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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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 30, 2019	2018_543561_0019	003554-17, 004647-18, 013926-18, 028391-18	Critical Incident System

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Wellington Park Care Centre
802 Hager Avenue BURLINGTON ON L7S 1X2

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

DARIA TRZOS (561), DIANNE BARSEVICH (581)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 29, 30, 2018, December 3, 5, 6, 7, 11, 12 and 13, 2018.

A Follow Up inspection, log number 002739-18, was conducted concurrently with this Critical Incident System (CIS) Inspection.

Complaint Inspections were conducted concurrently with this CIS inspection with the following log numbers:
029425-17 - related to reporting and complaints, environmental services, and plan of care,
012406-18, 018450-18 - related to alleged neglect and wound care.

PLEASE NOTE: Non compliance related to s. 19(1) of the LTCHA, identified during a complaint inspection number 2018_543561_0020, log numbers 012406-18, 018450 -18, is included in this report and issued as a Compliance Order (CO).

During the course of the inspection, the inspector(s) spoke with the Administrator, Clinical Director of Nursing (CDON), Social Services Worker (SSW), Environmental Services Manager (ESM), Registered Dietitian (RD), Behavioural Supports Ontario (BSO) Nurse, registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

During the course of the inspection, the inspectors toured the home, observed the provision of care, reviewed relevant documents including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

5 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 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 :

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

The Long Term Care Homes Act, 2007, O. Reg. 79/10, defines abuse and includes the different types of abuse.

A) A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2017, related to resident to resident abuse causing harm.

The clinical record review indicated that on an identified date in 2017, resident #014 had an altercation with resident #015. After monitoring of resident #015 there was no sign of injury. On an identified date in 2017, a test showed an injury to resident #015.

PSW #118 who witnessed the incident was interviewed and indicated that they observed an incident involving resident #014 and resident #015 that caused an injury. Both residents were monitored and the home took action.

The interview with the Clinical Director of Nursing (CDON) indicated that the incident did occur; however, they were not in the role of the CDON at the time and could not provide details of the incident.
Both residents no longer resided in the home. No further incidents between these two residents were documented.

B) A CIS report was submitted to the Director on an identified date in 2018, related to an incident involving resident #003 and resident #004 that caused an injury to resident #004.

The clinical record review indicated that on an identified date in 2018, that there was an incident involving resident #003 and resident #004 that caused an injury to resident #004.
The clinical record review also indicated that there was a previous incident in 2018, involving the two residents; no injury was documented after the incident.

The plan of care at the time of the incident for resident #003 was reviewed and indicated that resident #003 required an intervention to be in place to minimize the risk to others.

Interview with registered staff #107 indicated that during the incident on an identified date in 2018 the intervention was not in place.

CDON was interviewed and indicated that the plan of care for resident #003 stated that resident #003 required the identified intervention; however, it was not in place on the day of the incident.

The home failed to ensure that resident #004 was protected from abuse by another resident in the home.

C) A CIS report was submitted to the Director on an identified date in 2018, related to resident to resident abuse causing harm to a resident.

The clinical record review indicated that on an identified date in 2018, resident #012 had an altercation with resident #011 causing injury to resident #012. A similar incident occurred between resident #011 and resident #014 on an identified date in 2018. There was no injury sustained from this incident.

PSW #116 and #117 who witnessed the incident were interviewed and indicated that they were not able to intervene in time.

The CDON was interviewed and acknowledged that the incidents occurred which caused an injury to resident #012.

D) Clinical record review identified several incidents between resident #011 and resident #013 in 2018. Clinical record review identified that there was history of altercations with resident #013 in 2017. The home had completed an assessment for the two residents in 2017. The clinical record review also identified that resident #013's Substitute Decision Maker (SDM) was not in agreement with the interactions. The written plan of care was

reviewed and did not identify the incident or interventions to ensure that the staff protected resident #013 from abuse.

PSW #117 and PSW #116 were interviewed and were aware of the incidents.

RPN # 119 was interviewed and was aware of the incidents and interventions in place.

The interview with the BSO Nurse indicated that they were not aware of the assessment completed by the home in 2017. The interventions to prevent these incidents from occurring were developed in 2018.

The interview with the CDON indicated that the home had completed an assessment in 2017, for both residents. The CDON was aware that the SDM of resident #011 was not in agreement. The CDON stated that they were aware of the incidents that occurred in 2018.

The licensee failed to ensure that resident #013 was protected from abuse by resident #011.

E) A complaint and a CIS report were received by the Director related to improper/incompetent treatment of resident #002 that resulted in harm.

Clinical records review identified that resident #002 was admitted to the home on an identified date in 2018, with a health condition. The initial physiotherapy assessment identified goals of treatment.

The Local Health Integration Network (LHIN) admission assessments indicated that resident #002 had a treatment. The Physical Examination Medical Assessment completed by the home's physician on an identified date in 2018, indicated that the resident required treatment.

The admission head to toe assessment did not provide a description of the full assessment of the skin. When registered staff #105 who admitted the resident was interviewed, they indicated that the resident did not have the specified condition requiring treatment.

The clinical record review indicated that resident #002 went out for an appointment at a clinic after admission where there was a change in treatment. There was another

appointment several weeks later it was identified that the treatment was not completed at the home during the time period between the two appointments. There were no assessments completed between the admission and the appointments.

The home failed to follow up with the clinic when resident #002 returned from the appointment, and orders were not obtained for treatment and were not initiated. The resident's altered skin integrity was not assessed, monitored and no treatment was provided. The resident's skin condition deteriorated and required further treatment. The weekly skin assessments were not completed since admission to the home and the resident did not receive treatment for the wound after the initial appointment at the clinic.

The interview with resident #002's SDM, indicated that staff at the clinic reported that no treatment was done to the identified condition between the two appointments resident had at the clinic. Resident #002 was on several treatments for the deteriorated condition prior to their discharge from the home. The identified condition did not heal prior to discharge. The SDM also stated that resident #002 was not able to fully recover from what had happened in the home.

The investigation notes and the interview with the CDON confirmed that resident #002's condition was not assessed between the arrival at the home until the second appointment at the clinic. The home did not follow up with the clinic when the resident returned from the first appointment. Clinical records on an identified date in 2018 indicated that the treatment was not provided to the resident's condition. The investigation notes and the interview with the CDON indicated that the home put a plan in place to prevent such incidents.

The home failed to ensure that resident #002 was protected from neglect by anyone. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A CIS report was submitted to the Director on an identified date in 2018, related to abuse. The CIS report indicated that resident #003 had an incident with resident #004, that caused an injury to resident #004.

The plan of care for resident #003 stated that they were required to have an intervention in place.
The clinical record review indicated that the intervention was not in place during the incident on the identified day.

The interview with registered staff #107 indicated that on the day of the incident the intervention was not in place.

The CDON was interviewed and stated that resident #003 required an intervention; however, it was not in place on the day of the incident.
The CDON further stated that after the incident, the home initiated an intervention and it was not in place on specified occasions in March 2018 and April 2018.

The Administrator was interviewed and acknowledged the identified intervention was not provided as specified in the plan.

The home failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under the Act.

Clinical record review identified several incidents related to resident #011 having an incident with resident #013 in 2018. Clinical record review identified that there was a history with this behaviour towards resident #013 in 2017. The home had completed an assessment for the two residents in 2017. The clinical record review also identified that resident #013's SDM was not in agreement with the interactions. The management staff and the registered staff were informed of the assessment that was completed in 2017.

PSW #117 and PSW #116 were interviewed and were aware of the incidents.

RPN # 119 was interviewed and was aware of the incidents and interventions in place.

The interview with the CDON indicated that the home had completed an assessment in 2017, for both residents. The CDON was aware that the SDM of resident #011 was not in agreement. The CDON stated that they were aware of the incidents that occurred in 2018.
The CDON acknowledged that they were aware of the incidents that occurred in 2018 and did not to report them to the Director.

The home's policy titled "Abuse and Neglect", Index I.D: RCS P-10, reviewed date February 2018, stated that any person who has reasonable grounds to suspect that any of the following had occurred, or may occur, shall immediately report the suspicion to the Director of Long Term Care Homes:
b. abuse of a resident by anyone, that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that the alleged abuse of resident #013 by resident #011 was reported to the Director. [s. 24. (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 person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under the Act, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours.

Clinical record review identified several incidents between resident #011 and resident #013 in 2018. It also identified that there was a history with this behaviour in 2017.

The home had completed an assessment for the two residents in 2017. The clinical record review also identified that resident #013's SDM was not in agreement related to the incidents. The management staff and the registered staff were informed of the assessment that was completed in 2017.

The interview with the CDON indicated that the home had completed an assessment in 2017, for both residents.

The plan of care was reviewed and identified that no strategies were developed to ensure that resident #013 was protected from resident #011 since 2017. The BSO nurse was interviewed and stated that they were not aware of the assessment that was completed. They had only implemented interventions for this behaviour on an identified date in 2018.

The licensee failed to ensure that strategies were developed and implemented to respond to resident #011's identified behaviour. [s. 53. (4) (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 strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) Resident #003 had a plan of care indicating they were to be monitored an identified behaviour was to be documented using Dementia Observation System (DOS) record, which the home referred to as Resident Observation Record. Three months in 2018, were reviewed by LTCH Inspector #561. The record review identified that 14 days during the three month period reviewed the behaviour was not recorded on identified shifts.

B) Resident #011 had a plan of care indicating they were to be monitored and a behaviour documented using DOS in identified months in 2018. The record review identified that 35 days in the period reviewed there was no DOS documentation completed between identified hours.

Registered staff #107 was interviewed and indicated that the home used the DOS tool to document residents' behaviour after any new behaviour observed or an escalation of a responsive behaviour.

The CDON was interviewed and confirmed that the behaviour monitoring using the DOS form was to be documented on paper and acknowledged that it was not always completed.

The licensee failed to ensure that residents' responses to interventions under the responsive behaviour program were documented. [s. 30. (2)]

Issued on this 7th day of February, 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

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

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) :	DARIA TRZOS (561), DIANNE BARSEVICH (581)
Inspection No. / No de l'inspection :	2018_543561_0019
Log No. / No de registre :	003554-17, 004647-18, 013926-18, 028391-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 30, 2019
Licensee / Titulaire de permis :	Rykka Care Centres LP 3760 14th Avenue, Suite 402, MARKHAM, ON, L3R-3T7
LTC Home / Foyer de SLD :	Wellington Park Care Centre 802 Hager Avenue, BURLINGTON, ON, L7S-1X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Charlotte Nevills

To Rykka Care Centres 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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19 of the Long Term Care Homes Act, 2007.

The licensee shall prepare, submit and implement a plan to ensure that:

1. Resident #004, resident #013 and any other resident in the home are protected from abuse.
2. All residents are not neglected by the licensee or staff.

The plan must include, but is not limited, to the following:

i. a description of an ongoing auditing process to ensure that any resident requiring care of altered skin integrity receive appropriate assessments and interventions.
ii. who will be responsible for the audits and evaluating the results.
iii. how the audits will be documented.

Please submit the written plan, quoting log number 2018_543561_001 and Inspector, Daria Trzos, by email to HamiltonSAO.moh@ontario.ca by February 18, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from physical abuse by anyone.

The Long Term Care Homes Act, 2007, O. Reg. 79/10, defines abuse and includes the different types of abuse.

A) A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2017, related to resident to resident abuse causing harm.

The clinical record review indicated that on an identified date in 2017, resident #014 had an altercation with resident #015. After monitoring of resident #015 there was no sign of injury. On an identified date in 2017, a test showed an injury to resident #015.

PSW #118 who witnessed the incident was interviewed and indicated that they observed an incident involving resident #014 and resident #015 that caused an injury. Both residents were monitored and the home took action.

The interview with the Clinical Director of Nursing (CDON) indicated that the incident did occur; however, they were not in the role of the CDON at the time and could not provide details of the incident.
Both residents no longer resided in the home. No further incidents between these two residents were documented.

B) A CIS report was submitted to the Director on an identified date in 2018, related to an incident involving resident #003 and resident #004 that caused an injury to resident #004.

The clinical record review indicated that on an identified date in 2018, there was an incident involving resident #003 and resident #004 that caused an injury to resident #004.
The clinical record review also indicated that there was a previous incident in 2018, involving the two residents; no injury was documented after the incident.

The plan of care at the time of the incident for resident #003 was reviewed and indicated that resident #003 required an intervention to be in place to minimize the risk to others.

Interview with registered staff #107 indicated that during the incident on an identified date in 2018 the intervention was not in place.

CDON was interviewed and indicated that the plan of care for resident #003

stated that resident #003 required the identified intervention; however, it was not in place on the day of the incident.

The home failed to ensure that resident #004 was protected from abuse by another resident in the home.

C) A CIS report was submitted to the Director on an identified date in 2018, related to resident to resident abuse causing harm to a resident.

The clinical record review indicated that on an identified date in 2018, resident #012 had an altercation with resident #011 causing injury to resident #012. A similar incident occurred between resident #011 and resident #014 on an identified date in 2018. There was no injury sustained from this incident.

PSW #116 and #117 who witnessed the incident were interviewed and indicated that they were not able to intervene in time.

The CDON was interviewed and acknowledged that the incidents occurred which caused an injury to resident #012.

The licensee failed to ensure that resident #012 was protected from abuse by anyone. (561)

2. The licensee failed to ensure that residents were protected from abuse by anyone.

The Long Term Care Homes Act, 2007, O. Reg. 79/10, defines abuse and includes the different types of abuse.

Clinical record review identified several incidents between resident #011 and resident #013 in 2018. Clinical record review identified that there was history of altercations with resident #013 in 2017. The home had completed an assessment for the two residents in 2017. The clinical record review also identified that resident #013's Substitute Decision Maker (SDM) was not in agreement with the interactions. The written plan of care was reviewed and did not identify the incident or interventions to ensure that the staff protected resident #013 from abuse.

PSW #117 and PSW #116 were interviewed and were aware of the incidents. RPN # 119 was interviewed and was aware of the incidents and interventions in place.

The interview with the BSO Nurse indicated that they were not aware of the assessment completed by the home in 2017. The interventions to prevent these incidents from occurring where developed in 2018.

The interview with the CDON indicated that the home had completed an assessment in 2017, for both residents. The CDON was aware that the SDM of resident #011 was not in agreement. The CDON stated that they were aware of the incidents that occurred in 2018.

The licensee failed to ensure that resident #013 was protected from abuse by resident #011. (561)

3. The licensee failed to ensure that residents were protected from neglect by anyone.

This non-compliance was identified during Complaint Inspection log #018450-18.

The long term Care Homes Act, 2007, O. Reg. 79/10, defines neglect 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 pattern of inaction that jeopardizes the health, safety or well-being or one or more residents.

A complaint and a CIS report were received by the Director related to improper/incompetent treatment of resident #002 that resulted in harm.

Clinical records review identified that resident #002 was admitted to the home on an identified date in 2018, with a health condition. The initial physiotherapy assessment identified goals of treatment.

The Local Health Integration Network (LHIN) admission assessments indicated

that resident #002 had a treatment. The Physical Examination Medical Assessment completed by the home's physician on an identified date in 2018, indicated that the resident required treatment.

The admission head to toe assessment did not provide a description of the full assessment of the skin. When registered staff #105 who admitted the resident was interviewed, they indicated that the resident did not have the specified condition requiring treatment.

The clinical record review indicated that resident #002 went out for an appointment at a clinic after admission where there was a change in treatment. There was another appointment several weeks later it was identified that the treatment was not completed at the home during the time period between the two appointments. There were no assessments completed between the admission and the appointments.

The home failed to follow up with the clinic when resident #002 returned from the appointment, and orders were not obtained for treatment and were not initiated.
The resident's altered skin integrity was not assessed, monitored and no treatment was provided. The resident's skin condition deteriorated and required further treatment. The weekly skin assessments were not completed since admission to the home and the resident did not receive treatment for the wound after the initial appointment at the clinic.

The interview with resident #002's SDM, indicated that staff at the clinic reported that no treatment was done to the identified condition between the two appointments resident had at the clinic. Resident #002 was on several treatments for the deteriorated condition prior to their discharge from the home. The identified condition did not heal prior to discharge. The SDM also stated that resident #002 was not able to fully recover from what had happened in the home.

The investigation notes and the interview with the CDON confirmed that resident #002's condition was not assessed between the arrival at the home until the second appointment at the clinic. The home did not follow up with the clinic when the resident returned from the first appointment. Clinical records on an

identified date in 2018 indicated that the treatment was not provided to the resident's condition. The investigation notes and the interview with the CDON indicated that the home put a plan in place to prevent such incidents.

The home failed to ensure that resident #002 was protected from neglect by anyone.

The severity of this issue was determined to be a level 3 as there was actual harm to residents. The scope of the issue was a level 3 (widespread), as it related to five residents out of five reviewed. The home had a level 3 history as they had one or more related non compliance with the legislation in the last 36 months issued as a Voluntary Plan of Correction (VPC) on April 27, 2016 (2016_240506_0006). (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 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 30th day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

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