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
May 24, 2019	2019_740621_0015	002067-19	Complaint

Licensee/Titulaire de permis

City of Toronto
365 Bloor Street East 15th Floor TORONTO ON M4W 3L4

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

Carefree Lodge
306 Finch Avenue East NORTH YORK ON M2N 4S5

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

JULIE KUORIKOSKI (621), KATHERINE BARCA (625), MELISSA HAMILTON (693), STEVEN NACCARATO (744)

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): May 6 - 10, 2019.

The following intake was inspected during this Complaint inspection:

- On intake related to skin and wound management.

Additionally, Critical Incident System (CIS) inspection #2019_740621_0014 and Follow Up inspection #2019_740621_0013 were completed concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Acting Clinical Nurse Manager (ACNM), the Enterostomal Therapy (ET) Nurse, Registered Nurses (RNs), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), the complainant, and a resident.

The Inspector also conducted a tour of resident care areas, observed staff to resident care, reviewed relevant health records, and applicable licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 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 O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was developed and implemented in the home.

A complaint was submitted to the Director related to the skin and wound care of resident #002.

The home had not implemented their skin and wound program as follows:

(a) The home's policy titled "Skin Care and Wound Prevention and Management-RC-0518-02", published January 1, 2019, identified that staff were to promote infection prevention and control practices.

(i) Inspector #625 reviewed resident #002's health care record, with a focus on altered skin integrity, and identified documentation that indicated the resident had altered skin integrity in a specific location; medical tests which indicated the resident had a specific medical condition associated with the altered skin integrity; and that the resident had specific treatments and referrals ordered to address the altered skin integrity.

During observations of treatments completed for the resident's altered skin integrity, the Inspector observed staff:

- Use a communal container of a specific solution, with a label which read that it was for single use only, stored in a certain location, and dated with the previous days date;
- Use of a communal device, to modify a medical intervention used in the treatment of the resident's altered skin integrity. The staff cleaned the communal device with a particular treatment prior to using them; and
- Use of another type of communal device, stored in a certain location where other communal devices were kept, to apply a medical intervention used in the treatment of the resident's altered skin integrity. The staff cleaned the communal device with a particular treatment prior to using the device.

During an interview with the Enterostomal Therapy (ET) Nurse, they stated that they had first observed the altered skin integrity in a certain state of condition. At that time, they had recommended a specific treatment, and further stated:
- The use of a container of the identified solution should have been used for one resident. They also stated that it was not best practice to date a single use container of the solution to use later;
- They were not comfortable with cleaning communal devices using a particular treatment, as bacteria could have been on the device, and the device could not be completely cleaned. They stated that, if a specific device were used to remove certain treatments or came in contact with the area of altered skin integrity, it was not acceptable to have reused the device. They also stated multiple uses of a certain medical device was practiced in the community setting, with specific parameters being that they were used for the same person; and same area of altered skin integrity; and
- A specific medical device, when used, should never touch a resident. The ET Nurse identified that using the communal device to modify a treatment intervention was not best practice. The ET Nurse also identified that it was not best practice to use another type of device communally for the purposes of removing a therapeutic treatment from one location to another.

(ii) During observations of resident #002's treatment for altered skin integrity, Inspector #625 observed a communal container of solution on a specific day, which remained on the treatment cart 33 days after it was dated as opened. The container read that it was for single use only.

The Inspector reviewed a Physician's order from a specific date in May 2019, which identified that a specific type of solution was to be used to cleanse the area of altered skin integrity.

During an interview with the Acting Clinical Nurse Manager, they acknowledged that the container of specified solution on the treatment cart had been dated from a specific date in April 2019, and stated that the person who had completed the specified treatment, previously may have used the same container of solution.

(b) The home's policy titled "Skin Care and Wound Prevention and Management-RC-0518-02", published January 1, 2019, identified the focus was on prevention through a systematic, comprehensive interdisciplinary approach including documentation.

Refer to WN #2, findings #5 and #6 for details.

(c) The home's policy titled "Skin Care and Wound Prevention and Management-RC-0518-02", published January 1, 2019, identified that staff were to maintain a current and accurate care plan based on an individualized treatment plan.

Refer to WN #2, findings #1 and #7, respectively, for details.

(d) The home's policy titled "Skin Care and Wound Prevention and Management-RC-0518-02", published January 1, 2019, identified staff were to reassess all wounds using the Ulcer/Wound Assessment Record weekly or more frequently as indicated. For stage III or IV wounds, staff were to assess the wound weekly and complete the skin and wound assessment documentation sheet.

Refer to WN #3, finding #1 for details.

(e) The home's policy titled "Skin Care and Wound Prevention and Management-RC-0518-02", published January 1, 2019, indicated, for a stage II wound staff were to cleanse and cover the affected area with a dressing/treatment as per the Physician's orders.

Refer to WN #2, finding #3 for details.

(f) The home's policy titled "Skin Care and Wound Prevention and Management-RC-0518-02", published January 1, 2019, identified that a specified solution did not contain preservatives and was to be discarded 48 hours after being opened.

Inspector #625 observed a container of a specified solution opened and dated from a specific date in May 2019, used to clean resident #002's area of altered skin integrity, on

another later date in May 2019. The container's label indicated that it was a "Single use container".

During an interview with the Acting Clinical Nurse Manger, they stated that the home used containers of the specified solution for up to one week; acknowledged that the containers read that they were single use; and stated that internally they were told to keep the containers for seven days.

(g) The home's policy titled "Skin Care and Wound Prevention and Management-RC-0518-02", published January 1, 2019, identified staff were to check a healed wound area daily for two weeks and document in the progress notes daily for two weeks, then weekly for four weeks.

Inspector #625 reviewed a particular assessment record for resident #002's altered skin integrity. The record identified the altered skin integrity was healed on a particular date in April 2019.

During a review of the resident's progress notes, the Inspector was not able to locate any entries which identified that the specific area of altered skin integrity had healed, or any entries related to the monitoring of the altered skin integrity after it had healed.

During an interview with Inspector #625, the Acting Clinical Nurse Manager stated that staff were required to have entered a progress note that identified that the altered skin integrity had healed. They acknowledged that staff were required to check the condition of the area over a specific period of time, and document in a particular area of the resident's health record, at specific intervals of time. The Nurse Manager acknowledged that there was no documentation as expected, to identify that the area of altered skin integrity was healed, or that it had been monitored/checked, as required. [s. 48. (1) 2.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A complaint was submitted to the Director related to the skin and wound care of resident #002.

Inspector #625 reviewed resident #002's health care record and identified areas where this resident's plan of care was unclear:

(a) Documentation from specific dates in December 2018, January 2019 and February 2019, listed that the resident should be engaged in a certain activity at particular times, yet be engaged in another type of activity at some of the same times.

During an interview with the Acting Clinical Nurse Manager, they stated that documentation identified that resident #002 was engaged in either of two activities, when in a particular location of the home, which corresponded to specific dates and times. The Nurse Manager stated that, where staff had written both activities on the worksheets for the same time, the worksheet was unclear as to which date(s) the staff were to follow which direction.

(b) Inspector #625 had made multiple observations of resident #002, which included observations of the resident engaged in particular activities, at specific times, that were different than what was care planned for in a certain number and type of care plans, last updated on two specific dates in May and on a particular date in March 2019, respectively.

During interviews with PSW #122, they stated they completed a certain care activity with the resident, in a particular location, at an approximate time. The PSW stated the PSWs referred to the resident's care plans that identified the care they were to provide to the resident. They stated the next shift would complete a certain care activity with the resident, but they weren't sure of when that would occur.

During an interview with RN #123, they acknowledged that the resident #002's care plan of a particular focus, last updated in May 2019, identified the resident was to be in their mobility aide at a specific time and transferred back to a particular location of the home, at another specific time. The RN stated that staff completed a certain care activity later, at yet another specified time with the resident.

During an interview with the Acting Clinical Nurse Manager, they confirmed that resident #002 was in their mobility aide at a specified time, although their care plan identified they were to be engaged in another activity at that particular time.

(c) Resident #002's current care plan with a specific focus, last updated in May 2019, identified staff were to have provided a certain type of care to the resident's altered skin integrity, as ordered by the Physician.

The resident's Medication Administration Record (MAR), between specific dates in April and May 2019, identified staff were to have provided a specific type of care to resident #002's altered skin integrity.

A Physician's order dated from a particular date in May 2019, identified the treatment of the resident's altered skin integrity had changed, which was consistent with what was identified in the MAR, but not what was identified in the care plan.

During an interview with RN #105, they stated that the current Physician's order for the treatment of resident #002's altered skin integrity, dated from a specific day in May 2019, included specific instructions, which were not identified in the resident's care plan.

(d) Specific documents located in the home's PSW binder indicated the resident was to have a specific activity completed at specified times.

Resident #002's current care plan with a certain focus, last updated on a date in May 2019, identified that staff were to have completed certain care during particular resident activities, at specified times, to have achieved a certain outcome. Yet, the same care plan also indicated staff were to complete the same care at different times, including on an as needed basis, when the resident was engaged in one specific activity, to prevent a certain outcome.

Resident #002's current care plan of a different focus, last updated on a date in May 2019, identified staff were to continue to have completed a certain care activity, at specified times, to promote a certain outcome. Yet, the same care plan also indicated staff were to have completed the same care at different times, including on an as needed basis, when the resident was engaged in the same activity, to order to achieve a specified outcome.

During interviews with PSW #122, they stated they referred to resident care plans for

direction on what care staff were to have provided to residents.

(e) Resident #002's current care plan of another specific focus, last updated on a date in May 2019, listed a particular number of goals and interventions for the resident's altered skin integrity. However, the care plan did not identify which area(s) of the resident's body the interventions were applicable to.

During an interview with the Acting Clinical Nursing Manager, they stated that the identified interventions related to a specific treatment were not clear as to what it referred to, or to which part of the body. They further stated that the format of the care plan, and the lack of a specific area mentioned in the interventions, made it unclear.

(f) Inspector #625 reviewed resident #002's current MAR between specific dates in April and May 2019, which listed multiple treatments, times of treatment and locations of treatment as one entry.

The current Physician's order, dated on a specific date in April 2019, for particular areas of altered skin integrity, identified treatment over a certain number of days, with a particular number of treatments and a specified order of application to the treatment. The order also identified that for one area of altered skin integrity, to utilize only one specific treatment.

A particular consultation report, dated from April 2019, identified altered skin integrity in one area of resident #002's body, and a specific number of areas of altered skin integrity in another area of the resident's body. After an assessment of only one of the areas of altered skin integrity, the report suggested the application of a specific treatment over a specified number of days. The report then identified that the other location of altered skin integrity was to be treated with only one specific treatment.

The Inspector had observed treatments applied to a specific area of altered skin integrity on the resident and noted that the specific number of areas of altered skin integrity were less than what had been documented. The Inspector also observed staff care for one specific area of altered skin integrity, but observed staff not complete a treatment of an area of altered skin integrity on another part of the body.

During an interview with RN #105, they stated that the ET Nurse had suggested just one particular treatment to one area of altered skin integrity, but that the resident's MAR listed more than that. The RN also stated that the direction was confusing.

During an interview with the Acting Clinical Nurse Manager, they stated that they were unsure what the Physician's order referred to, from a specific date in April 2019, as there was no second open area on a specific region of the resident's body. They stated the Physician's order for one specified treatment was not listed as a separate entry on the Treatment Assessment Record (TAR), and that it had originated from a telephone order that was not clear as to what was to be done.

(g) A review of a specific assessment record for resident #002's current altered skin integrity, identified the resident had a specific number and type of areas of altered skin integrity in specific locations of the body.

The assessment records that were reviewed, listed a specific number of locations that staff were required to assess for altered skin integrity. However, on review of the assessment records, none identified the same distinct wound locations in a particular area of the body, nor did they illustrate their relative positions, or which locations corresponded to which specified areas of altered skin integrity. It was determined that a specific number of the body diagrams were blank and did not reflect the location of the altered skin integrity to be assessed. The Inspector was not able to determine the relative locations of altered skin integrity, or to which specific areas of altered skin integrity each assessment referred to.

During an interview with RN #124, they stated that the assessment records for resident #002 identified a particular number of areas of altered skin integrity present, but that some of the body diagrams on the assessment records only identified one specific location. The RN stated that it would have been helpful to see where each of the identified areas of altered skin integrity were located in relation to the others on the diagrams.

During interviews with the Acting Clinical Nurse Manager, they stated that resident #002 had not had an area of altered skin integrity on a specific location of their body, as identified in the assessment records, and that the other areas of altered skin integrity that had been identified, were visible and distinct from each other.

(h) A specific assessment record indicated resident #002 had altered skin integrity on one side of their body, with specific measurements, on specific dates from February to April 2019. The Inspector was not able to locate subsequent assessment records for the altered skin integrity, dated after a certain date in April 2019.

Another specific assessment record, from a certain date in April 2019, indicated the resident had an area of altered skin integrity on the other side of their body, with specified measurements.

On further review, the body diagrams on the assessment records for both areas of altered skin integrity, indicated the areas of altered integrity were located on only one side of the body.

During observations of resident #002's care, Inspector #625 noted altered skin integrity on only one side of the resident's body in a specific location.

During interviews with RN #105, they reviewed resident #002's specified assessment records, and stated the records identified resident #002 had more than one area of altered skin integrity on both sides of the resident's body, in specific locations.

During an interview with the Acting Clinical Nurse Manager, they stated there were no nursing progress notes that indicated resident #002 had altered skin integrity on a specific location on one side of their body, beginning on a particular date in April 2019. Further, the Nurse Manager stated that an area of altered skin integrity did not exist as the assessment record reflected.

(i) A review of the home's policy titled "Skin Care and Wound Prevention and Management – RC-0518-02", published on January 1, 2019, identified that staff were to identify residents at risk and establish an appropriate care plan. The policy contained distinct treatment protocols for residents with staged and unstageable pressure ulcers.

A review of resident #002's most current care plans, with a certain number of focus areas, identified areas of altered skin integrity that differed between care plans in their number, stage of severity and location on the body.

During an interview with the Acting Clinical Nurse Manager, they stated that the resident's current care plan was unclear as it referred to an area of altered skin integrity in a specific location, when the resident did not have altered skin integrity in that location of the body. They also acknowledged the care plan did not list all of the resident's current areas of altered skin integrity, and clarified to the Inspector the current number, type and location of each area of altered skin integrity. [s.6.(1)(c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A complaint was submitted to the Director related to the skin and wound care of resident #002.

(a) A specific type of assessment record had indicated that the resident had an area of altered skin integrity with specific measurements taken on assessments between certain dates between February and April 2019. The Inspector was not able to locate subsequent assessment records for one area of altered skin integrity, dated after a specific date in April 2019. Additionally, a specified number of the assessments had identified the location of the altered skin integrity to be on one specific side of the resident's body, while the body diagram reflected the altered skin integrity was on the opposite side.

During observations of treatments completed with resident #002, Inspector #625 noted altered skin integrity on one specific side and location of the resident, but did not observe one on the opposite side, in a specified area.

During an interview with the Acting Clinical Nurse Manager, they stated there were no nursing progress notes to indicate resident #002 had an area of altered skin integrity on a specific area of their body, which was identified to have begun on a day in April 2019. The Nurse Manager stated that the area of altered skin integrity was not in the location identified on the assessment record, but that the altered skin integrity was located in another specific area. They stated that staff had documented the area of altered skin integrity incorrectly a number of times, and acknowledged that the staff had not collaborated with each other in the assessment of the resident so that their assessments were consistent with and complemented each other.

(b) A review of a particular skin assessment record for resident #002, identified the resident had altered skin integrity in a certain location, with weekly assessments identifying more than one location of altered skin integrity with differing measurements.

During interviews with the Acting Clinical Manager, they acknowledged that more than one skin assessment record had been completed for resident #002's altered skin integrity in a specific location, for three particular dates in February 2019. They also

acknowledged that the measurements identified on more than one of the assessments completed for a particular date contained different measurements of the same wound.

(c) Review of skin assessment records for resident #002's altered skin integrity, identified over a particular period of time in early 2019, was determined to be of specific measurements. Subsequent assessments (initiated on the same assessment record for another area of altered skin integrity), over a specified period of time, in March 2019, identified the resident had altered skin integrity of a different size, type and location on the body. Further, a particular number of specified documents were left blank, and did not identify the location of the altered skin integrity.

During an interview with the Acting Clinical Nurse Manager, they stated that a specific area of altered skin integrity on resident #002 would not have progressed. However, they also indicated that, if a separate impairment to the resident's skin integrity was present, it should have been completed on a new assessment record. They acknowledged that staff had not collaborated with each other so that their assessments were consistent with and complemented each other, with regard to the a specified area of altered skin integrity for this resident.

(d) Resident #002's skin assessment records, included assessments completed on a specific area of altered skin integrity, for a certain number of dates, in the spring of 2019. The assessments did not identify whether the resident's altered skin integrity met certain criteria, and one assessment identified a specific location of altered skin integrity, whereas the other assessment was left blank.

A review of an ET Nurse assessment from a specific date in April 2019, identified assessment of a particular size and type of altered skin integrity, in a certain number of locations of the resident's body.

During an interview with RN #105, they stated that measurements they took of the resident's areas of altered skin integrity may have differed from those obtained by the ET Nurse.

During an interview with the ET Nurse, they stated that they trusted their own measurements of resident #002's areas of altered skin integrity, as the nursing staff's measurements did not account for specific aspects.

(e) Resident #002's skin assessment records, included assessments completed on a

specific area of altered skin integrity, for two specific dates in April 2019. Neither assessment however, identified the type of altered skin integrity present, although a component of the assessment required identification of skin breakdown using specified identifiers.

During an interview with the Acting Clinical Nurse Manger, they stated that resident #002's skin assessment documentation had not identified the type of altered skin integrity that the resident had on two specific dates in April 2019, and that it should have been listed for both dates. They acknowledged that staff had not collaborated with each other in the assessment of the resident so that their assessments were integrated and consistent with each other. [s. 6 (4)(a)]

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.

A complaint was submitted to the Director related to the skin and wound care of resident #002.

Inspector #625 reviewed resident #002's current physician's orders for treatment to a specific area of altered skin integrity, which included a specific type of treatment regime.

The Inspector observed a particular treatment completed to the resident's area of altered skin integrity and noted that a treatment, as ordered by the physician, was not place on the area of altered skin integrity. The Inspector also noted that a container of a specified solution located on the treatment cart was dated as opened more than one month prior. Additionally, the container read "No antimicrobial agent or other substance has been added" and "Single use container". Further, the physician's order had been in effect for seven days prior to observations made by the Inspector.

During interviews with the Acting Clinical Nurse Manager, they confirmed the container of a specified solution should not have been used. They also stated that staff who had completed prior treatments, may have used the solution. They also confirmed that they had not removed a specific type of treatment from resident #002's area of altered skin integrity, prior to completing the treatment observed by the Inspector, as one had not been in place. Further, the Nurse Manage confirmed that the Physician's order had not been followed by staff who had completed the previous treatment. [s.6 (7)]

4. The licensee has failed to ensure that the staff and others who provided direct care to

a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

A complaint was submitted to the Director related to the skin and wound care of resident #002.

(a) Inspector #625 reviewed resident #002's current care plans located on GoldCare, with a focus on skin and wound care, last updated on a day in April 2019.

During a review of the PSW binder for resident #002, Inspector #625 noted that the same care plan, was not present.

During an interview with PSW #122, they stated that resident #002's care plans would be located in the PSW binder and would have identified the care PSWs were to have provided to the resident.

During an interview with RN #123, they confirmed there were no versions of the specified care plan in the PSW binder. The RN printed out the current version of the care plan, which had been last updated on a day in May 2019.

(b) Inspector #625 reviewed resident #002's current care plans located on GoldCare, with a focus on skin and wound care. The Inspector identified a care plan with another specific focus, last updated on a day in May 2019.

During a review of resident #002's care plan, Inspector #625 noted that the care plan with the specified focus, had two versions in the PSW binder, last updated on certain dates in October and December 2018.

During an interview with RN #123, they confirmed that copies of the care plan of the specified care plan, located in the PSW binder, were not current. The RN printed out the current care plan version last updated in May 2019. The RN stated that the PSWs did not have access to GoldCare, but only had access to the PSW binders, and had not had access to the most current version of the care plan. [s.6 (8)]

5. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A complaint was submitted to the Director related to the skin and wound care of resident

#002.

On a date in May 2019, Inspector #625 reviewed resident #002's health care record, which included the Medication Administration Record (MAR), used by the home to record and document the administration/provision of treatments to the resident. The Inspector noted an entry for skin assessments to have been completed at certain intervals, which had not been signed as completed on a specific day in May 2019.

On another day in May 2019, the Inspector reviewed an assessment record of specific areas of altered skin integrity for resident #002, and noted that the records did not identify completion of a skin assessment due two days prior.

During an interview with RN #105, they reviewed resident #002's MAR and acknowledged that the skin assessment scheduled for a particular date in May 2019, had not been documented as completed. They also reviewed the resident's assessment records, and stated that the assessment due on a particular date in May 2019, had not been completed for the specific areas of altered skin integrity.

During an interview with RN #125, they stated they had worked as the RN in the home on a specific date in May 2019, and had completed the assessments of resident #002's areas of altered skin integrity. The RN reviewed resident #002's MAR and skin assessment records and acknowledged that they had not documented completion of the required assessments on that date.

During an interview with the Acting Clinical Nurse Manager, they acknowledged that assessment records for resident #002's altered skin integrity had not been documented on a specific date in May 2019. [s.6 (9)1]

6. A complaint was submitted to the Director related to the skin and wound care of resident #002.

Inspector #625 reviewed a PSW binder which contained an undated document, which identified resident #002 was to be in a specific program, as the resident required specified levels of assistance with a particular care activity. The document listed that PSWs were to ensure the resident had the care activity completed by staff at specific time intervals, and staff were to have recorded completion of the care activity on the document before the end of each shift.

The Inspector reviewed resident #002's health care record, including specific documents from December 2018, to May 2019, and noted missing documentation of the scheduled activity on 41 days, with gaps in documentation spanning from four to 18 consecutive hours in duration.

During an interview with RN #124, they reviewed resident #002's documentation and stated PSWs were required to have signed off on a particular document to indicate that the specified care activity had occurred during certain time intervals. The RN acknowledged the document contained blank areas where staff had not documented that the care activity had occurred.

During an interview with the Acting Clinical Nurse Manager, they stated that staff were required to have completed a certain care activity at particular time intervals, and to have documented that the care occurred on a specific document. The Acting Clinical Nurse Manager acknowledged that there were multiple undocumented areas present on resident #002's documentation, and stated that, at the very least, staff had not documented the care provided. [s.6 (9)1]

7. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed, or the care set out in the plan was no longer necessary.

Resident #002's current care plan, with a specific focus, last updated in May 2019, identified staff were to have completed a certain care activity, at particular time intervals, when the resident was in a specific location of the home, in order to have achieved a specified outcome.

The Inspector reviewed a particular assessment record, for a specific area of altered skin integrity. The last assessment, indicated the resident had altered skin integrity of a specific type and location on a particular date in February 2019.

During an interview with the Acting Clinical Nurse Manager, they stated that resident #002's current care plan identified the same area of altered skin integrity, but that it had resolved prior to a date in April 2019. [s.6 (10)(b)]

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 there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident; to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other; and to ensure that the provision of care set out in the plan of care was documented, to be implemented voluntarily.

WN #3: 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, if clinically indicated.

A complaint was submitted to the Director related to the skin and wound care of resident #002.

Inspector #625 reviewed resident #002's health care record, which included their Medication Administration Record (MAR), used by the home to record and document the administration/provision of treatments to the resident. The Inspector noted an entry for a particular assessment to have been completed on certain days and time intervals, had not been signed as completed on one of the required dates in May 2019.

Additionally, Inspector #625 reviewed resident #002's health care record and identified the absence of specific skin assessments, completed at certain time intervals for areas of altered skin integrity, as identified by the home, as follows:
- a skin assessment for one area of altered skin integrity was completed once in a 10 day period from a specific date in February, to another specific date in March 2019;
- assessment of a second identified area of altered skin integrity was completed 10 days apart from a specific date in February, to another specific date in March 2019;
- assessments of a third area of altered skin integrity was completed 10 days apart during January 2019; 28 days apart during April 2019; with the last assessment completed nine days prior to the time of inspection;
- assessments of a fourth area of altered skin integrity were completed 10 days apart during January 2019; and 10 days apart between specific dates in February and March 2019;
- assessment of a fifth area of altered skin integrity was completed 10 days apart between specific dates in February and March 2019;
- assessment of a sixth area of altered skin integrity was last completed nine days prior to the time of inspection; and
- assessment of a seventh area of altered skin integrity was last completed on a specific date in March 2019, and then documented as "healed" 14 days later.

During interviews with RN #105, they stated that resident #002 currently had a specific number of areas of altered skin integrity. The RN reviewed the resident's health care record and identified that the completion of a particular type of assessment at certain time intervals, had not been completed on a specific date in May 2019. The RN then reviewed another specific assessment record for resident #002, and acknowledged that the assessments for a specific number of areas of altered skin integrity, which were due on a specific date in May 2019, had not been completed since a particular date in April 2019, or nine days prior. The RN also stated that one area of altered skin integrity, had more than one area of skin breakdown, and a required assessment had not been

completed on a specific date in April 2019.

During an interview with RN #125, they stated that they had worked as the RN on a particular shift on a day in May 2019, and had not completed the required skin assessments for resident #002's areas of altered skin integrity.

During an interview with the Acting Clinical Nurse Manager, they reviewed resident #002's skin assessment documentation and acknowledged that specific assessments had not been completed for resident #002's areas of altered skin integrity, as required. [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 was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

Issued on this 6th day of June, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE KUORIKOSKI (621), KATHERINE BARCA (625), MELISSA HAMILTON (693), STEVEN NACCARATO (744)
Inspection No. / No de l'inspection :	2019_740621_0015
Log No. / No de registre :	002067-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 24, 2019
Licensee / Titulaire de permis :	City of Toronto 365 Bloor Street East, 15th Floor, TORONTO, ON, M4W-3L4
LTC Home / Foyer de SLD :	Carefree Lodge 306 Finch Avenue East, NORTH YORK, ON, M2N-4S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bambo Oluwadimu

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee must be compliant with s. 48(1)2 of Ontario Regulation 79/10.

Specifically, the licensee must ensure that direct care staff follow the home's policy titled "Skin Care and Wound Prevention and Management - RC-0518-02", published January 1, 2019, with respect to resident #002 in the following areas:

a) Ensure utilization of clinical best practice during dressing changes, in accordance with infection prevention and control practices; and as identified in the home's policy;

b) Ensure that provision of care as set out in the plan of care with respect to weekly wound assessments, turning and repositioning schedules, and administration/provision of treatments, is documented;

c) Ensure that maintenance of an individualized plan of care is both current and accurate;

d) Ensure all wounds are assessed/reassessed using the Ulcer/Wound Assessment Record weekly, or more frequently as indicated;

e) Ensure that Physician's orders for the resident's skin and wound care are followed as directed;

f) Ensure that use of normal saline during wound care is consistent with the home's policy, and best practice; and

g) Ensure that monitoring of healed/resolved wounds is completed and documented in the resident's progress notes.

Grounds / Motifs :

1. The licensee has failed to ensure that an interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was developed and implemented in the home.

A complaint was submitted to the Director related to the skin and wound care of resident #002.

The home had not implemented their skin and wound program as follows:

(a) The home's policy titled "Skin Care and Wound Prevention and Management- RC-0518-02", published January 1, 2019, identified that staff were to promote infection prevention and control practices.

(i) Inspector #625 reviewed resident #002's health care record, with a focus on altered skin integrity, and identified documentation that indicated the resident had altered skin integrity in a specific location; medical tests which indicated the resident had a specific medical condition associated with the altered skin integrity; and that the resident had specific treatments and referrals ordered to address the altered skin integrity.

During observations of treatments completed for the resident's altered skin integrity, the Inspector observed staff:
- Use a communal container of a specific solution, with a label which read that it was for single use only, stored in a certain location, and dated with the previous days date;
- Use of a communal device, to modify a medical intervention used in the treatment of the resident's altered skin integrity. The staff cleaned the communal device with a particular treatment prior to using them; and
- Use of another type of communal device, stored in a certain location where other communal devices were kept, to apply a medical intervention used in the treatment of the resident's altered skin integrity. The staff cleaned the communal device with a particular treatment prior to using the device.

During an interview with the Enterostomal Therapy (ET) Nurse, they stated that they had first observed the altered skin integrity in a certain state of condition. At that time, they had recommended a specific treatment, and further stated:
- The use of a container of the identified solution should have been used for one resident. They also stated that it was not best practice to date a single use container of the solution to use later;
- They were not comfortable with cleaning communal devices using a particular treatment, as bacteria could have been on the device, and the device could not be completely cleaned. They stated that, if a specific device were used to remove certain treatments or came in contact with the area of altered skin

integrity, it was not acceptable to have reused the device. They also stated multiple uses of a certain medical device was practiced in the community setting, with specific parameters being that they were used for the same person; and same area of altered skin integrity; and
- A specific medical device, when used, should never touch a resident. The ET Nurse identified that using the communal device to modify a treatment intervention was not best practice. The ET Nurse also identified that it was not best practice to use another type of device communally for the purposes of removing a therapeutic treatment from one location to another.

(ii) During observations of resident #002's treatment for altered skin integrity, Inspector #625 observed a communal container of solution on a specific day, which remained on the treatment cart 33 days after it was dated as opened. The container read that it was for single use only.

The Inspector reviewed a Physician's order from a specific date in May 2019, which identified that a specific type of solution was to be used to cleanse the area of altered skin integrity.

During an interview with the Acting Clinical Nurse Manager, they acknowledged that the container of specified solution on the treatment cart had been dated from a specific date in April 2019, and stated that the person who had completed the specified treatment, previously may have used the same container of solution.

(b) The home's policy titled "Skin Care and Wound Prevention and Management- RC-0518-02", published January 1, 2019, identified the focus was on prevention through a systematic, comprehensive interdisciplinary approach including documentation.

Refer to WN #2, findings #5 and #6 for details.

(c) The home's policy titled "Skin Care and Wound Prevention and Management- RC-0518-02", published January 1, 2019, identified that staff were to maintain a current and accurate care plan based on an individualized treatment plan.

Refer to WN #2, findings #1 and #7, respectively, for details.

(d) The home's policy titled "Skin Care and Wound Prevention and Management- RC-0518-02", published January 1, 2019, identified staff were to reassess all wounds using the Ulcer/Wound Assessment Record weekly or more frequently as indicated. For stage III or IV wounds, staff were to assess the wound weekly and complete the skin and wound assessment documentation sheet.

Refer to WN #3, finding #1 for details.

(e) The home's policy titled "Skin Care and Wound Prevention and Management- RC-0518-02", published January 1, 2019, indicated, for a stage II wound staff were to cleanse and cover the affected area with a dressing/treatment as per the Physician's orders.

Refer to WN #2, finding #3 for details.

(f) The home's policy titled "Skin Care and Wound Prevention and Management- RC-0518-02", published January 1, 2019, identified that a specified solution did not contain preservatives and was to be discarded 48 hours after being opened.

Inspector #625 observed a container of a specified solution opened and dated from a specific date in May 2019, used to clean resident #002's area of altered skin integrity, on another later date in May 2019. The container's label indicated that it was a "Single use container".

During an interview with the Acting Clinical Nurse Manger, they stated that the home used containers of the specified solution for up to one week; acknowledged that the containers read that they were single use; and stated that internally they were told to keep the containers for seven days.

(g) The home's policy titled "Skin Care and Wound Prevention and Management- RC-0518-02", published January 1, 2019, identified staff were to check a healed wound area daily for two weeks and document in the progress notes daily for two weeks, then weekly for four weeks.

Inspector #625 reviewed a particular assessment record for resident #002's altered skin integrity. The record identified the altered skin integrity was healed on a particular date in April 2019.

During a review of the resident's progress notes, the Inspector was not able to locate any entries which identified that the specific area of altered skin integrity had healed, or any entries related to the monitoring of the altered skin integrity after it had healed.

During an interview with Inspector #625, the Acting Clinical Nurse Manager stated that staff were required to have entered a progress note that identified that the altered skin integrity had healed. They acknowledged that staff were required to check the condition of the area over a specific period of time, and document in a particular area of the resident's health record, at specific intervals of time. The Nurse Manager acknowledged that there was no documentation as expected, to identify that the area of altered skin integrity was healed, or that it had been monitored/checked, as required.

The severity of the issue was determined to be a level three, as there was actual risk of harm to resident #002, resulting from the home's failure to ensure that an effective interdisciplinary skin and wound care program to promote skin integrity and prevent wound and pressure ulcer development had been implemented. The scope of the issue was isolated to one resident affected. The home did not have a compliance history pursuant to this specific area of the legislation. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 26, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 24th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Kuorikoski

Service Area Office /
Bureau régional de services : Toronto Service Area Office