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
Feb 8, 2019	2018_739694_0020	016591-17, 018014-17, 008205-18, 008346-18, 010950-18, 013957-18, 028288-18	Complaint

Licensee/Titulaire de permis

488491 Ontario Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Avalon Retirement Centre
355 Broadway Avenue ORANGEVILLE ON L9W 3Y3

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

AMANDA COULTER (694), KATHLEEN MILLAR (527)

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): December 4, 5, 6, 7, 10, 11, 12, 14 and 17, 2018.

Complaint Log #008205-18, log #018014-17, log #013957-18, and log #028288-18 related to complaints from family members. This inspection was completed in conjunction with Critical Incident Inspection 2018_730604_0019.

A Written Notification and Compliance Order related to O. Reg. 79/10, s. 50 (2) (b) (I) and (iv) was identified in a concurrent inspection 2018_739694_0019 (Log #010950-18 and Log #008346-18 related to fall prevention and Log #016591-17 related to personal support services) were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family members and residents.

During the course of the inspection, the inspector toured the facility, reviewed residents clinical records, reviewed the facility's policies and education attendance, completed observations and interviewed residents and staff.

Inspector Kiyomi Kornetsky, #743 also attended this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Nutrition and Hydration
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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 assessment.

The licensee's policy titled "Skin and Wound Care Program", directed registered staff to complete a wound assessment and treatment record in Point Click Care (PCC) under the assessments with initiation of actual altered skin integrity.

A) Resident #011 had developed an area of altered skin integrity, which was identified by Registered Practical Nurse (RPN) #148 in August 2017.

The clinical record was reviewed and there was a weekly wound note of the area of altered skin integrity in August 2017; however there was no wound and treatment assessment completed using a clinically appropriate assessment instrument by any of the registered staff. RPN #145 had documented on a specific date in July 2017, that the resident had a reddened area. The wound nurse, Registered Nurse (RN) #146 had received a referral on a specific date in August 2017, and they assessed resident #011's area of altered skin integrity and documented a wound note, but did not complete the clinically appropriate assessment instrument that was specifically designed for skin and

wound assessment in PCC.

RN #146 acknowledged the wound and treatment assessment in PCC was not done. The RN said that it was the unit charge nurse's responsibility to conduct the initial assessment and document in PCC.

RPN #135 acknowledged that resident #011 had not had a wound and treatment assessment completed when the area of altered skin integrity was first identified.

B) Resident #008 had a fall on a specific date in April 2018, resulting in a specific injury. The resident was transferred to the hospital. When the resident returned to the home on a specific date in May 2018, they had multiple areas of altered skin integrity.

The clinical record was reviewed and there was no wound assessment and treatment record in PCC under the assessments.

RPN #132 acknowledged that the registered staff were expected to complete the wound assessment in PCC. RPN #132 said that for resident #008, there should have been a wound assessment in PCC for the areas of altered skin integiry.

RPN #133 acknowledged the wound and treatment assessment was not completed for resident #008's multiple areas of altered skin integrity.

The licensee failed to ensure that when residents #008 and #011 exhibited altered skin integrity, 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 assessment. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed at least weekly by a member of the registered nursing staff if clinically indicated.

RPN #145 acknowledged that when residents experience altered skin integrity that the registered staff were expected to complete an initial wound and treatment assessment in PCC, then conduct weekly skin reassessments and document in the progress notes.

RN #117 and RN #133 both stated registered staff are expected to complete a Wound Assessment and Treatment for all new areas of altered skin integrity and weekly

thereafter.

A) Resident #003 sustained an area of altered skin integrity and received medical treatment on a specific date in May 2018. An initial wound assessment and treatment assessment was completed, but weekly reassessments were not completed after that date.

B) Resident #020 ‘s clinical record was reviewed. The resident had a new area of alteration to skin integrity on a specific date in September 2018. An initial wound assessment and treatment assessment was completed. A weekly reassessment was not completed on a specific date in October, and three dates in November 2018. The registered staff identified a new area of altered skin integrity on resident #020’s on a specific date in September 2018. A weekly reassessment was not completed on a specific date in October, November, and two dates in December 2018.

RN #133 acknowledged the weekly wound assessments were not completed.

C) Resident #004 sustained an area of altered skin integrity on a specific date in January 2018. An initial Wound assessment and treatment and a head-to-toe assessment were completed. A weekly reassessment was not completed three dates in February or a specific date in March 8, 2018.

RN #133, acknowledged the wound assessment was not completed weekly.

D) Resident #008 had a fall on a specific date in April 2018 and was transferred to the hospital for further assessment.

The clinical record was reviewed, which indicated the resident returned from the hospital on a specific date in May 2018. The resident's head-to-toe assessment indicated the resident had a wound and there were no weekly assessments conducted.

RPN #132 and #133 acknowledged weekly skin and wound assessments were not completed for resident #008, as it related to the resident's wound.

E) The clinical record of resident #011 was reviewed, which indicated the resident developed the following altered skin integrity and weekly skin assessments were not completed:

(i) On a specific date in April 2017, sustained an area of altered skin integrity. Weekly skin assessments were not completed on three dates in April and one in May 2017.
(ii) On a specific date in April 2017, the resident sustained an area of altered skin integrity. Weekly skin assessments were not completed on two dates in April and one in May 2017.
(iii) On a specific date in June 2017, the resident sustained an area of altered skin integrity. Weekly skin assessments were not completed.
(iv) On a specific date in July 2017, the resident sustained an area of altered skin integrity.Weekly skin assessments after a specific date in July 2017 were not completed.

Personal Support Worker (PSW) #128 identified that the resident had altered skin integrity during their admission to the home. The PSW said that they checked the resident's skin daily and if there were any abnormalities they were to report to the charge nurse.

F) Resident #010 sustained an area of altered skin integrity on a specific date in July 2017. The resident was transferred to the hospital on a specific date in July 2017 for further assessment.

The clinical record was reviewed, which indicated the resident developed an areas of altered skin integrity on a specific date in July 2017. The initial skin assessment was completed on a specific date in July 2017; however weekly skin reassessments were not completed. Another area of altered skin integrity did not have an initial assessment and/or weekly assessments conducted.

PSW #139 identified that the resident had an area of altered skin integrity and they reported to the charge nurse.

RPN #132 acknowledged that when residents experience altered skin integrity that the registered staff were expected to complete an initial skin and wound reassessment in Point Click Care (PCC) using the wound reassessment tool. This was not completed for resident #010.

The licensee failed to ensure that when resident #003, #004, #008, #010, #011 and #020 was exhibiting altered skin integrity they were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

A) Resident #003 sustained an areas of altered skin integrity on a specific date in May 2018.

The resident's clinical record was reviewed. The current written plan of care identified an area of altered skin integrity. Resident #003 was observed on a specific date in December 2018, and did not have the area of altered skin integirty.

RN #133 confirmed the current written plan of care for resident #003, it included an area of altered skin integrity. The area was healed and the plan of care had not been revised.

B) Resident #003's progress notes stated they were to be on Dementia Observation System (DOS) every 15 minutes which commenced on a specific date in May 2018.

Staff #120 acknowledged DOS charting was to be on the resident's written plan of care. PSW #120 confirmed DOS was not on the resident #003's written plan of care. Assessment records showed DOS was initiated on specific dates in May 2018 and not all

documentation was completed.

C) The licensee forwarded a complaint to the Ministry of Health and Long-Term Care (MOHLTC) with concerns related to residents #006 and #007 receiving incorrect diet textures. Resident #006 returned from hospital on a specific date in October 2018, with new orders for a specific diet. Records were reviewed and the written plan of care indicated that on a specific date in October 2018 some revisions were completed, however a specific diet was not revised until days later.

Registered Dietitian (RD) #103, Registered Nurse (RN) #123, and Director of Care (DOC) #101 stated that the care plan as well as the Master Diet List (MDL) should have been updated when new dietary orders were received.

RN #123 stated they received report on a specific date in October 2018, that resident #006 had new orders for a specific diet. RN #123 stated they did not update the written plan of care and they should have.

DOC #101 stated care plans were to be updated within 24 hours of any change, however, they should be updated right away.

D) Resident #007's care plan was not updated to reflect their diet changes.

A Clinical record review revealed RD #103 documented on a specific date in October 2018 resident #007 was choking. RD #103 wrote new diet orders on a specific date in October 2018.

The resident's written plan of care was not immediately updated to reflect the new order. As a result, RPN #141 provided resident #007 with a dietary supplement that had been discontinued. The resident's SDM informed RPN #141 about the diet changes, however, the written plan of care was never updated to reflect the orders.

DOC #101 stated that RPN #141 should have ensured that the new diet orders were processed immediately, that staff were informed, and that the written plan of care was updated when they co-signed the orders.

The licensee failed to ensure resident #003, #006 and #007's plan of care was reviewed and revised when the resident's care needs changed or the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or the care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The 2017-2018 annual program evaluation for the Skin and Wound Care program document was reviewed and the written record included the summary of changes made; however the date that those changes were implemented were not documented in the written record.

The DOC and Administrator acknowledged that an annual program evaluation was required and that the date(s) their plan to correct/celebrate were implemented for the Skin and Wound Care program were not documented in the written record for their annual evaluation.

The licensee failed to ensure the Skin and Wound Care annual program evaluation written record included the dates their plan to correct/celebrate were implemented. [s. 30. (1) 1.]

2. The licensee shall ensure that any actions taken with respect to a resident under a programs, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The clinical record for resident #003 was reviewed and Dementia Observation System (DOS) records were reviewed on specific dates in May 2018. Resident #003 eloped from the facility on a specific date and upon return from hospital the DOS documentation was initiated again.

DOS documentation from specific dates in May and June 2018 had multiple missing entries. PSW #120 acknowledged it is an expectation direct care staff complete the DOS every fifteen minutes and any blank spaces indicated that entries were missing.

The licensee failed to ensure that responsive behaviour assessments, specifically DOS assessments for resident #003 were documented. [s. 30. (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 (4) a written record was kept relating to each evaluation under paragraph (3) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to implement the procedure to ensure suction machines are maintained.

On a specific date in October 2018, resident #007 was unable to clear their airway. RPN #142 retrieved medical equipment, however, it was not working and the resident required transfer to hospital.

After the incident, the licensee implemented a nightly machine checklist that was completed by the registered staff. RN #144 documented that the machine was functioning on a specific date in December 2018. Long Term Care Homes (LTCH) inspector #743 checked the machine on specific dates in December 2018 and the machine was not working. Co-DOC #137 stated that the charger for the equipment had been missing since November, 2018. In order to charge the machine, registered staff borrowed a charger from another unit.

DOC #101 stated that the machines were working and one of them did not have a charger, but the staff were borrowing chargers from other units.

The licensee failed to ensure that machines, were maintained at a level that meets the manufacturer specifications, at a minimum. [s. 90. (2) (a)]

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 the procedure to maintain the suction machines is implemented, to be implemented voluntarily.

WN #5: 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, where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy and the policy was complied with.

In accordance with O. Reg 79/10, s.30, the licensee was required to provide a written description of each of the interdisciplinary programs, including falls prevention, required under s. 48 of this Regulation that included its goals and objectives and relevant policies, procedures and protocols. Specifically, staff did not comply with the licensee's policy regarding "Falls Prevention and Management Program", which is part of the licensee's fall prevention program.

Resident #011 had a number of unwitnessed falls in April and July 2017.

The licensee's policy titled ".Falls Prevention and Management Program", directed staff to ensure post fall assessments of residents included a head injury routine (HIR).

The clinical record indicated that the resident had a HIR initiated on some dates in April and July 2017. However, when the resident was at supper or sleeping, the HIR was not completed.

RPN #145 acknowledged that they were expected to perform the HIR for residents that had an unwitnessed fall or had a witnessed fall where they may have hit their head. The RPN acknowledged that registered staff were expected to complete the full HIR. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that, a written record was kept relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The 2017-2018 annual program evaluation for the Responsive Behaviour program document was reviewed and the written record included the summary of changes made; however the date that those changes were implemented were not documented in the written record.

The DOC and Administrator were interviewed separately and acknowledged that an annual program evaluation was required and that the date(s) their plan to correct/celebrate were implemented for the Responsive Behaviour program were not documented in the written record for their annual evaluation.

The licensee failed to ensure the Responsive Behaviour annual program evaluation written record included the dates their plan to correct/celebrate were implemented. [s. 53. (3) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the documented record of complaints is reviewed and analyzed for trends at least quarterly.

The licensee's documented record of complaints and the risk analysis quarterly report were reviewed. Complaints were not included in the review.

In an interview with the Administrator, they acknowledged complaints received by the home were not reviewed and analyzed on a quarterly basis.

The licensee failed to ensure complaints were reviewed and analyzed on a quarterly basis. [s. 101. (3)]

Issued on this 11th day of February, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA COULTER (694), KATHLEEN MILLAR (527)
Inspection No. / No de l'inspection :	2018_739694_0020
Log No. / No de registre :	016591-17, 018014-17, 008205-18, 008346-18, 010950-18, 013957-18, 028288-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 8, 2019
Licensee / Titulaire de permis :	488491 Ontario Inc. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	Avalon Retirement Centre 355 Broadway Avenue, ORANGEVILLE, ON, L9W-3Y3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Klara Hamvas

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To 488491 Ontario Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 be compliant with O. Reg. 79/10, s. 50 (2) (b) (iv). The licensee shall ensure that when a resident has altered skin integrity, the resident is assessed at least weekly by a member of the registered nursing staff if clinically indicated.

Specifically the licensee shall ensure that:
Residents #003, #004, #008, #010, #011 and #020 and any other resident experiencing altered skin integrity is assessed at least weekly by a member of the registered nursing staff.

Grounds / Motifs :

1. 1. The licensee failed to ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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 assessment.

The licensee's policy titled "Skin and Wound Care Program", directed registered staff to complete a wound assessment and treatment record in Point Click Care (PCC) under the assessments with initiation of actual altered skin integrity.

A) Resident #011 had developed an area of altered skin integrity, which was identified by Registered Practical Nurse (RPN) #148 in August 2017.

The clinical record was reviewed and there was a weekly wound note of the area of altered skin integrity in August 2017; however there was no wound and treatment assessment completed using a clinically appropriate assessment instrument by any of the registered staff. RPN #145 had documented on a specific date in July 2017, that the resident had a reddened area. The wound nurse, Registered Nurse (RN) #146 had received a referral on a specific date in August 2017, and they assessed resident #011's area of altered skin integrity and documented a wound note, but did not complete the clinically appropriate assessment instrument that was specifically designed for skin and wound assessment in PCC.

RN #146 acknowledged the wound and treatment assessment in PCC was not done. The RN said that it was the unit charge nurse's responsibility to conduct

the initial assessment and document in PCC.

RPN #135 acknowledged that resident #011 had not had a wound and treatment assessment completed when the area of altered skin integrity was first identified.

B) Resident #008 had a fall on a specific date in April 2018, resulting in a specific injury. The resident was transferred to the hospital. When the resident returned to the home on a specific date in May 2018, they had multiple areas of altered skin integrity.

The clinical record was reviewed and there was no wound assessment and treatment record in PCC under the assessments.

RPN #132 acknowledged that the registered staff were expected to complete the wound assessment in PCC. RPN #132 said that for resident #008, there should have been a wound assessment in PCC for the areas of altered skin integiry.

RPN #133 acknowledged the wound and treatment assessment was not completed for resident #008's multiple areas of altered skin integrity.

The licensee failed to ensure that when residents #008 and #011 exhibited altered skin integrity, 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 assessment. [s. 50. (2) (b) (i)] (527)

2. 2. The licensee failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed at least weekly by a member of the registered nursing staff if clinically indicated.

RPN #145 acknowledged that when residents experience altered skin integrity that the registered staff were expected to complete an initial wound and treatment assessment in PCC, then conduct weekly skin reassessments and document in the progress notes.

RN #117 and RN #133 both stated registered staff are expected to complete a Wound Assessment and Treatment for all new areas of altered skin integrity and

weekly thereafter.

A) Resident #003 sustained an area of altered skin integrity and received medical treatment on a specific date in May 2018. An initial wound assessment and treatment assessment was completed, but weekly reassessments were not completed after that date.

B) Resident #020 ‘s clinical record was reviewed. The resident had a new area of alteration to skin integrity on a specific date in September 2018. An initial wound assessment and treatment assessment was completed. A weekly reassessment was not completed on a specific date in October, and three dates in November 2018. The registered staff identified a new area of altered skin integrity on resident #020’s on a specific date in September 2018. A weekly reassessment was not completed on a specific date in October, November, and two dates in December 2018.

RN #133 acknowledged the weekly wound assessments were not completed.

C) Resident #004 sustained an area of altered skin integrity on a specific date in January 2018. An initial Wound assessment and treatment and a head-to-toe assessment were completed. A weekly reassessment was not completed three dates in February or a specific date in March 8, 2018.

RN #133, acknowledged the wound assessment was not completed weekly.

D) Resident #008 had a fall on a specific date in April 2018 and was transferred to the hospital for further assessment.

The clinical record was reviewed, which indicated the resident returned from the hospital on a specific date in May 2018. The resident's head-to-toe assessment indicated the resident had a wound and there were no weekly assessments conducted.

RPN #132 and #133 acknowledged weekly skin and wound assessments were not completed for resident #008, as it related to the resident's wound.

E) The clinical record of resident #011 was reviewed, which indicated the

resident developed the following altered skin integrity and weekly skin assessments were not completed:

(i) On a specific date in April 2017, sustained an area of altered skin integrity. Weekly skin assessments were not completed on three dates in April and one in May 2017.
(ii) On a specific date in April 2017, the resident sustained an area of altered skin integrity. Weekly skin assessments were not completed on two dates in April and one in May 2017.
(iii) On a specific date in June 2017, the resident sustained an area of altered skin integrity. Weekly skin assessments were not completed.
(iv) On a specific date in July 2017, the resident sustained an area of altered skin integrity.Weekly skin assessments after a specific date in July 2017 were not completed.

Personal Support Worker (PSW) #128 identified that the resident had altered skin integrity during their admission to the home. The PSW said that they checked the resident's skin daily and if there were any abnormalities they were to report to the charge nurse.

F) Resident #010 sustained an area of altered skin integrity on a specific date in July 2017. The resident was transferred to the hospital on a specific date in July 2017 for further assessment.

The clinical record was reviewed, which indicated the resident developed an areas of altered skin integrity on a specific date in July 2017. The initial skin assessment was completed on a specific date in July 2017; however weekly skin reassessments were not completed. Another area of altered skin integrity did not have an initial assessment and/or weekly assessments conducted.

PSW #139 identified that the resident had an area of altered skin integrity and they reported to the charge nurse.

RPN #132 acknowledged that when residents experience altered skin integrity that the registered staff were expected to complete an initial skin and wound reassessment in Point Click Care (PCC) using the wound reassessment tool. This was not completed for resident #010.

The licensee failed to ensure that when resident #003, #004, #008, #010, #011 and #020 was exhibiting altered skin integrity they were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)]

The severity of this issue was a level 2 as there was minimal harm or potential for actual harm to the residents. The scope was a level 3 as six out of six residents with altered skin integrity was not reassessed at least weekly. Compliance history was a level 4 as there was a related non compliance that included:
Voluntary Plan of Corrective (VPC) Action made under s. 50 (2) (b) (ii) of the Regulations, January 15, 2018, (2017_482640_0021). (694)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 8th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amanda Coulter

Service Area Office /
Bureau régional de services : Central West Service Area Office