Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2019	2019_565647_0021	031501-18, 002020-19, 015692-19, 015824-19	Complaint

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Bradford Valley Care Community
2656 6th Line Bradford ON L3Z 2A1

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

JENNIFER BROWN (647), SHANNON RUSSELL (692)

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): September 9 - 13, 2019.

The following intakes were completed during the course of this Complaint Inspection:
-one intake related to medication administration, continence care and housekeeping,
-one intake related to a fall, and
-two intakes related to plan of care.

Critical Incident System (CIS) inspection #2019_565647_0022 was conducted concurrently with this complaint inspection.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Nurse Practitioner (NP), Substitute Decision Makers (SDM), and residents.

During the course of the inspection, the Inspector(s) also conducted a daily tour of the resident care areas, observed staff to resident interactions and the provisions of care, reviewed training documents, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **3 WN(s)**
- **2 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 has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

A complaint was submitted to the Director, related to concerns of improper plan of care that resulted in a transfer to hospital and further led to an infection.

During an interview with the complainant, they indicated that resident #001 had been transferred to the hospital on an identified date, and diagnosed with an infection, and passed away in hospital 18 days later.

A record review of the hospital transcript notes titled "urgent consult", indicated that resident #001 had a breakdown in their skin integrity which look infected.

A record review of the progress notes from the identified period of time, did not identify any concerns related to an infection to the area until the day resident #001 was

transferred to the hospital. On the same day, as the resident was transferred to the hospital, there had been documentation that indicated altered skin integrity, and resident had been more confused and lethargic recently.

During an interview with Personal Support Worker (PSW) #117, they indicated that they frequently provided care to resident #001. PSW #117 had been unable to confirm the exact date, however, did indicate to the Inspector that approximately one week or one and a half weeks prior to the hospital transfer, that they had observed resident's altered skin integrity to the identified area. PSW #117 indicated that they reported this to Registered Practical Nurse (RPN) #122.

During an interview with RPN #122, they indicated that they had recalled PSW #117 informing them of the concern with resident #001's skin integrity. When Inspector #647 asked RPN #122 what actions they took following this report, RPN #122 indicated that they went into the hallway and looked at resident #001's specified area, however did not feel it was necessary to do any assessment or documentation.

During staff interviews with PSW's #107, #117, #119, and RPN's #116 and #122, it had been communicated to the Inspector that staff use a communication tool titled "unit daily record". The staff further indicated that this tool is for staff to pass on information from shift to shift for resident changes or things to monitor. Inspector #647 reviewed this document from the applicable time frame. The unit daily record sheets did not indicate that any altered skin integrity on resident #001 had been identified. There was an entry on an identified date, that indicated resident #001 had sustained a scratch, however when reviewed, this was not entered on any other unit daily record sheets for follow up or to monitor. Resident #001 reappeared on the unit daily record sheets on another identified date, when staff documented that they had identified a change in health status, then again when resident was transferred to the hospital.

A further record review included the resident specific assessments for the identified time frame. The Inspector was unable to locate any skin assessments that related to the identification of the impaired skin integrity.

In an interview with the Director of Care (DOC), they indicated that the home had not provided immediate intervention after the PSW first reported to RPN #122. [s. 50. (2) (b) (ii)]

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 Substitute Decision Maker (SDM), been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was submitted to the Director, related to concerns of not being informed of the resident's change in health condition that resulted in a transfer to hospital.

During an interview with the complainant, they indicated that resident #001 had been transferred to the hospital on an identified date, and diagnosed with an infection, and passed away in hospital 18 days later.

A record review of the progress notes from the specified time frame, did not identify any communication to the SDM related to an infection until the day resident #001 was transferred to the hospital.

During an interview with PSW #117, they indicated that they frequently provided care to resident #001. PSW #117 had been unable to confirm the exact date, however, did

indicate to the Inspector that approximately one week or one and a half weeks prior to the hospital transfer, that they had observed an alteration in the residents skin integrity. PSW #117 indicated that they reported this to RPN #122.

During an interview with RPN #122, they indicated that they had recalled PSW #117 informing them of the concern with resident #001's skin integrity. When Inspector #647 asked RPN #122 if there had been any communication with the SDM of this change, RPN #122 indicated they did not as they did not feel it was necessary.

In an interview with the DOC, they indicated that based on the documentation, they did not find documentation to indicate the SDM had been contacted when the concern was first reported to RPN #122. [s. 6. (5)]

2. A complaint was submitted to the Director, related to not being informed of the health status change of resident #003.

During an interview with the complainant, they indicated that when they visited resident #003 on an identified date, they found resident #003 to have no eye contact and be non-verbal towards them. The complainant indicated that PSW #107, had indicated to them, that they observed a health status change in resident #003 two days prior, and reported it to the nurse. The complainant further indicated that the home had not informed them of any concern regarding this. Resident #003 had been transferred to the hospital.

A record review of the progress notes from the identified period of time, did not identify any communication to the SDM related to a change in health status.

During an interview with PSW's #107 and #119, they indicated that they frequently provided care to resident #003. The PSW's indicated that when they went in to provide care to resident #003 the morning of identified date, they observed the resident to be acting differently than normal and not able to safely transfer. The PSW's indicated that after they provided care to resident #003, they brought them out to the nursing station and reported to RPN #105 that they were concerned about the change in condition of resident #003.

During an interview with RPN #105, they indicated that they had recalled PSW's #107 and #119, informing them of the concern with the change in health status. When Inspector #647 asked RPN #105 if there had been any communication with the SDM of this change, RPN #105 indicated they did not as they did not feel it was necessary.

In an interview with the DOC, they did not find documentation to indicate the SDM had been contacted when the concern was first reported to RPN #105. [s. 6. (5)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A complaint was submitted to the Director, related to medication administration, continence care needs, and laundry concerns. The complainant indicated that resident #004 had an identified diagnosis and was to receive treatment with a prescribed medication, however, there were occasions when the medication was not provided to the resident.

Inspector #692 reviewed resident #004's health care records, identifying a progress note, documented by Nurse Practitioner (NP) #127, which indicated that resident #004 had evidence of the identified diagnosis, and required a medication for treatment. A review of a document titled, "Digital Prescriber's Orders", identified an order for an identified medication to be provided to the resident twice daily for seven days. The Inspector also identified an order, for the identified medication to be provided twice daily for 30 days. A further review of the "Digital Prescriber's Orders" document, identified an order, for another identified medication to be provided to the resident twice daily for 14 days.

Inspector #692 reviewed resident #004's electronic Medication Administration Record (eMAR) for two specified months, identifying that there was not any documentation for the prescribed medication on two occasions. Resident #004's eMAR also identified there was not any documentation for the other identified medication on two occasions.

In a review of the home's policy titled, "The Medication Pass, #3-6", last revised January 2018, Inspector #692 identified that once registered staff had administered the medication to the resident they were to document on the eMAR in the proper space for each medication administered or document by the appropriate code if the medication was not given. The home's policy titled, "Documentation – Plan of Care, #VII-C-10.90", last revised April 2019, indicated that staff were to document on the care provided as specified in the resident's plan of care.

The Inspector reviewed resident #004's health care records and was unable to locate any documentation that indicated that the identified medications were provided to the resident or rationale as to why they were not applied.

In separate interviews with Inspector #692, RPN's #111 and #112, indicated that registered staff were to sign the eMAR once they had administered medications to residents by a check mark, which included their initials. Together, the Inspector and RPN's #111 and #112, reviewed resident #004's eMAR and progress notes for the identified time frame. RPN #111 confirmed that they were on duty on the identified dates, and that they recalled that the prescribed medications was provided to resident #004. RPN #111 stated that they had forgotten to sign the eMAR that the medication was provided. RPN #112 confirmed that they were on duty on the other identified dates, and that they had provided the prescribed medications to resident #004 but had forgotten to sign that it had been completed. Both RPN #111 and #112 indicated that they would have documented a progress note if the medications were not provided.

In an interview with the Inspector, RN #121 identified that all care that was provided to residents was to be documented in the resident's chart, indicating that the care was completed. They indicated if there was a blank space in a time slot on the eMAR that either the medication was not given, or the staff had not signed that it was completed. RN #121 also indicated that the expectation if the medication was not given the registered staff would document the appropriate code on the eMAR as well as document a progress note indicating the change.

In an interview with Inspector #692, the DOC indicated that staff were to ensure that they documented the care that they completed in the appropriate section of the resident's chart. Together, the Inspector and the DOC reviewed resident#004's eMAR for the identified months. The DOC indicated to the Inspector that the eMAR should not have been blank, as the registered staff were to sign that they completed the application of the creams. [s. 6. (9) 1.]

4. A complaint was submitted to the Director, related to medication administration. The complainant indicated that resident was to receive a specific treatment, yet there were occasions when the treatment was not completed.

Inspector #692 reviewed resident #002's health care records, identifying a progress note, documented by RN #121, which indicated that resident #002 had impaired skin integrity and required a specific treatment. A review of a document titled, "Physician Medication Review", identified an order for the specific treatment once daily, every two days, and as needed.

Inspector #692 reviewed resident #002's eMAR for the identified months, identifying that there was not any documentation indicating the specific treatment was completed on two occasions.

The Inspector reviewed resident #002's health care records and was unable to locate any documentation that indicated that the specified treatment was completed or rationale as to why they were not.

In an interview with Inspector #692, RPN #112 indicated that registered staff were to sign the eMAR once they had administered medications to residents by a check mark, which included their initials. Together, the Inspector and RPN #112, reviewed resident #002's eMAR and progress notes for the identified months. RPN #112 confirmed that they were on duty on the identified dates, and that they recalled that they did check and provide the specified treatment to resident #002 but had forgotten to sign on the eMAR. RPN #112 indicated that they would have documented a progress note if the treatment had not been provided.

In an interview with the Inspector, RN #121 identified that all care that was provided to residents was to be documented in the appropriate section of the resident's chart, indicating that the care was completed. They indicated if there was a blank space in a time slot on the eMAR that either the treatment was not provided, or the staff had not signed that it was completed. RN #121 also indicated that the expectation if the medication was not given the registered staff would document the appropriate code on the eMAR, as well as document a progress note indicating the change.

In an interview with Inspector #692, DOC indicated that staff were to ensure that they documented the care that they completed in the appropriate section of the resident's chart. Together, the Inspector and the DOC reviewed resident #002's eMAR for the identified months. The DOC indicated to the Inspector that the eMAR should not have been blank, as the registered staff were to sign that they completed the treatment. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the provision of the care set out in the plan of care is documented and to ensure that the Substitute Decision Maker (SDM), been provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Neglect within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was submitted to the Director, related to not being informed of the health status change of resident #003.

During an interview with the complainant, they indicated that when they visited resident #003 on an identified date, they found resident #003 to have no eye contact and be non-verbal towards them. The complainant indicated that PSW #107, had indicated to them, that they observed a health status change in resident #003 two days prior, and reported it to the nurse. The complainant further indicated that the home had not informed them of any concern regarding this. Resident #003 had been transferred to the hospital.

During an interview with PSW's #107 and #119, they indicated that they frequently provided care to resident #003. The PSW's indicated that when they went in to provide care to resident #003 on the identified date, they observed the resident to be acting much differently than normal, and not able to safely transfer as usual. Prior to this day, the PSW's describe resident #003 as a late riser, able to be transferred with two staff members, no history of grabbing objects in the air, and enjoyed meals. The PSW's indicated that after they provided morning care to resident #003, they brought them out to the nursing station and reported to RPN #105 that they were concerned about the change in condition of resident #003.

PSW #119 indicated that the PSW's left resident #003 in the presence of RPN #105, and went to complete morning care for other residents. When PSW #107 and #119, next saw resident #003 it was in the dining room for am snack. The PSW's continued to be concerned about the health change in resident #003 when they observed them to have spilled their coffee on the floor, unable to feed themselves, and appeared to be chewing on their fingers. The PSW's approached RPN #105 a second time and explained the change in status and expressed their concern again that they need to assess resident #003. The PSW's further indicated that both times there was another Registered staff in the room that was completing other duties.

An interview with RN #108, indicated that they were in the nursing station completing Resident Assessment Instrument (RAI) assessments when the PSW's came in the first time and informed RPN #105, that they were concerned about resident #003's health status. The RN indicated that RPN #105 did not leave the nursing station to assess resident #003. The RN further indicated that after the second time the PSW's approached the RPN, approximately two hours after the first time, they requested that RPN #105 assess resident #003.

During an interview with RPN #105, they indicated that they had vaguely recalled PSW's #107 and #119, informing them of the concern with the change in health status related to resident #003. RPN #105 could not recall if they completed a head to toe assessment, or any other intervention to assess the health status change for resident #003. RPN #105 stated to the Inspector that they thought they were just having "an off day".

A record review of the progress notes on the day the change in health condition had first been recognized by the PSW's, and any relevant assessments that may have been completed or considered. The Inspector did not identify any documentation that would

indicate there was a change in condition with resident #003.

During staff interviews with PSW's #107, #117, #119, and RPN's #116 and #122, it had been communicated to the Inspector that staff use a communication tool titled "unit daily record". The staff further indicated that this tool is for staff to pass on information from shift to shift for resident changes or things to monitor. There had been no documentation from RPN #105 that would indicate to the following shift, that resident #003 should be monitored. Inspector #647 reviewed this document from identified dates. The unit daily record sheets indicated that on the second day of the health status change, resident #003 was noted to be very confused, and on the day the resident was transferred to the hospital, they were acting much differently.

In an interview with the DOC, they indicated that they completed an investigation that included reviewing the surveillance video of the day and home area. The DOC indicated that the video confirmed that the PSW's informed RPN #105 on two occasions on the first day that resident #003 had a significant change in their health status. The video indicated that after the second time, the RPN walked out of the nursing station, approached resident #003 and asked the resident to grab the RPN's hands. After this task was completed, the RPN returned to the nursing station. The DOC indicated that after the investigation had concluded, RPN #105 had received a discipline for not assessing resident #003 when it was reported to them twice on the identified date, that the resident had a change in health status. [s. 19. (1)]

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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

Issued on this 20th day of September, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 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) :	JENNIFER BROWN (647), SHANNON RUSSELL (692)
Inspection No. / No de l'inspection :	2019_565647_0021
Log No. / No de registre :	031501-18, 002020-19, 015692-19, 015824-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 18, 2019
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Bradford Valley Care Community 2656 6th Line, Bradford, ON, L3Z-2A1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy VanBeek

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

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

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 r. 50. (2)(b)(ii) of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee must
a) ensure that any resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

b) re-educate all Registered Staff on the identification of altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

c) re-educate all Registered Staff on the process of completing skin assessments.

d) maintain a copy of the education and training attendance records.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

A complaint was submitted to the Director, related to concerns of improper plan of care that resulted in a transfer to hospital and further led to an infection.

During an interview with the complainant, they indicated that resident #001 had been transferred to the hospital on an identified date, and diagnosed with an infection, and passed away in hospital 18 days later.

A record review of the hospital transcript notes titled "urgent consult", indicated that resident #001 had a breakdown in their skin integrity which look infected.

A record review of the progress notes from the identified period of time, did not identify any concerns related to an infection to the area until the day resident #001 was transferred to the hospital. On the same day, as the resident was transferred to the hospital, there had been documentation that indicated altered

skin integrity, and resident had been more confused and lethargic recently.

During an interview with Personal Support Worker (PSW) #117, they indicated that they frequently provided care to resident #001. PSW #117 had been unable to confirm the exact date, however, did indicate to the Inspector that approximately one week or one and a half weeks prior to the hospital transfer, that they had observed resident's altered skin integrity to the identified area. PSW #117 indicated that they reported this to Registered Practical Nurse (RPN) #122.

During an interview with RPN #122, they indicated that they had recalled PSW #117 informing them of the concern with resident #001's skin integrity. When Inspector #647 asked RPN #122 what actions they took following this report, RPN #122 indicated that they went into the hallway and looked at resident #001's specified area, however did not feel it was necessary to do any assessment or documentation.

During staff interviews with PSW's #107, #117, #119, and RPN's #116 and #122, it had been communicated to the Inspector that staff use a communication tool titled "unit daily record". The staff further indicated that this tool is for staff to pass on information from shift to shift for resident changes or things to monitor. Inspector #647 reviewed this document from the applicable time frame. The unit daily record sheets did not indicate that any altered skin integrity on resident #001 had been identified. There was an entry on an identified date, that indicated resident #001 had sustained a scratch, however when reviewed, this was not entered on any other unit daily record sheets for follow up or to monitor. Resident #001 reappeared on the unit daily record sheets on another identified date, when staff documented that they had identified a change in health status, then again when resident was transferred to the hospital.

A further record review included the resident specific assessments for the identified time frame. The Inspector was unable to locate any skin assessments that related to the identification of the impaired skin integrity.

In an interview with the Director of Care (DOC), they indicated that the home had not provided immediate intervention after the PSW first reported to RPN #122.

The severity of this issue was determined to be a level three, as there was actual harm or actual risk of harm. The scope of the issue was a level one, as this had been isolated. The home had a level two compliance history, as they did have previous non-compliance to a different subsection of the LTCHA. (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 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 18th day of September, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Brown

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