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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 28, 2019	2019_745690_0001	000133-19	Resident Quality Inspection

Licensee/Titulaire de permis

The Ontario Mission of the Deaf
2395 Bayview Avenue NORTH YORK ON M2L 1A2

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

Bob Rumball Home for The Deaf
1 Royal Parkside Drive BARRIE ON L4M 0C4

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

TRACY MUCHMAKER (690), JENNIFER BROWN (647), SHANNON RUSSELL (692)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): January 7-11 and January 14-17, 2019.

The following intake was inspected on during this RQI inspection:

- One log related to a critical incident system report that the home submitted to the Director, related to a fall that resulted in an injury to a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family members and residents.

During the course of the inspection, the inspector(s) conducted a tour of the home, made observations in resident home areas, observation of care delivery processes including medication passes, reviewed the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Residents' Council
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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 provision of care set out in the plan of care was documented.

Resident #004 was identified as having altered skin integrity by Inspector #690 through a record review and a staff interview on an identified date.

Inspector #692 reviewed resident #004's health care records for a two month period. A Skin/Wound Assessment note on an identified date, indicated that resident #004 had acquired an area of altered skin integrity in a specified area. A review of resident #004's electronic medication/treatment administration record (eMAR/TAR) indicated that resident #004 was to have a specified treatment for the area of altered skin integrity, done at specified times. The Inspector reviewed resident #004's eMAR/TAR and was unable to locate documentation of the altered skin integrity treatment provided to resident #004 on 15 occasions during the two month period.

In an interview with Registered Practical Nurse (RPN) #105, they indicated that when a resident developed an area of altered skin integrity, the registered staff were to sign the eMAR/TAR when the area of altered skin integrity had been assessed and the specified treatment was done. RPN #105 confirmed there were 15 missing documentation entries on resident #004's eMAR/TAR for the two month period.

During an interview with RPN #106, who was also the wound care lead for the home,

they indicated that the registered staff were to document on the eMAR/TAR when a resident's area of altered skin integrity was scheduled to be assessed and the specified treatment was done. After reviewing resident #004's eMAR/TAR, the Wound Care Lead confirmed that the registered staff had not documented resident #004's specified treatment on their area of altered skin integrity on 15 occasions during the two month period.

Inspector #692 interviewed the Director of Care (DOC) who stated it was an expectation that when a resident had acquired an area of altered skin integrity, the registered staff were to document when the resident's area of altered skin integrity was assessed and when the specified treatment was done on the resident's eMAR/TAR to indicate it was completed. The DOC confirmed there were 15 missing documentation entries on resident #004's eMAR/TAR for the two month period, and there should have been documentation. [s. 6. (9) 1.]

2. Resident #008 was identified as having areas of altered skin integrity by Inspector #690 through a record review and a staff interview on an identified date.

Inspector #692 reviewed resident #008's health care records over a 25 day period. A Skin/Wound Assessment note on an identified date, indicated that resident #008 had acquired two areas of altered skin integrity. The skin/wound care assessment further indicated that the resident's areas of altered skin integrity were to have a specified treatment done at specified times. The Inspector reviewed resident #008's electronic eMAR/TAR and was unable to locate documentation of the specified treatment provided to resident #008 on nine occasions during the 25 day period.

In an interview with RPN #108, they indicated when a resident developed an area of altered skin integrity the registered staff were to sign the eMAR/TAR when the area of altered skin integrity had been assessed and the specified treatment was done. RPN #108 confirmed there were nine missing documentation entries on resident #008's eMAR/TAR during the 25 day period.

During an interview with RPN #106, who was also the wound care lead for the home, they indicated that the registered staff were to document on the eMAR/TAR when a resident's area of altered skin integrity was scheduled to be assessed and when the specified treatment was done. After reviewing resident #008's eMAR/TAR, the Wound Care Lead confirmed that the registered staff had not documented resident #008's specified treatment on nine occasions.

Inspector #692 interviewed the DOC who stated it was an expectation that when a resident had acquired an area of altered skin integrity, the registered staff were to document when the resident's area of altered skin integrity was assessed and when the specified treatment was done on the resident's eMAR/TAR to indicate it was completed. The DOC confirmed there were nine missing documented entries on resident #004's eMAR/TAR, and there should have been documentation. [s. 6. (9) 1.]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the care set out in the plan had not been effective.

Resident #007 was identified as having had a fall in the last 30 days on the most recent Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment and during a staff interview.

Inspector #690 reviewed resident #007's RAI-MDS assessment from an identified date, which indicated that resident #007 had a fall in the last 30 days.

A review of resident #007's electronic progress notes indicated that resident #007 had five falls over a six month period.

A review of resident #007's electronic care plan identified a focus that was initiated on admission, titled "Actual falls/potential for falls" related to a fall prior to admission and an identified diagnosis.The interventions listed were as follows: Falls risk assessment "FRAT" completed on all new admissions and the resident had a history of falling.

A further review of resident #007's electronic care plan identified a focus added to the care plan two months later, indicating that resident #007 had a fall on an identified date, and included interventions to prevent further falls.

A review of a policy titled "Falls Prevention and Management" #NUR-V-165, last revised September 2018, indicated in Appendix B Fall incident report under the heading "Plan of Care Updated/revised and printed" that after a resident had fallen, staff were to review the plan of care, add the date of the current fall, and review and revise the interventions to prevent falls and fall injury as appropriate.

In an interview with Inspector #690, Personal Support Worker (PSW) #111 indicated that resident #007 had a history of falls and that they would access the care plan on Point

Click Care (PCC) to find information on what falls interventions were in place to prevent falls. In a separate interview with Inspector #690, PSW #110 indicated that resident #007 was at risk for falls and had an identified intervention in place to signify that they were at risk for falling. PSW #110 further indicated that they would access the care plan on PCC to find information on resident #007's fall prevention interventions.

In an interview with Inspector #690, RPN #106 indicated that resident #007 was at risk for falls and that it was the responsibility of registered staff to update the care plan by adding the date of the most recent fall. RPN #106 further indicated that it was the expectation that registered staff would review the falls prevention interventions for effectiveness, and revise interventions after every fall as applicable. Together Inspector #690 and RPN #106 reviewed the electronic care plan for resident #007. RPN #106 indicated that there had been no revisions to the falls prevention focus and interventions on the care plan since the initial interventions were added to the care plan, two months after admission, and that there should have been, as resident #007 had sustained four falls after the initial interventions were added to the care plan, and the interventions were not effective in preventing further falls.

In an interview with Inspector #690, Registered Nurse (RN) #112 indicated that staff would utilize the care plan to find information on a resident's fall prevention interventions and that it was the expectation that staff would revise the care plan after every fall to include the date of the most recent fall and make revisions to the interventions to prevent further falls. Together Inspector #690 and RN #112 reviewed the care plan. RN #112 indicated that there had been no revisions to the care plan since the initial interventions were added to the care plan following the first fall, and that there should have been.

In an interview with Inspector #690, the DOC indicated that it was the expectation that the care plan was reviewed and revised after every fall and that staff were to add the date of the most recent fall to the care plan and revise the interventions when they were no longer effective. The DOC indicated that resident #007, had four falls since the care plan was last revised, and that there had been no revisions and that there should have been. [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 provision of care set out in the plan of care is documented, and to 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 goal in the plan is met, the residents care needs change or care set out in the plan is no longer necessary; or 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 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.

Resident #004 was identified as having an area of altered skin integrity by Inspector

#690 through a record review and a staff interview on an identified date.

Inspector #692 reviewed resident #004's skin/wound care assessments for a two month period. A skin/wound care assessment completed on an identified date, indicated that resident #004 had acquired an area of altered skin integrity. A skin/wound care assessment documented two weeks later, indicated that the area of altered skin integrity had worsened. The Inspector identified that skin/wound care assessments were not completed on five occasions.

The Inspector reviewed the homes policy titled "Skin and Wound Care" #NUR-III-02, last revised August 2018, indicated that the registered staff member in charge of the resident with altered skin integrity was to conduct the skin/wound assessment, at minimum weekly, or more frequent if required.

In an interview with RPN #108, they verified that resident #004 had an area of altered skin integrity. RPN #108 stated that the resident was to have an assessment of their area of altered skin integrity at least weekly; and the assessment was to be documented in the skin/wound assessment note in PCC.

In an interview with RPN #106 who was also the wound care lead for the home, they stated that their expectation from their registered staff members was to complete the skin/wound care assessments at a minimum of weekly and if required more frequently. The Wound Care Lead reviewed resident #004's skin/wound assessment notes and confirmed there were five weekly assessments not completed.

Together, Inspector #692 and the DOC reviewed resident #004's skin/wound assessment notes and determined there were five weekly assessments that were not completed. The DOC confirmed the expectation was that the registered staff were to conduct a skin/wound assessment note at a minimum of weekly for residents with altered skin integrity. [s. 50. (2) (b) (iv)]

2. Resident #008 was identified as having two areas of altered skin integrity by Inspector #690 through a record review and a staff interview on an identified.

Inspector #692 reviewed resident #008's skin/wound care assessments over a 25 day period. The Inspector identified that skin/wound care assessments for both areas of altered skin integrity were not completed on three occasions.

The Inspector reviewed the home's policy titled "Skin and Wound Care" #NUR-III-02, last revised August 2018, which indicated that the registered staff member in charge of the resident with altered skin integrity will conduct the skin/wound assessment, at minimum weekly, or more frequent if required.

In an interview with RPN #108, they verified that resident #008 had two areas of altered skin integrity. RPN #108 stated that the resident was to have an assessment of the areas of altered skin integrity at least weekly and to document in skin/wound assessment note in PCC.

In an interview with RPN #106 who was also the wound care lead for the home, they stated that their expectation from their registered staff members was to complete the skin/wound care assessments at minimum of weekly and if required more frequently. The Wound Care Lead reviewed resident #008's skin/wound assessment notes and confirmed there were three weekly assessments not completed for resident #008's areas of altered skin integrity on three occasions over the 25 day period.

Together, Inspector #692 and the DOC reviewed resident #008's skin/wound assessment notes and determined there were three weekly assessments that were not completed for resident #008's areas of altered skin integrity. The DOC confirmed the expectation was that the registered staff conduct a skin/wound assessment note at a minimum of weekly for residents with altered skin integrity. [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 is reassessed weekly by a member of the registered nursing staff, to be implemented voluntarily.

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

In accordance with O. Reg. 79/10, s.50. (1) 2, the licensee was required to ensure that the skin and wound program must, at a minimum, provide for strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.

Specifically, staff did not comply with the licensee's policy regarding "Skin and Wound Care– #NUR-III-02", last revised August 2018, which is part of the licensee's skin and wound care program.

The home's policy titled "Skin and Wound Care" #NUR-III-02, last reviewed August 2018, indicated that registered staff were to sign the eMAR/TAR indicating that the wound care treatment was completed.

Resident #005 was identified as having altered skin integrity in their RAI-MDS assessment from an identified date.

Inspector #692 conducted a record review of resident #005's health care records for a period of one month. A progress note on an identified date, indicated that resident #005 had acquired an area of altered skin integrity. The Inspector was unable to locate documentation of the specifed treatment provided to the area of altered skin integrity on resident #005's eMAR/TAR for the period of one month.

In an interview with RPN #108, they indicated that when a resident developed an area of altered skin integrity, the registered staff were to sign the eMAR/TAR when the area of altered skin integrity had been assessed and the specified treatment was done. RPN #108 stated they were unable to locate evidence of documentation of the treatment on the eMAR/TAR for the entire one month period.

During an interview with RPN #106, who was also the wound care lead for the home, they indicated that registered staff were to document on the eMAR/TAR when a resident's area of altered skin integrity was scheduled to be assessed and when the specified treatment was done. The Wound Care Lead confirmed that there was no evidence of the registered staff documenting on resident #005's eMAR/TAR for the one month period and that specified treatment should have been documented.

Inspector #692 interviewed the DOC who stated it was an expectation that when a resident had acquired an area of altered skin integrity, the registered staff were to document when the resident's area of altered skin integrity was assessed and when the specified treatment was done on the residents eMAR/TAR indicating that it was completed. The DOC confirmed there was no documentation on resident #005's eMAR/TAR for the one month period and that there should have been. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 28th day of January, 2019

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

Original report signed by the inspector.