body part and specific treatment was prescribed.

Review of resident #015's clinical record, weekly reassessment of the identified altered skin integrity was not completed by a registered nursing staff on an identified date, or after, and no further documentation in the clinical record was found related to the progression or healing of the above mentioned identified altered skin integrity to the identified body part.

Review of resident #015's clinical record indicated a specific treatment was ordered for an identified altered skin integrity to an identified body part was started on an identified date and was continued for an extended period of time until the order was discontinued. Review of resident #015's clinical record, no further specified assessment was completed for the identified altered skin integrity to the identified body part within the period of time when the specific treatment was administered by the registered nursing staff, and no further documentation was found regarding the status of the identified altered skin integrity.

Review of specified clinical record indicated that resident #015 was admitted to the hospital on an identified date for a specific diagnosis and received treatment, and an identified altered skin integrity to an identified body part was noted on the second day after resident #015 was admitted to the hospital.

Review of clinical record for an identified date written by RPN #153, indicated that a dressing was noted on the identified altered skin integrity to the identified body part on the day resident #015 returned to the home from the hospital on an identified date. Review of a specified assessment for an identified date, indicated the identified altered skin integrity was observed to the identified body part.

Review of the weekly specified assessments completed within the identified range of time for resident #015, showed that the weekly reassessment of the identified altered skin

integrity was not completed by a registered nursing staff for resident #015 on a number of identified dates.

In an interview, the Skin and Wound Program Lead (#150) confirmed that the weekly reassessment of the identified altered skin integrity was not completed by a registered nursing staff for resident #015 on a number of identified dates. [s. 50. (2) (b) (iv)]

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 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; 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 is 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 O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to provide additional training under the Skin and Wound Program, to all staff who provide the related care to resident #015.

Review of clinical records indicated resident #015 had a worsening of the identified

altered skin integrity to the identified body part within a specified range of time in between two hospital admissions. Resident #015 was admitted to the hospital after the worsening of identified altered skin integrity. During the course of the hospital admission, resident #015 was diagnosed with a deterioration of identified altered skin integrity with significant complications. Resident #015 was started on specific treatments and returned to the home on an identified date. Resident #015's was later started on a specific therapy for the identified altered skin integrity on an identified date as recommended by the specialist and the specialty nurse with the consent from the SDM.

The intake notes indicated the SDM was concerned with the staff not trained on how to use, operate, and troubleshoot the equipment required to administer the therapy. The SDM reported two incidents observed on two different identified dates. On the identified date of the first incident, when the PSW was changing resident #015, the SDM noticed the equipment was not working properly. The SDM informed RPN #152. RPN #152 brought the charge nurse (RN #100) in to check together. They told the SDM that the equipment was working fine, but the SDM was concerned that the nurses did not fix the identified issue immediately. The SDM stated that the evening charge nurse (RN #151) came later to check the equipment and resolved the identified issue for the resident. On the identified date of the second incident, the SDM observed the equipment was not working. The SDM spoke with the staff, but the staff did not make any attempt to resolve the issue. In an interview, the SDM stated they went to request the Skin and Wound Program Lead (#150) to come check the equipment and the lead confirmed that the equipment was not functioning. The SDM indicated that the issue was not about the equipment not functioning, it was about the staff who insisted that it was. The SDM felt that if the staff failed to identify issues with the equipment, it might lead to poor care.

Review of clinical record for the identified date of the first incident, indicated that resident #015 was under the care of RPN #152 and RN #100, and there was no documentation found regarding any issue with the equipment on that day.

In two separate interviews, RPN #152 and RN #100 both admitted that they had not attended the training for the equipment prior to working in the unit for resident #015 on the identified date of the first incident.

In regards to the second incident, the Skin and Wound Program Lead (#150) clarified in their email message received on an identified date that the staff were unaware that the equipment was running out of the time of the battery life, and therefore when it stopped working, the staff were unprepared. The home got a new piece of equipment in recently

and had a backup if this should happen again.

Review of the attendance record for the equipment training/in-service, there were total of three training sessions offered on two identified dates. The full-time RPN including RPN #140, #153 and #155 who were covering the unit for resident #015 for day, evening and night shifts, were not on these three attendance records.

In the interviews, RPN #140 and #155 admitted that they did not attend the training offered by the home. They stated that they learned how to change the dressing and manage the equipment from their co-workers.

In an interview, DOC #133 stated it had happened in one occasion that none of the registered nursing staff on duty was trained on the equipment and resident #015's dressing needed to be changed. DOC #133 had to call and ask RPN #140 to walk them through over the phone on the procedure for changing the dressing for resident #015. In an interview, RPN #140 acknowledged that the above mentioned incident occurred on their day off.

In an interview, DOC #133 stated the nurses worked in the unit for resident #015 were expected to attend the training. DOC #133 acknowledged that the first in-service would not have trained enough registered staff to ensure full coverage for resident #015's care. They were aware that concerns came up from resident #015's family during the period between the two in-services. However, they had not heard any further concerns from the SDM since the last in-service was offered. They assumed that the dressing was well taken care of by the nurses. They indicated that the staff attended the training were supposed to be trainers and were expected to mentor the other nurses who had not done the dressing before.

In summary, the home has failed to provide additional training on the system under the Skin and Wound Program, to all staff who provide the related care to resident #015. [s. 221. (1) 2.]

Issued on this 17th day of January, 2019

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

Original report signed by the inspector.