Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Feb 16, 2021	2021_725522_0001	022633-20, 023511-20	Critical Incident System

Licensee/Titulaire de permis

The Women's Christian Association of London
2022 Kains Road London ON N6A 0A8

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

McCormick Home
2022 Kains Road London ON N6K 0A8

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

JULIE LAMPMAN (522), AYESHA SARATHY (741)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 1, 2, 3, and 4, 2021.

The following intakes were inspected:
Critical Incident System (CIS) report #2965-000023-20/Log #022633-20 related to resident care;
CIS report #2965-000025-20/Log #023511-20 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Manager of Environmental Services, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeepers, a Registered Dietitian, a Screener, a family member and residents.

The inspector(s) also observed infection prevention and control practices within the home, observed residents and the care provided to them, reviewed resident clinical records and policies and procedures relevant to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. (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 :

1. The licensee has failed to ensure that the care set out in resident #011's plan of care was provided as specified in the plan related to their transfer status.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) related to an improper transfer of resident #011 by Personal Support Worker (PSW) #109 that resulted in harm to the resident. Resident #011's care plan and transfer logo in their room indicated the resident's transfer status.

PSW #109 said that they did not check the transfer logo on the resident's care card in their room and failed to transfer the resident as specified in their plan of care. The Director of Care (DOC) #119 said that it was the expectation of the home that staff check the transfer logo in residents' rooms every time they transfer a resident and that PSW #109 did not follow resident #011's plan of care when they transferred the resident.

Resident #011 sustained an area of altered skin integrity as a result of PSW #109's failure to transfer the resident as specified in their plan of care.

Sources: CIS report #2965-000023-20; resident #011's clinical record, including care plan, transfer logo and progress notes; interviews with PSW #109, DOC #119 and other staff. [s. 6. (7)]

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 care set out in a resident's plan of care related to transferring is provided as specified in the plan, 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 when resident #011 and #014 exhibited altered skin integrity, they were assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the residents' plans of care relating to nutrition and hydration were implemented.

A) When resident #011 sustained an area of altered skin integrity, a referral to Registered Dietitian (RD) #111 was made to assess the need for extra supplementation, if indicated.

There was no evidence to indicate that an assessment was completed by RD #111 for resident #011. The home's policy indicated that the RD was responsible to assess all residents with altered skin integrity.

RD #111 said that they received referrals to assess residents for skin tears through the "Referral to Dietitian" focus in the progress notes, and that they documented their assessments in the progress notes. RD #111 acknowledged that they missed the referral staff made for resident #011 and did not assess the resident. DOC #119 said that RD #111 did not complete an assessment when resident #011 had altered skin integrity and should have.

There was a risk that resident #011's altered skin integrity could have worsened as a result of RD #111 failing to assess the resident.

Sources: Resident #011's clinical record, including progress notes; the home's "Skin & Wound Management Program" policy #RC-100-01, last revised Sept 2018; and interviews with RD #111, DOC #119 and other staff.

B) Resident #014 had several areas of altered skin integrity. The home's policy indicated that when a resident presented with a new skin issue, a referral to the RD was required to be initiated and that the RD was responsible to assess the resident. There was no documentation to indicate that the RD was made aware of resident #014's new skin issues, referrals were made for the skin issues or that the resident was assessed by the RD.

Registered Nurse (RN) #118 said that for a new skin issue, a referral would be made to the RD in the progress notes. They said that they did not see any referrals to the RD in the progress notes for resident #014's altered skin integrity. DOC #119 said that staff did not refer to the RD when resident #014 had altered skin integrity and should have.

There was a risk that resident #014's altered skin integrity could have worsened as a result of staff failing to refer to RD #111.

Sources: Resident #014's clinical record, including progress notes; the home's "Skin & Wound Management Program" policy #RC-100-01, last revised Sept 2018; and interviews with RN #118, DOC #119 and other staff. [s. 50. (2) (b) (iii)]

2. A) The licensee has failed to ensure that when resident #010 exhibited altered skin integrity, they were reassessed at least weekly by a member of the registered nursing staff.

i) Review of resident #010's clinical record noted the resident had several areas of altered skin integrity.

Further review of resident #010's clinical record noted there were no weekly skin and wound assessments completed after the initial assessment.

ii) Review of resident #010's clinical records noted the resident had developed another area of altered skin integrity and a skin and wound assessment was completed. Further

review of resident #010's clinical record noted a weekly skin and wound assessment was not completed.

In an interview, Registered Practical Nurse (RPN) #117 reviewed resident #010's clinical record with Inspector and verified there were no weekly skin and wound assessments completed for resident #010 and that staff should be completing skin and wound assessments in the assessment tab in Point Click Care.

There was risk to resident #010 as weekly assessments were not completed to assess the areas of altered skin integrity and determine if treatment was effective.

Sources: Resident #010's clinical records and assessments; The home's "Skin & Wound Management Program" policy RC-100-01, last revised Sept 2018 and "Pressure Injuries" policy RC-1000-02, last revised September 2018; and interviews with RPN #117 and Director of Care #119. (522)

B) The licensee has failed to ensure that when resident #011 exhibited altered skin integrity, they were reassessed at least weekly by a member of the registered nursing staff.

Resident #011 sustained an area of altered skin integrity. An order was documented in the electronic Treatment Administration Record (eTAR) for a weekly wound assessment to be completed for the resident's altered skin integrity. There was no documented evidence that resident #011's altered skin integrity was assessed during a two week period.

Registered Practical Nurse (RPN) #112 and Registered Nurse (RN) #110 said that altered skin integrity should be assessed weekly and documented in the Assessments tab in PCC. They said that the weekly skin assessments scheduled for resident #011 were missed over a two week period. Director of Care (DOC) #119 said that staff received education on skin and wound assessments and should have completed all of the weekly skin assessments for resident #011 using the "Wound Weekly Assessment Tool".

There was a risk that resident #011's altered skin integrity could have worsened as a result of staff failing to reassess it at least weekly.

Sources: Resident #011's clinical record, including progress notes, skin and wound

assessments in PCC, orders and eTAR; interviews with RPN #112, RN #110 and DOC #119.

C) The licensee has failed to ensure that when resident #014 exhibited altered skin integrity, they were reassessed at least weekly by a member of the registered nursing staff.

Resident #014 sustained several areas of altered skin integrity. The eTAR indicated that no orders were made for the resident's altered skin integrity to be assessed at least weekly. There was no evidence that weekly skin assessments were completed for any of the areas of altered skin integrity that resident #014 had sustained.

Registered Nurse (RN) #118 said that altered skin integrity should be assessed weekly and documented in the eTAR under the notes of the specific task or using the "Pressure Seven Day Assessment" tool under Assessments in PCC. DOC #119 said that skin assessments were completed using the "Wound Weekly Observation Tool" in PCC and that weekly skin assessments should have been completed for resident #014's altered skin integrity.

There was a risk that resident #014's altered skin integrity could have worsened as a result of staff failing to reassess them at least weekly.

Sources: Resident #014's clinical record, including progress notes, skin and wound assessments in PCC, orders and eTAR; interviews with RN #118 and DOC #119. [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 a resident who exhibits altered skin integrity is assessed by a registered dietitian; and to ensure a resident who exhibits altered skin integrity is reassessed at least 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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program by ensuring contact precaution signage was posted for residents on contact precautions.

During a tour of the home, Inspectors observed isolation carts outside nine resident rooms throughout the home. There was no signage noted on the residents' rooms to inform visitors and staff what type of precautions were in place for the residents.

Review of the residents' electronic clinical records in Point Click Care noted eight of the residents had a diagnosis that required contact precautions. This caused potential risk to staff and visitors who may enter the residents' room as they would not know what appropriate infection control precautions to take.

Review of the home's "Contact Precautions" policy noted that residents with microorganisms which may be transmitted by contact with intact skin or with contaminated environmental surfaces should have signage for Contact Precautions posted on the outside of the resident's door.

In interviews, Registered Practical Nurse (RPN) #103, Personal Support Worker (PSW) #106 and Housekeeper #107 acknowledged there was missing contact precaution signage for the residents.

In an interview, Assistant Director of Care (ADOC) #101 stated residents on contact precautions should have contact precaution signage on their door.

Sources: Infection Prevention and Control tour; review of resident #001, #002, #003, #005, #006, #007, #008 and #009's clinical records; the home's "Contact Precautions" policy IC-300-09; and interviews with RPN #103, PSW #106, Housekeeper #107 and ADOC #101. [s. 229. (4)]

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 all staff participate in the implementation of the infection control program, to be implemented voluntarily.

Issued on this 16th day of February, 2021

[redacted]

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

Original report signed by the inspector.