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

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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
Mar 10, 2020	2020_678590_0004	001206-20, 002641-20	Complaint

Licensee/Titulaire de permis

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

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

Riverside Place
3181 Meadowbrook Lane WINDSOR ON N8T 0A4

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

ALICIA MARLATT (590)

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): February 18 - 20, 2020.

A Critical Incident System (CIS) inspection was completed concurrently during this complaint inspection for Log #001206-20 with associated CIS report #2972-000001-20.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, one Registered Nurse, four Registered Practical Nurses, two Personal Support Workers, one Recreation Aid, two residents and one family member.

During the course of the inspection, the inspector(s) observed resident/resident interactions, staff/resident interactions, infection prevention and control practices and the posting of required information.

During the course of the inspection, the inspector(s) reviewed two resident clinical records, one Critical Incident System report, one Infoline report, Risk Management reports and policies and procedures related to inspection topics.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone

and free from neglect by the licensee or staff in the home.

For the purpose of this inspection, the Long-Term Care Homes Act 2007 and Ontario Regulation 79/10 defines physical abuse as 'the physical force by a resident that causes physical injury to another resident'.

A complaint was received by the Ministry of Long-Term Care (MOLTC) reporting concerns about an altercation between resident #001 and 002 which resulted in resident #002 falling and sustaining an injury.

Review of both resident #001 and #002's clinical record showed that they were both moderately cognitively impaired.

Review of Risk Management report was completed. The report documented that staff member overheard the two residents arguing and saw resident #001 strike resident #002 and resident #002 lost their balance and fell to the floor.

Resident #001's progress notes written on the day of the altercation were reviewed. It was documented that the residents were heard arguing and that resident #001 struck resident #002 which resulted in resident #002's loss of balance and fall. Possible triggers identified that contributed to resident #001's actions were resident #002's verbal and physical behaviours towards resident #001.

Resident #002's progress notes written about the day of the altercation were reviewed. Registered staff arrived to find resident #002 laying on the floor complaining of pain. The note documented that a staff member was present at the time of the fall and that resident #001 pushed resident #002 during the altercation.

In an interview staff member #104, they shared that they overheard the two residents arguing while they were sitting in the lounge. They shared that they intervened when they heard the residents and attempted to remove them both from the area, but neither resident would move. The staff member visually monitored the situation for approximately another five minutes, then went around a corner to do some work close by, as both residents seemed to calm down and ignore each other. The staff member shared that they heard more arguing and immediately went back to these two residents. When specifically asked about how resident #002 ended up on the floor, the staff member described that it was a side swipe action that toppled them over, resident #001 had made contact with their hand on resident #002's upper arm and resident #002 lost their balance

and fell over to the side and backwards.

In an interview with Director of Care (DOC) #100, they shared that resident #001 has displayed behaviours in the past, however any physical behaviours they displayed towards others had been instigated by the other involved residents in some way.

In an interview with the Executive Director (ED) #106, they shared that they investigated this altercation in depth. The ED shared that they did not feel that resident #001 had the intention to injure resident #002. When inspector shared that the legislation provided no exceptions related to the 'intent' behind an injury caused by another resident, the ED agreed that there was no exception for intent. The ED also identified that there was no definition of what constitutes 'physical force' in the Act when discussing abuse and that could be interpreted as any unwanted touch with no injuries, an unwanted to touch that does causes injury, or an unwanted touch that causes pain and no injuries. The ED shared in this circumstance that they felt that physical force was not applied with the intent to cause an injury, but acknowledged that an interaction happened between resident #001 and 002 that did result in an injury. [s. 19. (1)]

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 residents are protected from abuse by anyone, 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A complaint was received by the MOLTC expressing concerns pertaining to resident #002's falls this year and the care provided afterwards for their injuries.

Review of resident #002's clinical record showed that this resident experienced their first fall on a specific day and their second fall approximately three weeks later. The first fall resulted in the resident sustaining a skin impairment that required treatments and monitoring for infection. The second fall resulted in a skin impairment that required medical intervention and monitoring for infection.

Review of resident #002's completed skin assessment tools for the first identified skin impairment showed that an assessment had been completed on a specific day, 10 days after the injury in 2020. Review of the skin assessments for the second skin impairment showed no completed assessments in 2020.

Review of resident #002's progress notes showed that there were some notes written addressing these skin impairments.

On the day of the first skin impairment and 10 days after in 2020, there was a skin and wound evaluation note written that described the type of impairment, its current progress, the goal of care, current measurements, exudate, pain and if any referrals were made. One month later in 2020, the Nurse Practitioner documented that there were scattered bruises throughout entire extremity with a treatment observed on the skin impairment. The next day staff documented that they observed improved bruising on the extremity, then there were no further notes written about the skin impairment.

A treatment on one of resident #002's extremities was observed during this inspection.

In regard to the second skin impairment, resident #002 was sent to the hospital and returned to the home the same day with a treatment intact. Staff documented that the resident was not cooperative when they returned from the hospital for an assessment. Over the next three days in 2020, staff wrote notes acknowledging the skin impairment and that it was dry and intact. The fourth day after, the Nurse Practitioner had seen the resident and observed the skin impairment, noting that it appeared to be healing. No further notes about the skin impairment were present.

Review of resident #002's electronic Treatment Administration Record (eTAR) showed an intervention initiated approximately three weeks after the first fall, scheduling weekly skin assessments to be done for the skin impairment which occurred from the first fall. There was an assessment due on a specific day and this area was empty on the eTAR.

In an interview with Registered Practical Nurse (RPN) #101 they shared that skin impairments were assessed at least weekly in the home. The RPN shared that the home had a specific skin and wound assessment tool they used to document the weekly assessments on and track the progress. The RPN shared that assessments would be completed during a scheduled treatment, so the assessments dates might be a day or two sooner or later than when it was technically due. The RPN reviewed the completed assessments and progress notes for both of resident #002's skin impairments and shared that up to a specific date in 2020, an initial assessment had not been documented on the homes' skin and wound assessment tool for the second skin impairment, nor were any subsequent assessments completed. The RPN shared that the initial assessment for the first skin impairment was written in a progress note and only one assessment had been documented on the assessment tool thereafter and that no other assessments had been performed to this date.

In an interview with ED #106, they confirmed the above assessments had not been documented using the homes assessment tool and that some weekly assessments were missing for resident #002. [s. 50. (2) (b) (iv)]

Issued on this 12th day of March, 2020

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

Original report signed by the inspector.