Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**London Service Area Office**
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775
londonsao.moh@ontario.ca

# Original Public Report

**Report Issue Date:** October 20, 2022

**Inspection Number:** 2022-1487-0003

**Inspection Type:**
Critical Incident System

**Licensee:** Blue Water Rest Home

**Long Term Care Home and City:** Blue Water Rest Home, Zurich

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Julie Lampman (522) | Julie Lampman Digitally signed by Julie Lampman Date: 2022.10.28 08:45:48 -04'00' |

**Additional Inspector(s)**
Loma Puckerin (705241)
Sharon Connell (741721)

## INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 3, 2022
October 4, 2022
October 5, 2022
October 6, 2022
October 7, 2022
October 11, 2022

The following intake(s) were inspected:

- Intake: #00002320 related to falls prevention

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The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Restraints/Personal Assistance Services Devices (PASD) Management
Falls Prevention and Management
Skin and Wound Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Training and Orientation

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 261 (1) 6.

The licensee has failed to ensure that staff who applied Personal Assistance Services Devices (PASDs) or monitored residents with PASDs received training in the application of the PASDs.

**Rationale and Summary**
During the inspection, a resident was observed with a Personal Assistance Services Device (PASD) in place. The PASD was observed to be incorrectly applied at the time of the observation.

Inspectors #522 and #741721 asked a staff member to observe the placement of the PASD. When Inspector #522 questioned the staff member on the application of the PASD, the staff member attempted to readjust the PASD but was unsuccessful. The registered staff member was not aware of how to adjust the resident's PASD and after several attempts was able to adjust the PASD properly.

Review of the home's annual Surge Training course outline noted the training did not include the application of the specific PASD that was used by the resident.

Nurse Clinician (NC) #100 confirmed that staff did not receive annual training that included the application and proper placement of the specific PASD used by the resident.
**Sources:** Resident observations, review of the resident's clinical record, the home's Surge Training, the home's Therapy Services video on PASDs, and staff interviews.
[522]

## WRITTEN NOTIFICATION: Skin and Wound Care

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident, who exhibited altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

**Rationale and Summary**
After experiencing a fall with injury, a resident had a Head to Toe Skin Assessment completed, which noted areas of altered skin integrity.

Upon further review of the resident's clinical record, it was noted that there was no documentation of weekly skin assessments of these areas of altered skin integrity.

Multiple staff confirmed that weekly skin assessments for altered skin integrity had not been completed for this resident. The Director of Care (DOC) stated weekly assessments of the altered skin integrity were an expectation of care and should include assessment, measurement, documentation, monitoring, and then follow up. The DOC noted that the weekly skin assessment tool lacked a prompt for staff to assess for this specific type of altered skin integrity.

The absence of weekly skin assessments of the resident's altered skin integrity increased the risk for complications, however the resident experienced no adverse outcomes related to this non-compliance.

**Sources:** Review of the resident's clinical record and interviews with the DOC and other staff.
[522]

## WRITTEN NOTIFICATION: Plan of Care

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident sustained an injury from their fall.

**Rationale and Summary**
A resident had a fall requiring examination, treatment and monitoring related to their injury.

A review of the resident's progress notes indicated that the resident required the use of a supportive device. Review of the resident's electronic Treatment Administration Record (eTAR), for the month when the injury occurred, noted no interventions related to the resident's injury or application of the resident's supportive device.

Only one progress note indicated an assessment of the resident's injured area. There were no other progress notes with documented assessments of the resident's injured area.

A registered staff member stated that when a resident had this type of injury, staff should monitor the injured area and place an order into the resident's eTAR to check the injured area daily.

The Director of Care (DOC) acknowledged there was no documentation in the resident's progress notes and eTAR related to an assessment of the resident's injured area. The DOC also acknowledged that there was no documentation of injury specific checks completed or application of the resident's supportive device.

There was risk that the resident could develop complications related to their injury without regular assessments.

**Sources:**
The affected resident's clinical record, and interviews with registered staff and the DOC.
[522]

## WRITTEN NOTIFICATION: Skin and Wound

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident had an initial skin assessment completed of their altered skin integrity.

**Rationale and Summary**
After experiencing a fall with injury, a resident had a Head to Toe Skin Assessment completed, which noted areas of altered skin integrity.

Further review of the resident's clinical record noted no documentation of an initial skin assessment of the resident's altered skin integrity.

A registered staff member acknowledged that the resident did not have an initial skin assessment for their altered skin integrity. They stated that the resident should have had an initial skin assessment completed after their head to toe skin assessment which had identified altered skin integrity.

The Director of Care (DOC) stated the home's weekly wound assessment did not prompt staff to look at this specific type of altered skin integrity and it should.

The absence of an initial skin assessment of this resident's altered skin integrity increased the risk for complications, however the resident experienced no adverse outcomes.

**Sources:** Review of the affected resident's clinical record, the home's Skin and Wound Program policy NRSG_1_1 updated March 2021, and interviews with a registered staff and the DOC. [522]

## COMPLIANCE ORDER CO #001 Requirements relating to the use of a PASD

**NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: O. Reg. 246/22, s. 120 (2) (b)

**The Inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

The licensee has failed to comply with O. Reg 246/22 s. 120 (2) (b).

A) The affected resident has their Personal Assistance Services Device (PASD) applied, when in use, as per the manufacturer's instructions.
B) Revise the home's training on PASDs to include hands on training on the application, including the dangers associated with the use of the PASD.
C) The specific staff member who failed to use the PASD as per manufacturer's instructions receives retraining on the application of the PASD, including the dangers associated with the use of PASDs.
D) Training must be documented, including the name of the staff member and the date the training occurred.

**Grounds**
The licensee has failed to ensure that a resident's PASD was applied by staff in accordance with the manufacturer's instructions.

**Rationale and Summary**
Review of a resident's care plan noted the resident used a PASD as a falls prevention intervention.

On two separate days during the inspection, the resident was observed to have a PASD in place that was applied incorrectly.

On the date of the second observation, Inspectors #522 and #741721 asked a staff member to observe the placement of the PASD. The staff member stated that the resident was able to adjust the PASD on their own. The staff member then proceeded to leave the resident without readjusting the PASD. When Inspector #522 questioned the staff member on the application of the PASD, the staff member attempted to readjust the PASD but was unsuccessful. The registered staff member was not aware of how to adjust the resident's PASD and after several

attempts was able to adjust the PASD properly.

On the same day, immediately after the staff member was observed having difficulty adjusting the PASD, the Director of Care (DOC) observed the resident's PASD with Inspectors #522 and #741721. The DOC checked the application of the PASD and stated that it was not applied correctly and then readjusted it.

The DOC verbally and physically demonstrated, step by step, the proper method for applying and positioning the PASD, and stated there was risk to the resident if it was not done correctly.

The specific manufacturer's written and video instructions for the resident's PASD were reviewed by the Inspector and confirmed the proper placement and application as noted by the DOC.

The affected resident was at actual risk of harm, as the staff member did not know the proper application of the resident's PASD.

**Sources:** Observations of the affected resident, review of the resident's clinical records, the home's "Minimizing Restraints" policy NRSG_10_2 revised January 2018, the PASD manufacturer's written and video instructions, and interviews with the DOC and other staff. [522]

**This order must be complied with by:** December 1, 2022

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## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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