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
Sep 13, 2019	2019_631210_0015	010915-19	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Weston Terrace Care Community
2005 Lawrence Avenue West TORONTO ON M9N 3V4

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

SLAVICA VUCKO (210)

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): Aug 6, 7, 8, 9, 12,13, 14, 15, 16, 2019.

The following Critical Incident System (CIS) intake was inspected:
- Log #011043-19, CIS #2874-000015-19 related to a letter to the Ministry of Long Term Care (MLTC) for improper/incompetent treatment of a resident that resulted in harm or risk to a resident.

During the course of the inspection, the inspector(s) spoke with the Acting Executive Director (ED), Acting Director of Care (Act DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Physiotherapist (PT), Occupational Therapist (OT), Enterostomal Therapy (ET) Nurse, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Medical Devices Supplier Company representative and resident's Subsitute Decision Maker (SDM).

During the course of the inspection, the inspector(s) observed staff and resident interactions and the provision of care, reviewed clinical records, staff training records, and relevant policies and procedures.

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)**
- **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 O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A complaint was submitted to the Ministry of Long Term Care (MLTC) on a specified date, by a family member of resident #005 about the care provided, and an area of impaired skin integrity that deteriorated. The complainant further indicated that a new cushion was ordered for the resident's wheelchair and that it was never installed.

A review of resident #005's clinical record indicated the resident's status was that they used a wheelchair for mobility.

According to the interview with RPN #102 during a specified time period resident #005 was using their wheelchair (with the cushion on it) for mobility. According to the RPN and the family member the resident stayed in bed all the time for approximately two weeks before they passed away.

A review of the Wheelchair Cushions Operation Manual, the safety information section indicated the cushion to be checked for inflation frequently, at least once a day. Not to use under-inflated or an over-inflated cushion because the product benefits will be reduced or eliminated, resulting in an increased risk to skin and other soft tissue. The cushion adjustment should be done while the individual is sitting in the chair in their usual position. The recommended distance between the individual and the seating surface should be 1.5 to 2.5 centimeters (cm).

According to the Enterostomal Therapy (ET) nurse assessment report on a specified date, resident #005's cushion on the wheelchair was flat and the nurse was informed. A referral was sent to the Physiotherapist (PT). They assessed the cushion and identified it to be appropriately inflated. The Physician's order from a later date, indicated the seat pressure to be checked by the Occupational Therapist (OT).

According to the OT assessment notes from a specified date, resident #005's cushion was with insufficient air. The OT inflated the cushion and provided instructions to nursing to re-assess the air once client was in the wheelchair. The OT documented that they would follow up with nursing regarding the cushion inflation.

The ET nurse assessed the cushion on a later date to be overinflated, and adjustment was done. During interview about the process for new cushion delivery RPN #102 checked and found in the devices repair binder a form indicating that a new cushion was delivered for resident #005 on a specified date, and there was no signature by registered staff on it. According to the interview with staff #104 (representative from the medical devices supply company) a new cushion was provided to the resident on the specified

date, and it was left in the resident's room because the resident was sitting on the wheelchair. According to staff #104, the cushion gets delivered with neutral air that needs to be adjusted when the resident sits on it, according to the resident's weight.

Interview with resident's Substitute Decision Maker (SDM) indicated they visited the resident after the new cushion was delivered, and they found the old cushion on the wheelchair and the new cushion was not installed on the wheelchair. According to the OT notes, the new cushion was assessed few days after it was delivered, to be adequately inflated. During interview the OT was not able to confirm if the cushion was installed on the wheelchair and if it was assessed on the wheelchair with the resident sitting on it.

Interview with RPN #122 who worked on the day when the cushion was delivered, indicated they were not aware that a new cushion was delivered for resident #005 and that it needed to be installed on the wheelchair or assessed. The OT notes indicated they checked the cushion positioning on the wheelchair one week after the initial assessment, and that they would follow up in one week. During interview the OT was not able to confirm if it was the new or old cushion on the wheelchair, however indicated that if it was not documented meant it was properly inflated.

During interviews with PSWs #119, #120 and #121 they were not able to demonstrate appropriate assessment techniques of a cushion when they place a resident on a wheelchair with a cushion on it, according to the manufacturer's instructions as explained above.
-PSW #119 indicated they never inflated the specified cushion, they would assess it by pressing on sides around the resident and would tell the nurse to inflate it if necessary.
-PSW #120 indicated they assess the specified cushion on the side where the resident sits, they have inflated a cushion before and would inform the nurse.
-PSW #121 indicated they check the specified cushion on sides where resident sits, if not able to inflate they would inform maintenance.
PSWs #119, #120 and #121 indicated they have not been provided training in proper assessment or inflation of the specified cushion mentioned above.

A review of resident #005's clinical record and interviews with PSWs #119, #120, #121, RPN #102, and acting DOC were not able to confirm that resident #005's cushion inflation was adjusted according to the manufacturer's instructions as stated above.

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 staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #005 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, received 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.

A complaint was submitted to the MLTC on a specified date, by a family member of resident #005 about an area of impaired skin integrity that deteriorated.

A review of resident #005's clinical record indicated the resident was admitted in the home on a specified date and required total care for all activities of daily living (ADL). The resident passed away on a specified date.

A review of the point of care (POC) flow sheets indicated that PSWs documented that resident #005 had red area on a specified body area for several days, and an open area on the same body area after that. Interview with PSW #120 indicated that the expectation is impaired skin integrity to be reported to registered staff and documented in the POC flow sheets.

A review of the physician orders indicated they ordered a treatment on a specified date, for dressing on the specified area for one week.

A review of the Skin and Wound Care consultation report from the ET nurse from a specified date, indicated the resident had an area of impaired skin integrity on a body area defined with certain dimensions.

A review of the home's skin assessment record indicated the impaired skin integrity on the specified area was assessed 9 days after the ET nurse assessment.

The home's weekly skin assessment indicated that two weeks later the impaired skin integrity deteriorated.

The ET nurse assessed the impaired skin integrity again on the specified body area one month later, to be deteriorated further.

Interview with the Wound Care Lead RPN # 125 indicated the expectation was the PSWs to report to registered staff new skin issues, when they provide continence care and full head to toe assessment when providing bath.

Interview with PSW #124 indicated they document new altered skin integrity, the type of skin problem and the area affected in POC, and report to registered staff for further assessment.

Interview with RPN #102, #125 and #100 and review of the skin and wound assessment record indicated that resident #005's impaired skin integrity on the specified body area was not assessed when it was first noticed by PSWs. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds been assessed by a registered dietitian who is a member of the staff of the home.

A review of the Registered Dietitian (RD) assessment notes indicated they assessed resident #005 for altered weight on a specified date and recommended resource 2.0 three times a day. Two weeks later, the RD received a referral and ordered protein to facilitate healing of impaired skin integrity. One month later the protein was increased more.

A review of the home's policy Skin and Wound Care Management Protocol, Policy # VII-G-10.92, dated May 2019, indicated the RD will assess residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, change resident's plan of care relating to nutrition and hydration.

A review of the POC flow sheets indicated that on a specified date PSWs documented that resident #005 had red area on a specified body area for several days, and an open area on the same specified area after that.

Interview with the Wound Care Lead RPN # 125 indicated the expectation was a referral should be sent to RD for any kind of skin issues.

Interview with the RD indicated that a referral should be sent to them when staff noticed the impaired skin integrity for the first time, and they would have considered ordering the protein earlier.

A review of resident #005's clinical record and interview with the RD confirmed that a referral was not sent to them when resident #005 started having impaired skin integrity on the specified body area. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that equipment, supplies, devices and positioning aids were readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

A review of the ET nurse assessment report from a specified date, indicated they suggested a therapeutic surface for treatment of resident #005's impaired skin integrity on a specified body area. The ET Nurse assessed the resident again one month later and indicated that resident #005's impaired skin integrity on the specified body area deteriorated into a more advanced stage, and the resident did not have a therapeutic surface.

Interview with the Wound Care Program Lead RPN # 124 and RPN #102 indicated when there is a resident with a deteriorating or non-healing impaired skin integrity, a therapeutic surface should be considered. The management of the home is informed and is responsible for arrangement of the surface. The DOC and ED were not in the home during the inspection to be interviewed.

RPN #102 indicated that after the ET visit they shared with management during the morning meeting about the need of a therapeutice surface for resident #005.

Review of the OT notes indicated that on a specified date, the OT obtained consent from resident #005's SDM to provide their contact number to the sales representative to arrange for rental/purchase of a therapeutic surface to maximize pressure relief while in bed. Interview with the OT indicated they were new at the home and were not sure what the home's process was for providing therapeutic surfaces to residents. According to the progress notes the surface was delivered on a specified date, and the family was involved in the arrangement.

During interviews with the acting ED, acting DOC, ADOC, RPN #100, RPN #102 and RPN #124 indicated that the expectation was for a resident with a non-healing impaired skin integrity, that a therapeutic surface should be arranged, and they were not able to explain why resident #005 was not provided one when it was initially recommended by the ET nurse. [s. 50. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, received 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

Interviews with PSWs and RPNs revealed different explanations about how to assess and inflate a specified therapeutic cushion.

Review of the home's educational record and interviews with PSW #119, #120, #121, RPN #102, ADOC #100, acting DOC and ED confirmed that direct care staff have not been provided training in proper assessment and inflation of the above mentioned cushions. [s. 76. (2)]

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 at the home have received training as required by this section, in all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities, to be implemented voluntarily.

Issued on this 20th day of September, 2019

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

Original report signed by the inspector.