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
May 7, 2021	2021_738753_0008	002281-21, 005331-21	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Peel
10 Peel Centre Drive Suite B, 3rd Floor Brampton ON L6T 4B9

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

Peel Manor
525 Main Street North Brampton ON L6X 1N9

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

KATHERINE ADAMSKI (753), APRIL TOLENTINO (218)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 8-9, 12-15, 2021.

**The following intakes were completed during this critical incident inspection:
Log # 002281-21 and log #005331-21 related to incidents that caused an injury to a resident and resulted in hospitalization with a significant change in condition.**

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Skin and Wound Lead, Falls Committee Lead, Supervisor of Care, Recreation Staff, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

The inspectors observed infection prevention and control measures, dining, resident to resident and staff to resident interactions, and general care of residents. A review of relevant documentation was completed.

**The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Skin and Wound Care**

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001.

Resident #001's care plan directed staff to implement specific interventions to keep them safe.

Direct care staff were either not aware of some of the interventions that were required to be implemented for resident #001, or they were not implemented at the time of the inspection.

Resident #001's care plan not being implemented as specified put the resident at potential risk of harm.

Sources: Observations of resident #001, resident #001's care plan, kardex, documentation survey reports, progress notes, interviews with registered staff and other staff. [s. 6. (7)]

2. The licensee failed to ensure that the provision of care set out in the plan of care for resident #002 was documented.

Resident #002 had an incident that resulted in multiple injuries.

Resident #002's plan of care was revised in relation to the incident but the revisions were not documented in the resident's plan of care.

As a result, staff were not aware of the changes that were made to resident's #002 plan of care and interventions were not in place at the time of inspection.

Resident #002 was placed at potential risk of harm due to changes in their plan of care not being documented and staff being unaware of the changes to their plan of care.

Sources: Resident #002’s plan of care, interviews with registered staff and other staff. [s. 6. (9) 1.]

3. The licensee has failed to ensure that different approaches were considered in the revision of the plan of care for resident #002 when the care set out in the plan of care was not effective.

Resident #002 fell frequently. No new interventions were considered for the resident in relation to falls until after they sustained a fall resulting in an injury.

The resident’s plan of care was not revised after the previous falls incidents to consider different interventions which placed them at potential risk for additional falls.

Sources: Resident #002's post falls assessments, progress notes, plan of care, the home's Falls and Prevention and Management Program policy (last revised November 21, 2018), interviews with the Falls Committee Lead and other staff. [s. 6. (11) (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 the care set out in the plan of care is provided to resident #001; and that different approaches are considered in the revision of the plan of care for resident #002 , to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home’s policy "Fall Prevention and Management Program" was complied with for resident's #001, #002, #003, and #004.

Ontario Regulation (O. Reg.) 79/10, s. 30 (1) 1 requires the licensee to have a written description of each of the interdisciplinary programs, including falls prevention and management, required under s. 48 of this regulation. The written description must include relevant policies, procedures, and protocols and provide methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Specifically, staff did not comply with the home's policy "Falls Prevention and Management Program", last revised on November 21, 2018.

The "Falls Prevention and Management Program" policy required staff to do the

following:

-Document a resident's falls risk level in their plan of care,
-Post a pictogram on a resident's bedroom door, walking aide and wheelchair if they are at high risk for falls or fall frequently,
-Consider referring a resident to physiotherapy (PT) if they: sustain an injury due to a fall and it affects their mobility; experience a decline in functional status; demonstrate unsafe mobility post fall, or they fall frequently.

a) Resident #002 was high risk for falls and sustained multiple falls.

The resident's care plan did not specify that they were at high risk for falls and there were no pictograms observed where required for this resident to identify this. Furthermore, staff did not refer the resident to PT, despite them meeting the criteria for a PT referral. The Falls Committee Lead stated that the resident should have been referred to PT. (218)

b) Resident #001's care plan specified that they were at risk for falls and they had a history of falling frequently. There were no pictograms observed where required for this resident to identify this.

c) Staff stated that resident #003 was at high risk for falls and they had a history of falling frequently. Resident #003's care plan did not specify their level of falls risk and there were no pictograms observed where required for this resident to identify this.

d) Resident #004's care plan specified that they were at high risk for falls and they had a history of falling frequently. There were no pictograms observed where required for this resident to identify this.

The home failing to ensure that their "Fall Prevention and Management Program" policy was implemented put resident's #001, #002, #003, and #004 at potential risk of harm.

Sources: Observations of resident's #001, #002, #003, and #004, resident #001, #002, #003, and #004's care plan and post fall assessments, the home's Falls and Prevention and Management Program policy (last revised November 21, 2018), interviews with the Falls Committee Lead and other staff. [s. 8. (1) (a),s. 8. (1) (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 the home's Fall Prevention and Management Program policy is complied with for resident's #001, #002, #003, and #004, 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 when resident #001 developed a skin concern, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

Staff observed a new skin concern for resident #001. Staff implemented interventions to treat the skin concern but did not complete an assessment of the areas until several days later.

Once the initial skin concern was assessed by staff, it was determined that the resident had sustained a significant injury due to an unknown cause.

On two other occasions, new skin concerns were identified on the resident, but no assessment of the areas were completed.

Staff stated that skin and wound assessments were not completed for resident #001's new skin concerns because they were related to chronic conditions and treatment options were in place as needed. Staff also stated that because some of the concerns could be related to preexisting medical conditions, an initial skin and wound assessment was not always done.

When resident #001's skin concerns were not assessed by registered nursing staff using a clinically appropriate assessment instrument, specifically designed for skin and wound assessment, there was potential risk of harm to the resident because there may have been a delay in diagnosing their injury and providing the resident with appropriate treatment interventions in a timely manner.

Sources: Resident #001's progress notes, assessments tab, risk management, and diagnostic reports, the home's Skin and Wound Care Program policy (revised June 27, 2016), interviews with the Skin and Wound Care Lead(s) and other staff. [s. 50. (2) (b) (i)]

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 when resident #001 develops a skin concern, they receive 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 assessments, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day about an incident that caused an injury to resident #001 and for which the resident was taken to a hospital.

Resident #001 was transferred to the hospital for further assessment. One day later, the home was notified that the resident had sustained an injury, however they did not report this information to Director until three days later.

Sources: The home's investigative notes, resident #001's progress notes, assessments tab, diagnostic report, interview with the Skin and Wound Care Lead(s) and other staff. [s. 107. (3) 4.]

Issued on this 13th day of May, 2021

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

Original report signed by the inspector.