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

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Amended Public Report (A2)

Report Issue Date November 17, 2022
Inspection Number [2022_1342_0001]
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
AXR Operating (National) LP, by its general partners, c/o Revera Long Term Care Inc.

Long-Term Care Home and City
Burloak LTC, Burlington

Lead Inspector
Daria Trzos (561)

Inspector Digital Signature
Daria Trzos Digitally signed by Daria Trzos Date: 2023.01.09 12:30:35 -05'00'

Additional Inspector(s)
Kelly Hayes (583), Olive Mameza Nenzeko (C205)

AMENDED INSPECTION REPORT SUMMARY

This public inspection report has been revised to reflect a change to Compliance Order (CO) #02 and CO #03 due dates from December 30, 2022 to January 27, 2023. The Complaint, Critical Incident System, and Follow-Up inspection #2022_1342_0001 was completed on September 1, 2, 6-9, 12-14, 16, 2022, October 3-7, 11-14, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 1, 2, 6-9, 12-14, 16, 2022, October 3-7, 11-14, 2022

The following intake(s) were inspected:

- Log #007913-22 Follow-up (FU) to compliance order (CO) #001, issued on May 6, 2022, under inspection #2022_868561_0001 related to LTCHA, s. 6(7) with the compliance due date of August 18, 2022.
- Log #007914-22 FU to CO #002, issued on May 6, 2022, under inspection #2022_868561_0001 related to LTCHA, s. 19(1) with the compliance due date of August 18, 2022
- Log #007915-22 FU to CO #003, issued on May 6, 2022, under inspection #2022_868561_0001 related to O. Reg. 79/10, s. 9(2) with the compliance due date of August 18, 2022

- Log #008678-22 (Complaint) related to falls, wound management, staffing, IPAC, housekeeping
- Log #008058-22 (Critical Incident [CI] 2857-000012-22) related to falls management which was also part of the complaint log #008678-22
- Log #017965-22 (Complaint) related to wound management and personal hygiene
- Log #011095-22 and #015431-22 (Complaints) related to neglect and management of a health condition
- Log #010622-22 (CI 2857-000013-22) related to a health condition incident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s. 6 (7)	2022_868561_0001	001	Daria Trzos (561)
LTCHA, 2007	s. 19 (1)	2022_868561_0001	002	Daria Trzos (561)
O. Reg. 79/10	s. 9 (2)	2022_868561_0001	003	Daria Trzos (561)

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Safe and Secure Home
- Skin and Wound Prevention and Management
- Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION [IPAC]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102(2)(b)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, issued by the Director with respect to infection prevention and control was complied with.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes, dated April 2022, section 9.1 states that

the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. One of the minimum routine practices that shall be included is proper use of PPE, including appropriate selection, application, removal, and disposal.

The home was declared to be in COVID outbreak on a home area by Public Health. All residents were placed on isolation and each resident had a droplet precautions signage on their door. Inspector made observations on the affected home area and identified the following:

i. observed registered staff administering medications to residents, and they failed to disinfect the face shield when exiting each resident room.

ii. observed a PSW feeding a resident and was not wearing gloves. The PSW also failed to disinfect the face shield when they exited the resident's room.

iii. observed a PSW feeding another resident and was not wearing gloves.

iv. observed a PSW entering a resident's room and failed to disinfect the face shield after exiting their room.

Interview with registered staff confirmed that the expectation was to wear gloves when feeding a resident on droplet precautions and that the face shields were needed to be disinfected after exiting a room with residents on droplet precautions. DOC confirmed that gloves needed to be worn when feeding a resident on droplet precautions.

ED and DOC contacted the IPAC Hub and they confirmed that best practice was to disinfect the face shields after each interaction with a resident on droplet precautions.

Sources: observations; Routine Practices and Additional Precautions policy (March 31, 2022); interviews with staff.
[561]

WRITTEN NOTIFICATION [PASD-INCLUSION IN THE PLAN OF CARE]

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 36(4)4.

The licensee has failed to ensure that the use of a personal assistance services device (PASD) under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if the use of the PASD had been consented to by the resident or their substitute decision maker (SDM).

Rationale and Summary

A resident had a fall and sustained an injury for which they were sent to the hospital for further assessment. PSW staff performed a transfer and applied a PASD. The resident's SDM had removed the consent to apply this PASD. The plan of care was not updated to indicate that the resident was no longer to use the PASD.

Sources: CI; resident's plan of care, Personal Assistance Services Device (PASD) policy (March 31, 2022); interviews with staff.
[561]

WRITTEN NOTIFICATION [INTEGRATION OF ASSESSMENTS]

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s 6(4)(a)

The licensee has failed to ensure the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and consistent with each other related to wounds.

Rationale and Summary
A resident's written plan of care and assessments indicated that the resident had an altered skin integrity. The minimum data set (MDS) quarterly assessment and the resident assessment protocol (RAP) indicated that the resident did not have any altered skin integrity. The ADOC confirmed that the MDS quarterly assessment and the RAP was not consistent with the written plan of care and other assessments.

Sources: resident's plan of care including MDS/RAP; interview with ADOC.
[561]

WRITTEN NOTIFICATION [SDM AND PLAN OF CARE]

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6(5)

The licensee has failed to ensure that a resident's substitute decision-maker, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
A complaint was received after a resident was admitted to hospital with a significant change in their medical condition.

The SDM was notified the resident had a change in condition and of a new treatment. The SDM shared they were not aware of the resident's offer to be tested for a new onset of another medical condition and further deterioration of their condition.

The SDM felt they were not given an opportunity to fully participate in the resident's plan of care when their medical condition changed, and more support was required.

Sources: resident's plan of care; interview with SDM and staff.
[583]

WRITTEN NOTIFICATION [REVISION OF PLAN OF CARE]

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6(10)(b)

1. The licensee has failed to ensure that the plan of care for a resident was reviewed and revised when the resident's care needs changed related to fall interventions.

Rationale and Summary
A resident had a fall and sustained an injury. An identified intervention was not in place. Physiotherapist (PT) assessment indicated that this specific intervention should have been in place as it was recommended by PT. The plan of care was reviewed and did not have this intervention listed as one that was being used. The PT and the DOC stated that any recommendations made by PT was to be implemented and the care plan should have been revised to include it as an intervention for falls.

Not revising the plan of care and implementing interventions may have placed the resident at an increased risk. It may have delayed staff response to the fall.

Sources: resident's plan of care; interviews with staff.
[561]

2. The licensee has failed to ensure that when a resident was reassessed, the plan of care was revised when the resident's care needs changed, or care set out in the plan was no longer necessary.

Rationale and Summary
The home had a process in place for altered skin integrity.
The plan of care for a resident indicated that the resident had an altered skin integrity and had a significant change in the condition of the wound. New treatment was obtained and the resident was to be reassessed after a specified time. There was no evidence indicating that this had occurred.

When the plan of care was not reviewed and revised there was an increased risk for the resident's wound to deteriorate.

Sources: resident's plan of care; New Skin Impairment/New wound Assessment policy (reviewed March 31, 2022, last modified March 1, 2021); interviews with staff.

[561]

WRITTEN NOTIFICATION [MAINTENANCE]

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 19(2)(c)

The licensee has failed to ensure that the home and furnishings were maintained in a good state of repair, specifically in the serveries.

Rationale and Summary
The following disrepair was observed:

Brant Servery:
Floor lifting and split in multiple areas, wall damage to corners and above base trim, cabinetry laminate peeling and cracked, missing cabinet doors and countertop around small sink below window was soft when pressed, and indication that the wood support under the laminate was wet. The counter laminate was also split, allowing water to seep into the wood underneath.

Stephenson Servery:
Casement style window was covered in plastic and sealed partially by tape. The window was observed to be open about two inches and a large amount of debris had entered from the outside where an active construction site was located.

All serveries in the resident home areas, except Triller, were noted to have significant disrepair to the flooring and cabinetry and contained equipment that was no longer in use. The management team at the home were aware and identified they needed renovation.

Sources: observations, interviews with the ED, maintenance department and other staff.
[583]

WRITTEN NOTIFICATION [HYPOGLYCEMIA DIRECTIVE]

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 174.1(3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

Rationale and Summary
The Directive revised April 2022, indicated the licensee was required to ensure that,

A) All uses of a specific medication in the Directive and incidents of a medical condition were required to be reviewed and analyzed; corrective action is taken as necessary; and a written record is kept of everything.

A resident had the specified medical condition that required treatment with a medication. The home documented immediate actions taken to assess and maintain the resident's health and reported the incident.
Inspector requested the home's documented record of the review/analysis and corrective action taken related to the incident. The management team shared they did not have this record and no concerns were found related to the incident.

During the inspection it was determined the home's procedure for the management of this condition and doctor's orders were not followed and that the order for this medication had been discontinued in error from the electronic Medication Administration Record (MAR), causing additional delay in the resident receiving the treatment.

The incident was not reviewed and analyzed; corrective action was not taken as necessary; and a written record was not kept of everything.

B) An interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider meets at least quarterly to evaluate every written record (as noted above) to identify utilization trends and patterns and to identify any changes necessary to improve the use of the identified medication in the long-term care home in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's Professional/Advisory Committee minutes from their quarterly meeting in 2022, were reviewed and an interview was completed with the pharmacist who was in attendance. Records of the homes review/analysis and corrective action taken to guide further discussion was not presented to the committee.

The interdisciplinary team noted the incident occurred and that the resident was admitted to hospital but did not identify any changes necessary to improve the care and treatment of the identified medical condition and use of the medication in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Sources: resident's records; Professional Advisory Committee/Medical Advisory Committee meeting minute; critical incident report the home's procedure (reviewed March 31, 2022); interviews with staff.
[583]

WRITTEN NOTIFICATION [UNSAFE TRANSFER]

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 40

The licensee has failed to ensure that staff used safe transferring technique when they transferred a resident.

Rationale and Summary

The CI report submitted to the Director indicated that a resident fell and sustained an injury.

The resident was not transferred with the method as indicated in the plan of care. The PSW staff was not aware that the resident's transfer status had changed.

Failing to use safe transferring techniques may increase the risk of injury.

Sources: CI; resident's plan of care; interviews with staff.
[561]

WRITTEN NOTIFICATION [SKIN ASSESSMENT]

NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 50(2)(a)ii

The licensee has failed to ensure that a resident received an assessment by a member of the registered nursing staff when they returned from hospital.

Rationale and Summary

A resident was sent to the hospital and their records indicated that the resident had an altered skin integrity upon discharge. Upon return the resident was not assessed for skin and wound. Several days later the plan of care indicated that the resident's altered skin integrity had deteriorated.

If the comprehensive skin assessment was completed upon return from the hospital, the resident's wound might have been detected earlier and treated. This might have prevented further deterioration.

Sources: resident's plan of care; Prevention of Skin breakdown policy (reviewed March 31, 2022 and last modified March 9, 2020); interviews with staff.
[561]

WRITTEN NOTIFICATION [RD ASSESSMENT]

NC#10 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 55(2)(b)iii

The licensee has failed to ensure that, a resident exhibiting altered skin integrity, was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

Rationale and Summary

A resident had an altered skin integrity. The plan of care indicated the resident was also at a high nutritional risk. The referral was not sent to the registered dietitian (RD) to assess the resident. The home's policy and interview with registered staff confirmed that the process was to sent the referral to RD for any new and worsening wounds.
Failing to refer new and worsening wounds to RD may have increased the risk for wound deterioration.

Sources: resident's progress notes, skin and wound assessments, care plan, New Skin Impairment/New wound Assessment policy (reviewed March 31, 2022, last modified March 1, 2021); interview with staff.
[561]

WRITTEN NOTIFICATION [NUTRITION POLICY]

NC#11 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 74(2)(d)

The licensee has failed to comply with the system to monitor and evaluate the food intake of a resident.

Rationale and Summary

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration and that it is complied with.

Specifically, staff did not comply with the procedure "LTC – Food and Fluid Intake Monitoring", which was part of the home's Nutritional Care and Hydration Program. The procedure identified a referral was to be sent to the RD when a resident's recorded food intake was less than 50 Per cent (%) for three consecutive days and was a change in the resident's usual intake.

Multiple entries were documented by registered nursing staff that a resident ate less than 50% for three consecutive days and that this was a significant change in their intake. The resident was placed at risk when the system to monitor and evaluate food intake was not followed.

A referral was sent to the RD after the physician requested. Nutrition interventions were not put into place until six days later and the resident had lost a total of ten per cent of their body weight by that time.

Sources: LTC – Food and Fluid Intake Monitoring Procedure (dated March 31, 2022); resident's plan of care; interviews with staff.
[583]

WRITTEN NOTIFICATION [POLICY RELATED TO RD REFERRAL]

NC#12 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 74(2)(e)

The licensee has failed to comply with the procedures related to the nutritional care of a resident.

Rationale and Summary

In accordance with O. Reg 246/22 s. 11(1) (b), the licensee is required to ensure that there is a weight monitoring system to measure and record weights for all residents.

Specifically, staff did not comply with the procedure "LTC – Resident Nutritional Assessment" and "LTC – Weight and Height Monitoring", which was part of the home's Nutritional Care and Hydration Program. The procedures identified significant changes would be communicated in a referral to the RD and that significant weight changes included a weight loss of greater than or equal to 5% of total body weight over one month.

The RD saw a resident for weight loss but documented it as not significant and no interventions were put in place at that time. The following day resident was re-weighed per the physician's request. The weight was documented in the progress notes instead of the weight section; therefore, a significant weight loss alert was not triggered, and a referral was not sent to the RD.

Resident was placed at risk when the RD was unaware of resident's further weight loss that triggered a significant change.

A referral was sent to the RD after the physician requested. Nutrition interventions were not put into place until six days later and the resident had lost a total of ten per cent of their body weight by that time.

Sources: LTC – Resident Nutritional Assessment and Weight and Height Monitoring Procedure (dated March 31, 2022); resident's plan of care; interviews with staff.
[583]

WRITTEN NOTIFICATION [CLEANING SCHEDULES]

NC#13 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 78(7)(c)

The licensee has failed to ensure that the home had and that the staff of the home complied with the cleaning schedule for the serveries and dishwashing areas located on the serveries.

Rationale and Summary

The following cleanliness issues were observed:

Brant Servery:

Accumulated debris and stains were observed under the dishwasher, fridge and stove and in the cupboards and cabinet drawers (where food and dishes were located). Debris and dust was observed in the window and sill above the counter. Pest control records dated October 6, 2022, identified food debris accumulation in dining areas required cleaning to eliminate a food source for pest and noted organic matter under dishwasher in Brant servery required cleaning. Food debris and organic matter accumulation was noted to still be of concern by inspectors on October 13, 2022.

Stevenson Servery:

Casement style window was covered in plastic and sealed partially by tape. The window was observed to be open about two inches and a large amount of debris had entered from the outside where an active construction site was located.

All Serveries:

Food stains and debris was observed on the walls, ceiling tiles were stained, floors were stained around perimeter edges on all serveries except Triller.

The home had a cleaning checklist located on each servery which was being signed off daily by food service workers. The checklist did not include any scheduled cleaning for the walls, under fridge/stove, ceilings or windows in the servery. Staff identified some surfaces were difficult to clean due to the age of the materials and staff were not aware of any deep clean processes in place for the serveries. At the time of the inspection the home did not have a permanent Dietary Manager in place.

Sources: observations; cleaning schedule worksheets; Marquise Job Routine Dietary Aid 1-10; Area Equipment Cleaning Procedures (revised February 2022); interviews with the ED, Consulting Food Service Representative, and other staff.
[583]

WRITTEN NOTIFICATION [ANALYSIS OF AN INCIDENT]

NC#14 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 115(5)4 ii

The licensee has failed to ensure that the analysis and follow-up actions were completed after the home submitted a critical incident related to a resident sustaining an injury after a fall for which they were sent to hospital for further assessment.

Rationale and Summary

A CI report was submitted to the Director related to a fall of a resident with injury for which they were sent to the hospital for further assessment. During the inspection, Inspector asked for investigation notes related to the fall and the home did not have any documentation of the investigation notes as there were no concerns identified related to the management of the fall. The CI report did not include any analysis of the fall and any actions the home took to prevent recurrence. After reviewing the resident's records, inspector identified that the resident was unsafely transferred on the day of the fall, the PASD was used without the consent of the SDM, an intervention recommended by the PT was not implemented and the plan of care was not revised with the recommended intervention.

Not completing analysis and follow up into a critical incident such as this one, may increase the risk of recurrence.

Sources: CI; resident's plan of care; interviews with staff.
[561]

WRITTEN NOTIFICATION [MEDICATION MANAGEMENT SYSTEM]

NC#15 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 123(3)(a)

The licensee has failed to ensure that the written policies and procedures for the medication management system to ensure the accurate acquisition and administration of drugs were implemented.

Rationale and Summary

A resident had a severe medical condition that required treatment with a medication.

At the time of the incident the resident had an order for a medication, but it had been removed from the eMAR in error back in 2020. At the time of the incident the registered nursing staff were unaware the resident had an order for the medication and spent time phoning the physician and SDM for a new order delaying the time it took for the resident to be administered the medication.

In an interview with the pharmacist and upon review of the home's medication policies it was identified that the discrepancy between quarterly paper prescribers order review and the eMAR should have been identified if they were implemented correctly during the reviews completed between 2020 and 2022. The medication was most recently ordered to be continued by the physician.

Sources: Medication Management Policy (reviewed March 31, 2022); Medication Review Policy (reviewed March 31, 2022); resident's records; interviews with staff.
[583]

COMPLIANCE ORDER [CO#01] [NEGLECT]

NC#01 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 24(1)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021, s. 24(1)

The licensee shall ensure that no resident is neglected by the licensee or staff in the home.

Specifically, the licensee shall:

1. Ensure that an interdisciplinary team, meet to identify any changes necessary to improve the use of an identified medication and the care and treatment of severe medical condition in the home in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. Keep a record of the date of the meeting, who attended and any changes that are implemented.
2. Ensure any policies or guidance documents related to the use of the medication and treatment of the medical condition are reviewed and revised to reflect any changes that are implemented.
3. Educate registered nursing staff on the policies and related guidance documents and maintain an attendance record. Document the education provided including the date and staff member who provided the education.
4. Complete an audit of all residents in the home who are receiving interventions to manage their medical condition to ensure that written orders correlate with eMAR. Document any trends, patterns or changes that were made.
5. Review and revise any guidance documents related to communication with the SDM, to ensure that when required the SDM has been provided an opportunity to participate fully in the development and implementation of the resident's plan of care. Share with all regulated health professionals in the home and maintain a record of who received the information.

Grounds

The licensee has failed to ensure that a resident was protected from neglect.

Section 7, of the Ontario Regulation 246/22, 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 a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary

A) The home's management of an identified medical condition algorithm directed staff to provide an intervention if a resident had symptoms of the condition.

The resident was found with symptoms with an identified condition and the registered staff initiated an intervention that was not part of the algorithm as the one based on it was not available in the medication cart. Nurse in charge was also called to assess the resident and their condition deteriorated. The resident did not tolerate the intervention given and their condition further deteriorated. The identified medication for the medical condition was not tried initially and the registered staff were not aware there was an order for this medication as it was discontinued from the eMAR in error.

Prior to this incident the resident had a decline and was awaiting a referral to a specialist. The resident was put at risk when staff did not initially administer the interventions for the medical condition as indicated in the algorithm.

The order for the medication had been discontinued from the eMAR in error and the error had not been identified during the home's quarterly medication reviews. Additional time was taken to phone the SDM and physician to get an order for the medication and to go off the unit to the emergency box prior to being administered to the resident. The resident was then transferred to hospital. The resident was put at risk when additional time was taken to order a drug that was already prescribed for the resident.

B) The physician ordered an intervention for the medical condition and to hold a medication based on parameters in the order. It was noted neither of the orders had been added to the electronic chart. Staff needed to monitor symptoms for the medical condition. Prior to the incident the resident showed symptoms of the condition and the medication was no held and the staff did not monitor for the symptoms. This happened on three different days. The resident was put at increased risk when the orders were not followed.

When the resident was transferred to hospital, they had a number of comorbidities identified and required a transfer to the intensive care unit. Prior to the incident there were significant changes in the resident's condition that the SDM and family were not unaware of. The SDM felt they were not given an opportunity to fully participate in the resident's plan of when more support was required.

A pattern of inaction was identified that put resident's health, safety and well being at risk.

Sources: resident's records; interviews with staff; Diabetes Management Policy (reviewed March 31, 2022); hospital health records.
[583]

This order must be complied with by December 30, 2022

COMPLIANCE ORDER [CO#02] [WOUND MANAGEMENT]

NC#02 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 55(2)(b)(ii)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (b) prepare, submit and implement a written plan for achieving compliance with a requirement under this Act.

Compliance Plan [*FLTCA, 2021, s. 155 (1) (b)*]

Specifically, the licensee shall prepare, submit and implement a plan to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

The plan must include but is not limited to:

1. How the home will ensure that residents on a home area, exhibiting altered skin integrity receives immediate treatment and interventions to promote healing and prevent infections.
2. The plan must include an auditing system to ensure point #1 is being completed. The home shall determine the type of auditing system and for how long it should be completed and by whom.
3. Training of registered staff including agency staff on the proper wound assessment process and proper administration of treatments for the wounds.
4. The home shall keep record of the audits and training, including the dates and names of staff that participated.

Please submit the written plan for achieving compliance for inspection [2022_1342_0001] to [Daria Trzos], LTC Homes Inspector, MLTC, by email to [HamiltonSAO.moh@ontario.ca] by November 23, 2022

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

Grounds

1.The licensee has failed to ensure a resident exhibiting altered skin integrity, received immediate treatment and interventions to promote healing, and prevent infection.

Rationale and Summary

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s.

50(2)(b)(ii) of the LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 55(2)(b)(ii) of the FLTCA.

i) A resident was admitted to the home with no evidence of altered skin integrity. Several weeks later, a progress note, and the skin and wound assessment indicated that the resident had an altered skin integrity. The picture included in the assessment showed an altered skin integrity not consistent with the description in the assessment. The registered staff confirmed that the staff did not classify the wound properly. There were no prior assessments of this wound and no treatment initiated prior to this date; however, the picture of the wound in the assessment appeared to be over a week old.

ii) The ADOC assessed resident's skin alteration and indicated that the resident's altered skin integrity deteriorated and had signs of infection. Tests were ordered and returned positive for an infection. There was no evidence indicating that any prior treatments or assessments were completed for the identified area of concern.
The altered skin integrity had also deteriorated two months later. The skin and wound assessment identified deterioration and signs of infection again. The resident was sent to the hospital as they required more vigorous treatment.

iii) A resident was sent to the hospital for treatment of a condition and the documentation from the visit identified an altered skin integrity on the day of readmission to the home. Upon return registered staff failed to complete a skin assessment and did not identify any concerns with the resident's skin. Few days later a new comprehensive skin and wound assessment indicated that the resident had an altered skin integrity with signs of deterioration. The ADOC assessed the resident and documented that the wound was deteriorating and required a treatment. The order was not obtained from the physician until several days later and caused a delay in initiation of treatment. The weekly wound assessments were not completed for the identified skin alteration for a period of several weeks. Subsequently, the altered skin integrity became infected which required further treatment.

Interviews with the registered staff indicated that the home did not have a wound care nurse in the home to oversee the complicated wounds prior to July 2022. The home also had staffing issues and many shifts were being covered with agency nurses. Treatments were not always completed and PSW staff did not always turn and reposition residents or change their briefs due to shortage of staff. The current wound care nurse was interviewed and stated that prior to their start in July 2022, there was no designated staff to oversee the wounds in the home. The staff did not always classify the wounds correctly. The home had a nurse practitioner; however, they were not utilizing them for wound care assessments. The outside resources were also not being utilized. Only once since this resident's admission the wound care nurse through Home and Community Care Support Services (HCCSS) was referred to; however, their recommendation was not used.

The DOC confirmed they had issues with the wound care program and there was no continuity of care when agency nursing staff were covering shifts at that time. In the month of April 2022,

the home had seven wound infections, five in the month of May and June 2022, three in the month of July 2022 and 10 wound infections in the month of August 2022.

Sources: resident's plan of care; home's wound care policies and procedures; interviews with staff.
[561]

2. The licensee has failed to ensure that, a resident exhibiting altered skin integrity, received immediate treatment and interventions to promote healing, and prevent infection.

Rationale and Summary
A resident had a history of altered skin integrity which have healed. The skin and wound assessment indicated that the resident had an altered skin integrity in different areas. There was no treatment initiated, RD referral was not sent, and the physician was not notified after the staff identified the altered skin integrity. On an identified date a skin and wound assessment identified a deterioration of the skin and treatment was initiated. Several days later there was further deterioration.
ADOC assessed the skin and identified that there was deterioration and a new treatment was initiated. Again, several days later there was even further deterioration and registered staff attempted to contact the physician with no success. ADOC was called to assess the resident's skin again and identified signs of infection. An order for treatment was obtained from the physician. Different courses of antibiotic treatment were tried as the infection was not healing.

Sources: resident's plan of care; New Skin Impairment/New wound Assessment policy (reviewed March 31, 2022, last modified March 1, 2021); interviews with staff.
[561]

This order must be complied with by January 27, 2023

COMPLIANCE ORDER [CO#03] [WEEKLY SKIN ASSESSMENTS]

NC#03 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 55(2)(b)(iv)

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]
The licensee has failed to comply with O. Reg. 246/22, s. 55(2)(b)(iv)

The licensee has failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff.

Specifically, the licensee must ensure that:

1. A resident's areas of altered skin integrity are reassessed weekly by a member of the registered nursing staff.
2. Complete a weekly audit of the resident to ensure that weekly skin assessments are completed, if clinically indicated. The audits are to be completed for a minimum of one month, or until all staff are compliant with the process.
3. Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings and any corrective actions taken.

Grounds

Non-compliance with: O. Reg. 246/22 s. 55(2)(b)(iv)

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 50(2)(b)(iv) of the LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 55(2)(b)(iv) of the FLTCA.

i) A resident was admitted to the home with no altered skin integrity. The resident was sent to the hospital for treatment of a condition and returned to the home that same day. The records from the visit identified that the resident had an altered skin integrity. No skin assessment was completed by registered staff upon return from hospital. Several weeks later a new comprehensive skin assessment identified that the resident had an altered skin integrity. There were no weekly skin assessments completed for several weeks in different months.

Registered staff and the DOC confirmed that weekly assessments were not always completed. The home also did not have a wound care nurse in the home to oversee the wound care program.

ii) A resident's plan of care also identified that the resident acquired an altered skin integrity in the home. There were no prior assessments of this altered skin integrity completed. Registered staff and the wound care nurse confirmed that this skin alteration must have developed at least over a week prior.

ADOC indicated that a resident had an altered skin integrity that was not new and showed signs of infection. The resident was sent to the hospital for more vigorous treatment for the infection. This altered skin integrity might have been incorrectly classified and therefore, weekly assessments might have been missed. The wound care nurse also stated that sometimes the staff did not know how to properly classify the wounds and use the app correctly.

Sources: resident's plan of care; New Skin Impairment/New wound Assessment policy (reviewed March 31, 2022, last modified March 1, 2021); interviews with staff.
[561]

This order must be complied with by January 27, 2023

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.