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
Sep 22, 2021	2021_777731_0021	007556-21, 009842-21, 010087-21, 011524-21, 012463-21	Critical Incident System

Licensee/Titulaire de permis

S & R Nursing Homes Ltd.
265 North Front Street Suite 200 Sarnia ON N7T 7X1

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

Afton Park Place Long Term Care Community
1200 Afton Drive Sarnia ON N7S 6L6

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

KRISTEN MURRAY (731), ALICIA MARLATT (590)

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): August 11, 12, 13, 16, 17, 18, 19, 20, 23 and 24, 2021 on-site, and August 26, 27 and 30, 2021 off-site.

The following Critical Incident intakes were completed within this inspection:

Related to allegations of abuse and neglect:
Critical Incident Log #007556-21 / CI 2872-000014-21
Critical Incident Log #011524-21 / CI 2872-000025-21

Related to medication incidents:
Critical Incident Log #010087-21 / CI 2872-000022-21
Critical Incident Log #012463-21 / CI 2872-000029-21

Related to skin and wound:
Critical Incident Log #009842-21 / CI 2872-000020-21

An IPAC inspection and Air Temperature inspection were also completed during the Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care (MRC), the Assistant Manager of Resident Care (AMRC), the Resident Care Co-ordinator (RCC), the Director of Environmental Services, the Corporate Director of Environmental Services, a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Housekeeper, and residents.

The inspectors also observed resident rooms and common areas, observed snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed air temperature records, and reviewed the home's investigation documentation.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **8 WN(s)**
- **2 VPC(s)**
- **4 CO(s)**
- **1 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plans of care for two residents, who required treatments for altered skin integrity, was provided to the residents as specified in their plans.

Two residents had areas of altered skin integrity. Treatments for the areas of altered skin integrity were not provided to the residents according to the orders in their plans of care. One of the resident's areas of altered skin integrity deteriorated in the absence of treatments.

The Manager of Resident Care (MRC) stated that the expectation in the home was that the treatments for areas of altered skin integrity should be in the electronic treatment administration record (eTAR) and signed off once the treatment was completed. The MRC confirmed that treatment for cleansing and applying the dressing to the two residents' areas of altered skin integrity had not been signed off as completed on numerous occasions.

There was actual risk that the residents' areas of altered skin integrity would worsen in the absence of treatments and dressing changes as per the residents' care plans.

The home's skin and wound policy stated that each resident who was exhibiting an area of altered skin integrity should have had the area monitored with each dressing change or treatment, and the registered team member should have initiated treatment and provided interventions for the residents to relieve or reduce pain, promote healing, and prevent infection.

Sources: Critical Incident System Report; the LTCH's "Skin & Wound Program" policy,

number RCM 10-06-01 (last revised March 4, 2019); clinical records for two residents, including progress notes, eTARs, and care plans; and interviews with the MRC and other staff. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of care set out in the plans of care for two residents, was documented.

A resident's bladder function was not documented by the staff when they were provided continence care. The Resident Care Coordinator (RCC) stated that continence care was a task for each shift and it should have been documented when the care was provided to the resident.

The home's continence care policy stated that bladder and bowel function was supposed to be documented every shift on Point of Care (POC) by the Personal Support Workers (PSWs).

A resident had areas of altered skin integrity. Documentation was not completed for the monitoring of the areas in the electronic treatment administration record (eTAR). The Manager of Resident Care (MRC) confirmed that the documentation for monitoring the areas of altered skin integrity should have been completed.

There was minimal risk of harm to the residents related to staff not documenting the provision of care.

Sources: The LTCH's "Continence Care and Bowel Management" policy, number RCM 10-01-02 (last revised October 24, 2017); clinical records for two residents, including eTARs, care records and care plans; and interviews with the Resident Care Coordinator (RCC), the MRC and other staff. [s. 6. (9) 1.]

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 O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).
(e) continence care products are not used as an alternative to providing assistance to a person to toilet; O. Reg. 79/10, s. 51 (2).
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that five residents who required continence care products had sufficient changes to remain clean, dry and comfortable, and failed to ensure that continence care products were not used as an alternative to providing assistance to toilet another resident.

Five residents were found incontinent of urine. The home's investigation documentation identified that the residents were not toileted, checked or changed during the previous shift. Two of the residents had a history of altered skin integrity.

A resident requested to be toileted as per their plan of care and was not. During an interview with the resident, they recalled a situation where they asked to be toileted according to their plan of care, and they were not.

The Resident Care Coordinator (RCC) stated that the expectation in the home was that residents were provided comfort rounds every two hours during the night shift, which including ensuring peri care needs were met. The RCC confirmed that five residents were not provided sufficient changes of their continence care products to remain clean, dry, and comfortable. The RCC confirmed that the expectation in the home was that if a resident requested to be toileted, they should be provided that assistance.

There was minimal risk of harm to the residents related to not being provided the required continence care assistance and the residents being saturated in urine could have increased the risk of altered skin integrity.

The home's continence care policy stated that each resident who was unable to toilet independently some or all of the time would receive assistance from staff to manage and maintain continence. The home's policy stated that continence care products would not be used as an alternative to providing assistance to a person to toilet, and that residents who required continence care products would have sufficient changes to remain clean, dry and comfortable.

Sources: Critical Incident System Report; the LTCH's investigation documentation; the LTCH's "Continence Care and Bowel Management" policy, number RCM 10-01-02 (last revised October 24, 2017); clinical records for six residents, including progress notes and care plans; and interviews with two residents, the Resident Care Coordinator (RCC) and other staff. [s. 51. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when two residents were demonstrating responsive behaviours, strategies were developed and implemented to respond to the behaviours and actions were taken to respond to the needs of the residents, including assessment.

A resident had a history of responsive behaviours and had specific interventions in place for staff to follow when the resident was demonstrating the behaviour, including an assessment completed for the resident. The resident was expressing the behaviour and Dementia Observation Scale (DOS) monitoring was not initiated for the resident, an assessment was not completed for the resident and other interventions were not implemented for the resident to respond to the responsive behaviour. The MRC confirmed that strategies developed to respond to the resident's behaviours were not implemented.

The home's policy stated that the registered team member would initiate a DOS as applicable for continued monitoring.

A resident began exhibiting new responsive behaviours. The resident did not have any documented interventions or strategies developed to respond to the behaviours. No assessment related to the new behaviours was identified for the resident, and no DOS monitoring was initiated for the resident. A Registered Practical Nurse (RPN) stated the expectation in the home was that the front line registered team member would identify any responsive behaviour, develop interventions, initiate DOS monitoring, refer the resident to the Behavioural Supports Ontario (BSO) team if necessary, and update the resident's care plan to include the new responsive behaviour.

The home's responsive behaviours policy stated that the registered team member would complete a clinical assessment when a responsive behaviour occurs to identify the causes and triggers. The policy also stated staff were to utilize tools such as DOS monitoring and other protocols to assist in understanding the cause of the behaviour, track patterns and develop interventions.

There was minimal risk of harm to the residents related to not having strategies developed and implemented when the residents were exhibiting responsive behaviours.

Sources: The LTCH's "Responsive Behaviour Program" policy, number RCM 10-05-00 (last revised May 27, 2019) and "Suicide Risk in LTC" policy, number RCM 12-04 (last revised November 3, 2015); clinical records for two residents, including progress notes, care plans, BSO binder, paper chart, and assessments; and interviews with the MRC, an RPN, and other staff. [s. 53. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 four residents, who were exhibiting altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff.

Four residents had areas of altered skin integrity. Weekly skin assessments were not completed for the areas on numerous occasions. One of the resident's areas of altered skin integrity deteriorated during the absence of weekly skin assessments.

The MRC stated that the expectation in the home was that residents who were exhibiting areas of altered skin integrity should have been assessed weekly by the registered nursing staff on duty until the area had healed. The MRC confirmed that weekly skin and wound assessments were not completed for the four residents, for their areas of altered skin integrity.

There was actual risk that the residents' areas of altered skin integrity would worsen in the absence of weekly skin assessments.

The home's skin and wound policy stated that each resident who was exhibiting an area of altered skin integrity should have had the area monitored with each dressing change or treatment, and the registered team member should have reassessed the areas weekly, at minimum, using the altered skin integrity assessment until the areas were resolved.

Sources: Critical Incident System Report; the LTCH's "Skin & Wound Program" policy, number RCM 10-06-01 (last revised March 4, 2019); clinical records for four resident, including progress notes, skin assessments, eTARs, and care plans; and interviews with the MRC and other staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a controlled substance was administered to a resident in accordance with the directions for use specified by the prescriber.

A resident was administered the wrong dosage of a controlled substance. The medication error was identified immediately by the registered staff involved and the resident received medical intervention after the medication error was identified.

In an interview with a Registered Nurse (RN), they shared that they had failed to check the electronic Medication Administration Record (eMAR), which would have identified at that time, that the medication dose was for a different resident. The RN administered the resident the dosage prescribed for a different resident #001. The RN stated that they had accidentally failed to complete the appropriate medication checks on their own before administering the medication.

In an interview with the Assistant Manager of Resident Care (AMRC), they shared that the RN had been honest regarding the error and informed them that they failed to check the eMAR correctly and complete the 10 medication rights.

Sources: LTCH's policy titled 'Medication Administration', policy number: RCM 17-10 and last revised on January 16, 2019; Silver Fox Pharmacy policy number: 8.1, titled 'Drug Administration: Controlled Substances', last revised in March 2020; the clinical records of two residents; LTCH's 'Education/Performance Communication Tool'; LTCH's internal hand written investigation notes; interviews with an RN and the AMRC. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that for every drug ordered and received in the home, a record was kept of the date the drug was ordered, the signature of the person placing the order, the strength and quantity of drug, the prescription number, the date the drug was received in the home or the signature of the person acknowledging receipt of the drug.

Review of the LTCH's Drug Record's showed that documentation had not been completed as required when ordering and receiving drugs over the course of two months. Of the 27 drugs listed on the forms reviewed:

- Seven drugs were missing the date the drug was ordered and the signature of the person placing the order
- Four drugs were missing the prescription number
- Seven drugs were missing the date they were received in the home
- Nine drugs were missing the signature of the person acknowledging receipt of the drug on behalf of the home

In an interview with the MRC they stated that the documentation on the forms had not been completed as per the homes' policies, was not acceptable and that they would be following up with the appropriate staff members.

Sources: LTCH's Drug Records #27, 84, 88 and 89; Silver Fox Pharmacy policy number 6 titled Drug Record, last revised in March 2020; Silver Fox Pharmacy policy number 7 titled Drug Storage, last revised in March 2020; interviews with the MRC and other staff. [s. 133.]

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 for every drug ordered and received in the home, a record is kept of the date the drug was ordered, the signature of the person placing the order, the strength and quantity of the drug, the prescription number, the date the drug was received in the home and the signature of the person acknowledging receipt of the drug, to be implemented voluntarily.

WN #7: 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 has failed to ensure that the home's policy titled 'Hot Weather Related Illness' was in compliance with all applicable requirements under the Act.

O. Reg 79/10 s. 20. (1) States that every licensee of a long-term care home shall ensure that a written heat related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices.

O. Reg 79/10 s. 20. (1.3) (a) and (b) States that the heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented,
(a) any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and
(b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 21 (2) and (3) reaches 26 degrees Celsius or above, for the remainder of the day and the following day.

Review of the home's policy related to temperatures showed that it was not in compliance with the Act.

The policy titled 'Hot Weather Related Illness', policy number: RCM 12-03, and last revised on July 17, 2020, stated that the home would implement an 'Intervention Alert' when the air temperature was between 27 and 31 degrees.

In an interview with the Corporate Director of Environmental Services, they shared that the 'Hot Weather Related Illness' policy's annual revision was due within the next two weeks and that the policy would be revised accordingly to reflect the appropriate maximum temperature range of 26 degrees, not 27 degrees, as required by legislation.

Sources: LTCH's policy titled 'Hot Weather Related Illness', policy number: RCM 12-03, last revised on July 17, 2020; interview with the Corporate Director of Environmental Services. [s. 8. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperatures were measured and documented in writing in at least two resident bedrooms in different parts of the home.

Review of each units ‘MPR-14 Hot Weather Monitoring’ forms for the month of July 2021, showed that the air temperatures that had been recorded, did not identify if they were recorded in the residents’ rooms and that there were days that were missing air temperature documentation.

When asked if the form used identified the location of where the temperature was taken, whether it was in a common area or a resident room, the Director of Environmental Services stated that the form did not identify that. They stated that there were missing temperatures on the forms that had not been taken due to Maintenances absence in the building and the task had not been designated to any other staff members in their absence to complete as the home had central air conditioning.

Sources: LTCH’s ‘MPR-14 Hot Weather Monitoring’ forms for the month of July 2021; interview with the Director of Environmental Services. [s. 21. (2) 1.]

2. The licensee has failed to ensure that the air temperature was measured and documented in writing in one resident common area on every floor of the home.

Review of each units ‘MPR-14 Hot Weather Monitoring’ forms for the month of July 2021, showed that air temperatures had not been recorded in a common area on every floor of the home, on a consistent basis. Also reviewed, were the same titled forms which identified they were for the location of the Snoezlen room, a common area on the second floor, and the Centre, an identified common area located on the first floor.

For the first floor, Inspector was not able to locate an air temperature measured and documented in writing in one common area on multiple dates.

When asked if the form used identified the location of where the temperature was taken, whether it was in a common area or a resident room, the Director of Environmental Services stated that the form did not identify that. They stated that there were missing temperatures on the forms that had not been taken due to Maintenances absence in the building and the task had not been designated to any other staff members in their absence to complete as the home had central air conditioning.

Sources: LTCH’s ‘MPR-14 Hot Weather Monitoring’ forms for the month of July 2021; interview with the Director of Environmental Services. [s. 21. (2) 2.]

3. The licensee has failed to ensure that the temperatures required to be measured under subsection (2), were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The home has a total of four resident home areas. Review of the ‘MPR-14 Hot Weather Monitoring’ records for the month of July 2021, for each home area showed the temperatures were not documented on each resident home area at least once every morning, afternoon, and evening or night.

In an interview with the Director of Environmental Services, they shared that they observed the missing temperature recordings and stated that the home is getting a new computerized system that will automatically record the air temperatures all the time, in over twenty areas throughout the home using sensors that were installed recently. They shared that they had not communicated to the staff the need to complete the air temperature recordings when the maintenance staff were not in the home, noting the home had central air conditioning.

Sources: LTCH's 'MPR-14 Hot Weather Monitoring' forms for the month of July 2021; interview with Director of Environmental Services #108. [s. 21. (3)]

Issued on this 12th day of October, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	KRISTEN MURRAY (731), ALICIA MARLATT (590)
Inspection No. / No de l’inspection :	2021_777731_0021
Log No. / No de registre :	007556-21, 009842-21, 010087-21, 011524-21, 012463-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 22, 2021
Licensee / Titulaire de permis :	S & R Nursing Homes Ltd. 265 North Front Street, Suite 200, Sarnia, ON, N7T-7X1
LTC Home / Foyer de SLD :	Afton Park Place Long Term Care Community 1200 Afton Drive, Sarnia, ON, N7S-6L6
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Jeff Harvey

To S & R Nursing Homes Ltd., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must comply with s. 6 (7) of the LTCHA.

Specifically, the licensee must:

-Implement a monitoring process to ensure any existing or new treatments for areas of altered skin integrity are provided to residents #008 and #015 according to the orders in their plans of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plans of care for two residents, who required treatments for altered skin integrity, was provided to the residents as specified in their plans.

Two residents had areas of altered skin integrity. Treatments for the areas of altered skin integrity were not provided to the residents according to the orders in their plans of care. One of the resident's areas of altered skin integrity deteriorated in the absence of treatments.

The Manager of Resident Care (MRC) stated that the expectation in the home was that the treatments for areas of altered skin integrity should be in the electronic treatment administration record (eTAR) and signed off once the treatment was completed. The MRC confirmed that treatment for cleansing and applying the dressing to the two residents' areas of altered skin integrity had not been signed off as completed on numerous occasions.

There was actual risk that the residents' areas of altered skin integrity would worsen in the absence of treatments and dressing changes as per the residents'

care plans.

The home's skin and wound policy stated that each resident who was exhibiting an area of altered skin integrity should have had the area monitored with each dressing change or treatment, and the registered team member should have initiated treatment and provided interventions for the residents to relieve or reduce pain, promote healing, and prevent infection.

Sources: Critical Incident System Report; the LTCH's "Skin & Wound Program" policy, number RCM 10-06-01 (last revised March 4, 2019); clinical records for two residents, including progress notes, eTARs, and care plans; and interviews with the MRC and other staff.

An order was made by taking the following factors into account:

Severity: There was actual risk that the residents' areas of altered skin integrity would worsen in the absence of treatments and dressing changes as per the residents' plans of care. During the time treatments were not completed, one of the resident's wounds worsened.

Scope: Out of four residents reviewed, two residents did not have treatments provided according to their plan of care.

Compliance History: The licensee currently has a Compliance Order (CO) to the same subsection of the legislation, related to a different issue, that was not past-due at the time of the inspection (CO #002, inspection #2021_725522_0005 with a compliance due date of August 21, 2021). (731)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 22, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must comply with s. 51. (2) of O. Reg. 79/10.

Specifically the licensee must:

-Ensure residents #003, #005, #006, #007, and #008 are provided sufficient changes to remain clean, dry and comfortable; and

-Ensure that resident #004 is toileted as per their care plan.

Grounds / Motifs :

1. The licensee failed to ensure that five residents who required continence care products had sufficient changes to remain clean, dry and comfortable, and failed to ensure that continence care products were not used as an alternative to providing assistance to toilet another resident.

Five residents were found incontinent of urine. The home's investigation documentation identified that the residents were not toileted, checked or changed during the previous shift. Two of the residents had a history of altered skin integrity.

A resident requested to be toileted as per their plan of care and was not. During an interview with the resident, they recalled a situation where they asked to be toileted according to their plan of care, and they were not.

The Resident Care Coordinator (RCC) stated that the expectation in the home was that residents were provided comfort rounds every two hours during the night shift, which including ensuring peri care needs were met. The RCC confirmed that five residents were not provided sufficient changes of their continence care products to remain clean, dry, and comfortable. The RCC confirmed that the expectation in the home was that if a resident requested to be toileted, they should be provided that assistance.

There was minimal risk of harm to the residents related to not being provided the required continence care assistance and the residents being saturated in urine could have increased the risk of altered skin integrity.

The home's continence care policy stated that each resident who was unable to

toilet independently some or all of the time would receive assistance from staff to manage and maintain continence. The home's policy stated that continence care products would not be used as an alternative to providing assistance to a person to toilet, and that residents who required continence care products would have sufficient changes to remain clean, dry and comfortable.

Sources: Critical Incident System Report; the LTCH's investigation documentation; the LTCH's "Continence Care and Bowel Management" policy, number RCM 10-01-02 (last revised October 24, 2017); clinical records for six residents, including progress notes and care plans; and interviews with two residents, the Resident Care Coordinator (RCC) and other staff.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to the residents related to not being provided the required continence care assistance, and the residents being saturated in urine could have increased the risk of altered skin integrity. One resident had a history of altered skin integrity and another resident had an area of altered skin integrity at the time of the incident.

Scope: This non-compliance was widespread as six out of six residents were affected.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with different sections of the legislation. (731)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 22, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must comply with s. 53. (4) of O. Reg. 79/10.

Specifically the licensee must:

-Ensure resident #004's interventions for staff to respond when the resident is exhibiting responsive behaviours are implemented; and

-Ensure resident #009 has strategies developed and implemented to respond to the resident when exhibiting responsive behaviours.

Grounds / Motifs :

1. The licensee has failed to ensure that when two residents were demonstrating responsive behaviours, strategies were developed and implemented to respond to the behaviours and actions were taken to respond to the needs of the residents, including assessment.

A resident had a history of responsive behaviours and had specific interventions in place for staff to follow when the resident was demonstrating the behaviour, including an assessment completed for the resident. The resident was expressing the behaviour and Dementia Observation Scale (DOS) monitoring was not initiated for the resident, an assessment was not completed for the resident and other interventions were not implemented for the resident to

respond to the responsive behaviour. The MRC confirmed that strategies developed to respond to the resident's behaviours were not implemented.

The home's policy stated that the registered team member would initiate a DOS as applicable for continued monitoring.

A resident began exhibiting new responsive behaviours. The resident did not have any documented interventions or strategies developed to respond to the behaviours. No assessment related to the new behaviours was identified for the resident, and no DOS monitoring was initiated for the resident. A Registered Practical Nurse (RPN) stated the expectation in the home was that the front line registered team member would identify any responsive behaviour, develop interventions, initiate DOS monitoring, refer the resident to the Behavioural Supports Ontario (BSO) team if necessary, and update the resident's care plan to include the new responsive behaviour.

The home's responsive behaviours policy stated that the registered team member would complete a clinical assessment when a responsive behaviour occurs to identify the causes and triggers. The policy also stated staff were to utilize tools such as DOS monitoring and other protocols to assist in understanding the cause of the behaviour, track patterns and develop interventions.

There was minimal risk of harm to the residents related to not having strategies developed and implemented when the residents were exhibiting responsive behaviours.

Sources: The LTCH's "Responsive Behaviour Program" policy, number RCM 10 -05-00 (last revised May 27, 2019) and "Suicide Risk in LTC" policy, number RCM 12-04 (last revised November 3, 2015); clinical records for two residents, including progress notes, care plans, BSO binder, paper chart, and assessments; and interviews with the MRC, an RPN, and other staff.

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to the residents related to not having strategies developed and implemented when the residents were exhibiting

responsive behaviours.

Scope: Out of four residents reviewed, two residents did not have strategies developed or implemented for responsive behaviours, demonstrating a pattern of non-compliance.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with different sections of the legislation. (731)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 01, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(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

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must comply with s. 50. (2) of O. Reg. 79/10.

Specifically, the licensee must:

-Implement a monitoring process to ensure weekly skin and wound assessments are completed for residents #007, #008, #010, and #015 for any existing or new areas of altered skin integrity.

-Document and continue the monitoring until residents #007, #008, #010, and #015 are no long required to be reassessed weekly.

Grounds / Motifs :

1. The licensee has failed to ensure that four residents, who were exhibiting altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff.

Four residents had areas of altered skin integrity. Weekly skin assessments were not completed for the areas on numerous occasions. One of the resident's areas of altered skin integrity deteriorated during the absence of weekly skin assessments.

The MRC stated that the expectation in the home was that residents who were exhibiting areas of altered skin integrity should have been assessed weekly by the registered nursing staff on duty until the area had healed. The MRC confirmed that weekly skin and wound assessments were not completed for the four residents, for their areas of altered skin integrity.

There was actual risk that the residents' areas of altered skin integrity would worsen in the absence of weekly skin assessments.

The home's skin and wound policy stated that each resident who was exhibiting an area of altered skin integrity should have had the area monitored with each dressing change or treatment, and the registered team member should have reassessed the areas weekly, at minimum, using the altered skin integrity assessment until the areas were resolved.

Sources: Critical Incident System Report; the LTCH's "Skin & Wound Program"

policy, number RCM 10-06-01 (last revised March 4, 2019); clinical records for four resident, including progress notes, skin assessments, eTARs, and care plans; and interviews with the MRC and other staff.

An order was made by taking the following factors into account:

Severity: There was actual risk that the residents' areas of altered skin integrity would worsen in the absence of weekly skin and wound assessments. During a time weekly assessments were not completed, one of the resident's wounds worsened.

Scope: Four out of four residents did not have weekly skin and wound assessments completed for their areas of altered skin integrity.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10 s. 50. (2) and a Voluntary Plan of Correction (VPC) was issued to the home. (731)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 22, 2021

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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 22nd day of September, 2021

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Kristen Murray

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