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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 29, 2017	2017_605213_0007	002943-17, 003266-17, 003331-17, 004743-17, 005232-17, 006220-17, 006363-17, 006365-17, 007872-17, 008435-17	Follow up

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE WOODSTOCK NURSING HOME
81 FYFE AVENUE WOODSTOCK ON N4S 8Y2

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

RHONDA KUKOLY (213), MARIAN MACDONALD (137), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 2017.

This follow up inspection was completed related to:

Order #001 issued January 25, 2017 with a compliance date of April 28, 2017 in

Inspection #2016_229213_0038 regarding care plan based on an interdisciplinary assessment of safety risks.
Order #002 issued January 25, 2017 with a compliance date of January 27, 2017 in Inspection #2016_229213_0038 regarding reporting abuse/neglect to the Director.
Order #001 issued January 25, 2017 with a compliance date of March 1, 2017 in Inspection #2016_303563_0042 regarding skin and wound assessments.
Order #002 issued January 25, 2017 with a compliance date of March 1, 2017 in Inspection #2016_303563_0042 regarding daily hygiene and grooming.
Order #003 issued January 25, 2017 with a compliance date of March 1, 2017 in Inspection #2016_303563_0042 regarding immediate investigation and appropriate actions for suspected abuse/neglect.
Order #004 issued January 25, 2017 with a compliance date of March 1, 2017 in Inspection #2016_303563_0042 regarding care plan clear direction, reviewed and revised when care needs change and staff access.
Log #006220-17, Critical Incident #2636-000022-17 regarding improper care for a resident.
Log #003331-17, Critical Incident #2636-000012-17 regarding improper care for a resident.
Log #003266-17, Critical Incident #2636-000011-17 regarding improper care for a resident.
Log #007872-17, Critical Incident #2636-000027-17 regarding alleged staff to resident abuse.
Log #002943-17, Critical Incident #2636-000010-17 regarding alleged staff to resident abuse.
Log #005232-17, Critical Incident #2636-000020-17 regarding alleged staff to resident abuse.
Log #008435-17, Critical Incident #2636-000029-17 regarding alleged staff to resident neglect.
Log #004669-17, Critical Incident #2636-000018-17 regarding resident to resident abuse.
Log #006646-17, Infoline #IL-50060-LO, Complaint regarding care concerns.
Follow up to Immediate Order #901 issued January 25, 2017 with a compliance date of January 27, 2017 in Inspection #2016_229213_0035 regarding medication administration.

This inspection was completed concurrently while in the home completing a complaint inspection #2017_605213_0008.

During the course of the inspection, the inspector(s) spoke with the Regional Manager, the Vice President of Operations for Caressant Care Nursing and Retirement Homes Limited, the Administrator, the Director of Care, a Resident Care Coordinator, a Pharmacist, an Occupational Therapist, the Retirement Home Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, a Scheduling Clerk, an Administrative Assistant, a Ward Clerk, residents and family members.

The Inspectors also made observations and reviewed health records, internal investigation records, complaint logs and documentation, meeting minutes, audits, education records, evaluations, policies and procedures and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2016_229213_0038	137
O.Reg 79/10 s. 26. (3)	CO #001	2016_229213_0038	213
O.Reg 79/10 s. 32.	CO #002	2016_303563_0042	155
LTCHA, 2007 S.O. 2007, c.8 s. 6.	CO #004	2016_303563_0042	155

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	Legendé 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,
(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; O. Reg. 79/10, s. 50 (2).
(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).
(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 O. Reg. 79/10, s. 50 (2).
(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).

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 comply with Compliance Order #003 issued in Inspection #2016_303563_0042 on January 25, 2017 with a compliance date of March 1, 2017.

Compliance Order #003, issued in Inspection #2016_303563_0042 on January 25, 2017 with a compliance date of March 1, 2017 stated:
“Specifically, the home will ensure that there is a process to:
• Educate all nursing staff related to the types of altered skin integrity, roles and responsibilities related to recognition, reporting, documentation, assessments and appropriate strategies.
• Educate all registered staff related to the process for completing a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and the process for completing a skin assessment when the home's software for skin assessments is inaccessible;
• Develop and implement a process for tracking staff education to ensure completion.
• Ensure that a written record related to the annual evaluation of the skin and wound care management program including the summary of changes made and the date those changes were implemented is completed.

The education records for the home for 2017 and the home’s skin and wound care management program evaluation were requested.

The Regional Manager (RM) provided the written Skin and Wound Care Management Program Evaluation for the period of January 1, 2016 to October 20, 2016. The date was initially dated October 20, 2016, but this date was crossed off with “completed: Jan 10, 2017” and initialed with the RM’s initials. In the area “summary of changes made over the past year with dates of change”, was written: “Assess residents on admission for improvements needed in seating, refer to OT, two air loss mattresses in January”. There were no dates indicated other than "January". In the area “Indicators to Review (over past year): TAR documentation and follow-up assessments”, was written: “assessments not always done as scheduled”. The “Areas for Improvement” included: “continue with OT referrals, continue with nutrition referrals”, there was no reference to improving assessments being done on time.

In an interview with the RM, they said that the evaluation had been started in 2016 and had not been completed, so they directed that it was completed in January and that was the reason for the date being changed. The RM agreed that the written record of the annual evaluation with the date of January 10, 2017 did not include dates that changes were made other than two air loss mattresses in January.

The RM provided a binder of education that included certificates of attendance. The certificate noted the staff name, attended the following in-services, TOPICS: Pixalere,

Wound Care, Abuse & Neglect, Mandatory Reporting, Medication Administration, DATE: February 22, 2017, PROVIDED BY: Corporate Educator, Caressant Care Nursing and Retirement Home Limited. No documentation or record of monitoring or tracking of education completion was provided to the Inspector. There was no certificate for an identified Registered Practical Nurse.

In an interview with the RM, they said that the expectation was that all registered staff attend a four hour education session that included wound care and Pixilere. The Regional Manager said that they did not have a monitoring or tracking tool, or a process for tracking staff education. The RM was not able to confirm if an identified RPN received the education related to wound care and Pixilere and said that they weren't sure why the RPN was missed.

In an interview with the RM and the Administrator, the RM stated that one of the Registered Nurses provided education related to skin and wound including observation, reporting and documentation for all personal support workers (PSWs). There was no documentation or record if the PSWs received the education or on what dates the education was received.

The licensee failed to comply with Compliance Order #003 issued in Inspection #2016_303563_0042 on January 25, 2017 with a compliance date of March 1, 2017 when no process tracking of staff education was developed or implemented, the home could not confirm the completion of education related to skin and wound care, and an annual evaluation of the skin and wound care management program did not include the summary of changes made and the date those changes were implemented. [s. 50. (2)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Compliance Order #001 was issued January 25, 2017 in inspection #2016_303563_0042 with a compliance date of March 1, 2017. The order stated that the licensee shall ensure that three identified residents, and all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, and is reassessed at least weekly by a member of the registered nursing

staff, if clinically indicated.

a) An Incident Note in Point Click Care (PCC) for a resident on an identified date stated that the resident suffered an injury and altered skin integrity as a result. The injury was observed by the Inspector and a PSW shared that they were aware of the resident's injury and subsequent altered skin integrity.

In an interview, a Resident Care Coordinator (RCC) said that when a resident has an area of altered skin integrity it should be assessed and the assessment completed in the Pixalere electronic documentation system. The area of altered skin integrity should also be entered in PCC in the Treatment Administration Record (TAR) which would create the schedule to remind staff when the assessments should be completed in Pixalere. If there is a treatment to be done to the area of altered skin integrity this should also be entered in PCC in the TAR. The RCC said that there was nothing documented in Pixalere or on the TAR in PCC related to the resident's altered skin integrity. The RCC shared that the altered skin integrity should have been assessed using Pixalere and documented on the TAR in PCC.

b) An Incident Note in PCC for another identified resident stated that this resident suffered an injury resulting in altered skin integrity and treatment was provided.

In an interview, an RCC shared that when a resident has an area of altered skin integrity it should be assessed and the assessment completed in the Pixalere electronic documentation system. The area of altered skin integrity should also be entered in PCC in the TAR which would create the schedule to remind staff when the assessments should be completed in Pixalere. If there is a treatment to be done to the area of altered skin integrity this should also be entered in PCC in the TAR. The RCC shared that there was nothing documented in Pixalere or on the TAR in PCC related to the area of altered skin integrity for the resident. The RCC shared that the altered skin integrity should have been assessed using Pixalere and documented on the TAR in PCC.

The Caressant Care Nursing & Retirement Homes Ltd., Policy and Procedure Subject: Wound Assessment dated July, 2016 stated, "All residents with skin and wound issues shall have these appropriately treated and assessed by the Registered Staff in conjunction with the Wound Care Champion and Managers in the home. Registered staff shall utilize the E-TAR (Electronic Treatment Administration Record) on Point Click Care and the Pixalere wound assessment program to document and assess wound treatments and wound progress. All residents with skin and wound issues shall have these areas

assessed by registered staff every 7 days".

The licensee failed to ensure that when two residents had altered skin integrity, skin assessments were completed by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that the 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 if clinically indicated.

Compliance Order #001 was issued January 25, 2017 in inspection #2016_303563_0042 with a compliance date of March 1, 2017. The order stated that the licensee shall ensure that three identified residents and all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

An Incident Note in PCC for an identified resident stated that this resident suffered an injury resulting in altered skin integrity and treatment was provided.

A review of the resident's progress notes for a one month time period was completed. There was no documentation to support that there was any further treatment or assessment done for the resident's area of altered skin integrity.

The resident's Treatment Administration Record (TAR) for the month time period was reviewed and there was no documentation to reflect that the altered skin integrity was reassessed weekly or any other treatment was provided since the injury occurred.

In an interview, a Resident Care Coordinator (RCC) shared that when a resident has an area of altered skin integrity it should be assessed and the assessment completed in the Pixalere electronic documentation system. The area of altered skin integrity should also be entered in Point Click Care (PCC) in the Treatment Administration Record (TAR) which would create the schedule to remind staff when the assessments should be completed in Pixalere. If there is a treatment to be done to the area of altered skin integrity this should also be entered in PCC in the TAR. The RCC shared that there was

nothing documented in Pixalere or on the TAR in PCC related to the resident's altered skin integrity. The RCC shared that the altered skin integrity should have been assessed using Pixalere and documented on the TAR in PCC.

Review of Caressant Care Nursing & Retirement Homes Ltd., Policy and Procedure Subject: Wound Assessment dated July, 2016 states that "All residents with skin and wound issues shall have these appropriately treated and assessed by the Registered Staff in conjunction with the Wound Care Champion and Managers in the home. Registered staff shall utilize the E-TAR (Electronic Treatment Administration Record) on Point Click Care and the Pixalere wound assessment program to document and assess wound treatments and wound progress. All residents with skin and wound issues shall have these areas assessed by registered staff every 7 days".

The licensee failed to ensure that a resident's area of altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff.

The severity of this non-compliance is minimum harm/potential for actual harm and the scope was a pattern. The home does have a history of non-compliance in this subsection of the legislation, it was issued as a Written Notification during the Resident Quality Inspection December 8, 2014 and August 30, 2016 and as Compliance Order January 25, 2017 in Inspection #2016_303563_0042 with a compliance date of March 1, 2017. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with Compliance Order #003, issued in Inspection #2016_303563_0042 on January 25, 2017 with a compliance date of March 1, 2017.

Compliance Order #003, issued in Inspection #2016_303563_0042 on January 25, 2017 with a compliance date of March 1, 2017 stated:
"Specifically, the licensee shall ensure that:
• All staff are educated on the written policy to promote zero tolerance of abuse and neglect of residents; including mandatory reporting, roles and responsibilities, the process for investigating abuse and neglect and the immediate and long term appropriate actions to be taken;
• The Administrator, the Director of Care, and all other management staff of the home are educated on the process for investigating abuse and neglect, roles and responsibilities, mandatory reporting, as well as immediate and long term appropriate actions to be taken;

• There is a process for monitoring and tracking staff education to ensure all processes are completed and implemented."

The education records for the home for 2017 were requested. The home provided a binder of quizzes and "Abuse & Neglect Staff Acknowledgement Sheets". The purpose of the Staff Acknowledgement Sheets was to confirm that the staff received the training and understood the content. Some of the quizzes and acknowledgment sheets had staff names and dates, some had just a name and no date and some were blank. Some staff had a quiz completed and no acknowledgement sheet. There was not a quiz and staff acknowledgement sheet for every Personal Support Worker indicating that education was completed or when it was completed. Some of the acknowledgement sheets were signed and dated by the Resident Care Coordinators and some only had the staff signature. In reviewing the quizzes and acknowledgment sheets, an identified Personal Support Worker (PSW) did not have a signed Abuse & Neglect Staff Acknowledgement Sheet and had made a note on the sheet that they did not fully understand the policy and had questions. In reviewing the registered staff quizzes and acknowledgment sheets, there were three registered nurses (RN), and one registered practical nurse (RPN), who had no documentation at all related to the education being completed, the quiz or the acknowledgment sheet. No documentation or record of monitoring or tracking of education completion was provided to the Inspector.

Another binder was provided of education that included certificates of attendance. The certificate noted the staff name, attended the following in-services, TOPICS: Pixalere, Wound Care, Abuse & Neglect, Mandatory Reporting, Medication Administration, DATE:

February 22, 2017, PROVIDED BY: Corporate Educator, Caressant Care Nursing and Retirement Home Limited. There was no certificate for a Registered Practical Nurse. No documentation or record of monitoring or tracking of education completion was provided to the Inspector.

In an interview with the PSW, they said that they had questions related to the home's policy related to the prevention of abuse and neglect and with this, did not sign the acknowledgement sheet. The PSW said no one from the home had contacted or spoken to them related to their questions, that they still did not fully understand the entire policy and had still not signed the acknowledgement sheet.

In an interview with the Director of Nursing (DON), they said that the expectation was that all staff reviewed a binder of information related to the home's policy related to the prevention of abuse and neglect, completed a quiz related to the content and signed "Abuse & Neglect Staff Acknowledgement Sheet". The DON said both the quiz and acknowledgment sheet should have been dated with the staff member's name on each as well as the signature of the Resident Care Coordinator who reviewed the quiz with them. The DON said that they did not have a monitoring or tracking tool, or a process for tracking staff training and could not confirm if all staff had completed the training related to the written policy to promote zero tolerance of abuse and neglect of residents.

In an interview with the Regional Manager (RM), they said that the expectation was that all staff reviewed a binder of information related to the home's policy related to the prevention of abuse and neglect, completed a quiz related to the content and signed "Abuse & Neglect Staff Acknowledgement Sheet". They said both the quiz and acknowledgment sheet should have been dated with the staff member's name on each. The RM said that they did not have a monitoring or tracking tool, or a process for tracking staff training and could not confirm if all staff had completed the training related to the written policy to promote zero tolerance of abuse and neglect of residents. The RM was not able to confirm if all staff had received the training or which staff had received the training and which had not .

In another interview with the RM, they said that education was provided for management staff related to the process for investigating abuse and neglect, roles and responsibilities, mandatory reporting, as well as immediate and long term appropriate actions to be taken. The RM said that there was no record or documentation of what management staff attended the training. The RM was not able to confirm if all management staff attended the training or which management had or had not attended the training.

The licensee failed to comply with Compliance Order #003, specifically that:
• All staff were trained on the written policy to promote zero tolerance of abuse and neglect of residents; including mandatory reporting, roles and responsibilities, the process for investigating abuse and neglect and the immediate and long term appropriate actions to be taken;
• The Administrator, the Director of Care, and all other management staff of the home were trained on the process for investigating abuse and neglect, roles and responsibilities, mandatory reporting, as well as immediate and long term appropriate actions to be taken;
• There was a process for monitoring and tracking staff training to ensure all processes were completed and implemented. [s. 23.]

2. The licensee has failed to ensure that the results of every investigation of abuse of a resident by anyone or neglect of a resident by the licensee or staff, were reported to the Director.

Ministry of Health and Long Term Care Critical Incident Reports are the means in which homes report as required, under the Long Term Care Homes Act and Ontario Regulations, to the Director.

Critical Incident System (CIS) report #2636-000020-17, was submitted by the home related to an incident of alleged neglect towards a resident. The CIS report was last amended on an identified date, stating that the investigation had been initiated and will follow up. The results of the investigation were not reported to the Director in the amended CIS report as of the date of the inspection, months after the incident. The CIS report was amended by the home with the results of the investigations during the inspection after a meeting with the Administrator and Regional Manager.

Critical Incident System (CIS) report #2636-000027-17, was submitted by the home related to an incident of alleged neglect towards a resident. The CIS report had not been amended since the original report submitted stating, will determine at the conclusion of investigation. The results of the investigation were not reported to the Director as of the date of the inspection. The CIS report was amended by the home with the results of the investigations after a meeting with the Administrator and Regional Manager.

Critical Incident System (CIS) report #2636-000029-17, was submitted by the home related to an incident of alleged neglect towards a resident. The CIS report had not been

amended since the original report submitted stating, will determine at the end of investigation. The results of the investigation were not reported to the Director as of the date of the inspection. The CIS report was amended by the home with the results of the investigations after a meeting with the Administrator and Regional Manager.

In a meeting with the Administrator and Regional Manager, they agreed that the three CIS reports noted above had not been amended with the outcomes of the investigations and therefore were not reported to the Director.

The licensee failed to ensure that the results of every investigation of abuse of a resident by anyone or neglect of a resident by the licensee or staff, were reported to the Director.

The severity of this non-compliance is minimal risk and the scope is widespread. The home does have a history of non-compliance in this subsection of the legislation, it was issued as a Voluntary Plan of Correction during the RQI August 30, 2016 and as Compliance Order January 25, 2017 in Inspection #2016_303563_0042 with a compliance date of March 1, 2017. [s. 23. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) report, 2636-000022-17, was submitted to the Ministry of Health and Long Term Care (MOHLTC) by the home related to an incident of alleged improper/incompetent treatment of a resident that resulted in harm or risk to a resident. Under description of the incident, including events leading up to the incident, the Director of Nursing (DON) wrote that the resident was supposed to use an assitive device and the device was not provided which resulted in an injury. Under what care was given or action taken as a result of the incident, the Director of Nursing wrote that the resident was assessed, treatment was provided and the Manager on call notified and Power of Attorney notified.

A Critical Incident System (CIS) report, 2636-000011-17, was submitted to the MOHLTC by the home six weeks previously, related to an incident of alleged improper/incompetent treatment of a resident that resulted in harm or risk to a resident. Under what immediate actions have been taken to prevent recurrence it stated care plan updated to ensure resident uses an assistive device.

The current care plan was reviewed in Point Click Care (PCC) and showed that the care plan and kardex for the resident was revised on an identified date, stating resident uses assistive devices, and specified the device.

The Director of Nursing (DON) shared that when they were informed of the incident involving the resident the following day, they felt it was improper/incompetent treatment as the PCC Care Plan, Kardex and other sources of information all showed that resident used an assistive device. The DON also shared that this was the second injury for the resident and the care plan had been updated related to the use of the assistive device after the first incident in order to prevent it from happening again.

The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in the resident's plan of care, resulting in injury.

The severity of the non-compliance is minimal harm/potential for actual harm and the scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. [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 #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of drugs and treatments with respect to the resident.

A Registered Practical Nurse (RPN) was observed to crush a resident's medications, and give them to a resident. When asked how the RPN knew that the resident's medications were to be crushed, the RPN pulled open the drawer of the medication cart where the strip medications packages were kept for the residents and showed Inspector #155 the top of the bin for the resident there was notation that medications were to be crushed. The RPN showed the Inspector that for some other residents, the Electronic Medication Administration Records (MARs) did have it in the "allergy" section that medications were to be crushed. Inspector #155 asked the RPN if they crushed resident's medication when they administer it and the RPN answered, yes all the medications were crushed for that resident.

In an interview, a Medical Pharmacies Clinical Consultant Pharmacist shared that the identified medication should not be crushed. When they reviewed the resident's record, Pharmacist said that according to the records, this resident took their medications whole. They shared that if the resident was to get their medications crushed it was to be noted in the allergy section in Point Click Care (PCC) so that it would appear on their electronic records and the Electronic MARs, so that all disciplines would be aware that medications

were to be crushed.The Pharmacist was not aware that there were notes on the top of the strip package bins in the medication carts directing staff to crush medications. They said that when they completed medication reviews, it was based on the resident's electric records and not the notations on the bins in the medication carts.

In an interview, another RPN shared that if a resident needs their medications crushed, it was noted on the top of the strip package bins in the medication carts. The RPN pulled open the drawer of the medication cart and showed Inspector #155 the notations on the top of the strip package bins stating medications crushed for a number of residents.

In an interview with Director of Nursing (DON), when asked how staff know if medications were to be crushed, the DON said that it was on the strip package med bins in the medication cart but would prefer it to be in the allergy section in PCC. When asked how the staff would communicate a change in a resident's ability to take medications whole, the DON said that the registered staff would phone the pharmacy and let them know. When asked if the registered staff would notify the pharmacy in writing, the DON answered that there was nothing to their knowledge that would be filled out.

Four days after the initial observation, another RPN was observed administering medications to the same resident with the medications crushed. The RPN shared that they were new to working on that unit, but knew if the residents took medications crushed as it was written on the top of the strip package bin in the medication cart. The RPN pulled open the drawer of the medication cart and showed Inspector #155 that on the top of the resident's bin it was written crushed. A Registered Nurse (RN) was sitting at the nursing station and shared that if a resident is to get their medication crushed it was also on the MAR. The current MAR, paper chart, and physician's orders in PCC for the resident were reviewed, and there was no notation on the MAR, Physicians Orders, or the Three Month Medication Review (TMMR) that the medications for this resident were to be crushed.

During an interview with Regional Manager (RM), they shared that if it was noted on the top of the strip package bin that the resident gets their medication crushed, that would be considered part of the resident's plan of care.

Medical Pharmacies Pharmacy Policy and Procedure Manual for LTC Homes; Section 5, "Handling of Medications; Policy 5-3, Crushing Medications" was reviewed, and Regional Manager shared that it was the current policy.
The policy stated:

" • To identify a resident's change in condition leading to an inability to swallow medications and the need for medication to be crushed before administration.
• To encourage inter-professional discussion between nurses and pharmacists to appropriately change medications to a suitable dosage form and communicate this in writing to the others on the healthcare team.
• To facilitate safe administration of medication to a resident experiencing difficulty swallowing a solid dosage form, certain medications may be crushed or capsules emptied and mixed with applesauce or jam. Only medications which have been deemed acceptable for crushing may be administered in this manner.
Procedure:
1. Nurse to assess and document the change in condition of the resident.
• A swallowing assessment may be ordered by a specialist confirming inability to swallow solid dosage forms.
2. Nurse to communicate in writing via the prescriber's order form "resident condition changed and solid medication requires crushing." (Note a physician's order or signature is not required).
• The order form is common place for healthcare team to note that medications require crushing.
• Future orders should include "crush meds" note next to allergies for consistent communication.
3. Pharmacist will complete a review of the medication profile and make necessary changes to the dosage forms. In certain situations, new orders may be required to for alternate therapy.
4. Future MARS will have "Crush Meds" note."

In an interview, the Regional Manager agreed that the plan of care for the resident regarding crushing of medications was developed and implemented without the other appropriate disciplines disciplines, including the pharmacist, having knowledge of it and therefore the plan of care relating to medications for this resident was not based on an interdisciplinary assessment of drugs and treatments.

The licensee failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of drugs and treatments with respect to a resident.

The severity of this non-compliance is potential for actual harm and the scope is isolated. The home dos not have a history of non-compliance in this sub-section of the legislation. [s. 26. (3) 17.]

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 plan of care is based on, at a minimum, an interdisciplinary assessment of drugs and treatments with respect to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was restrained by a physical device as described in paragraph 3 of subsection 30 (1) only if the restraining of the resident was included in the resident's plan of care.

A resident was observed sitting upright in a chair and appeared to be sleeping with a physical device applied.

A Personal Support Worker (PSW) shared that this resident had responsive behaviours at times that were a risk for injury. The PSW said that other interventions were trialed, but this resident now had a physical device to keep the resident safe and that it was to be on at all times. The PSW shared that they had taken the resident to the toilet, repositioned resident in the chair, and reapplied the physical device.

A Registered Nurse (RN) was sitting at the north nursing station. The paper chart for the resident was reviewed and the Prescriber's Orders form for this resident showed that, a telephone order was written that stated restraint to be applied PRN. There were no notations made that this physician's order was noted or processed. When asked what the process was when there was a physician's order written for a restraint, the RN shared that it was to be entered into Point Click Care (PCC) orders section to appear on the Medication Administration Record (MAR). The RN checked the current MAR for the resident and there was no documentation of the order. The RN said that the order should have been noted and placed in the MAR as this was where the registered staff document

that the resident was assessed for the application of the restraint every shift and checked hourly by the registered staff to ensure that the resident is safe. A Registered Practical Nurse (RPN), who was also sitting at the nursing station, stated that maybe the order did not get put into the MAR for this resident as the resident was only to have it applied only when it was needed (PRN). The current plan of care in PCC was reviewed and there was no reference, goal, or intervention related to the use of a physical device.

The RPN and the RN were advised by Inspector #155 that resident had the physical device on. The RPN got up and removed the physical device noting that the resident was sleeping in the chair. The RPN and the RN shared that they were not aware that the resident had the physical device on as they had not assessed the resident for the use of it or checked on the resident hourly for the use as the physical device was not to be on.

Inspector #213 and #155 returned to the nursing station. The Regional Manager and the Administrator were at the nursing station talking to the RN. The Regional Manager shared that the way the order was worded was inappropriate, and were concerned that the order had not been processed yet, that there was no documentation as to why the physical device was applied, how long it had been on, or what alternatives had been tried.

The Regional Manager shared that the restraint order should have been noted in PCC on the MAR as that was where the registered staff have to sign that they assessed the need for the restraint and that they were assessing it hourly. They said that the PSWs document the time of release and repositioning in Point of Care documentation in PCC.

The licensee failed to ensure that a resident was restrained by a physical device only if the restraining was included in the resident plan of care. [s. 31.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident is restrained by a physical device as described in paragraph 3 of subsection 30 (1) only if the restraining of the resident is included in the resident's plan of care, the resident is monitored while restrained, the resident is released and repositioned, the resident's condition is reassessed and the effectiveness of the restraining evaluated, and the resident is restrained only as long as was necessary to address the risk, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Progress notes in Point Click Care (PCC) for a resident were reviewed for a one month period. The progress notes stated that the resident had a fall on four different dates in a period of one week.

The Director of Nursing (DON) shared that when a resident had fallen, the registered staff that responded to the fall were to complete the Safety Plan-Post Fall Investigation form and then were to enter the information into Risk Management in PCC. The DON

said that they did not have any Safety Plan- Post Fall Investigation forms for the resident for the identified time period, but that the Resident Care Coordinator would have them.

The Resident Care Coordinator (RCC) was asked if they had any Safety Plan-Post Investigation forms for the resident for the identified time period. After checking their office and the charting room on north, the RCC shared that there were not any Safety Plan-Post Investigation forms for that resident for that time period.

The Caressant Care Nursing & Retirement Homes Ltd. policy and procedure for nursing; "Subject: Safety Plan-Resident"; dated September 2013; Part C-Post Fall Management states the interdisciplinary team will complete an internal incident report, Post Fall Investigation and detailed progress note.

The Regional Manager (RM) shared that when a resident has fallen the registered staff responding to the fall can use the Safety Plan-Post Fall Investigation form to record their assessment, but the information from the Safety Plan-Post Fall Investigation form must be entered into Risk Management in PCC. The RM said that the Risk Management incident report in PCC is the post falls assessment which serves as the clinically appropriate assessment instrument that is specifically designed for falls.

The RM agreed that there were no Risk Management post falls assessments done in PCC for that resident for that time period.

The licensee failed to ensure that when a resident had fallen that the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The severity of this non-compliance is minimal harm/potential for actual harm and the scope is widespread. The home does have a history of non-compliance in this subsection of the legislation, it was issued November 26, 2016 as a Voluntary Plan of Correction in the Resident Quality inspection. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including access to these areas restricted to persons who dispense, prescribe or administer drugs in the home, and the Administrator.

During an observation on a home area, Inspector #137 saw that the medication room door was open and there was no registered staff member present. A Housekeeper was cleaning the floor, inside the medication room.

A Registered Nurse (RN) was observed at the medication cart by the dining room entrance on the home area, and then left the cart to administer medications in the dining room. The medication room was not visible to the RN while standing at the medication cart or while in the dining room.

A Resident Care Coordinator (RCC) observed the housekeeper in the medication room and said the Housekeeper should not have access to the medication room, without a registered staff member present.

During an interview, the RN told the Inspector they did not know that only persons who dispensed, prescribed or administered drugs in the home and the Administrator could have access to the medication room, that anyone else had to be under the supervision of a registered staff member.

The licensee failed to ensure that access to the medication room was restricted to persons who dispense, prescribe or administer drugs in the home, and the Administrator when a Housekeeper was in the room with no registered staff present or in view.

The severity of the non-compliance is minimum risk and the scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. [s. 130. 2.]

Issued on this 19th day of July, 2017

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

Ministére 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) :	RHONDA KUKOLY (213), MARIAN MACDONALD (137), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2017_605213_0007
Log No. / Registre no:	002943-17, 003266-17, 003331-17, 004743-17, 005232-17, 006220-17, 006363-17, 006365-17, 007872-17, 008435-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 29, 2017
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE WOODSTOCK NURSING HOME 81 FYFE AVENUE, WOODSTOCK, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angel Roth

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_303563_0042, CO #001;

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 shall ensure that all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
Specifically, the home will ensure that:
1. All nursing staff are trained related to the types of altered skin integrity, roles and responsibilities related to recognition, reporting, documentation, assessments and appropriate strategies.
2. All registered staff are trained related to the process for completing a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and the process for completing a skin assessment when the home's software for skin assessments is inaccessible.
3. Develop and implement a tracking and monitoring system for all altered skin integrity in the home, including assessments and reassessments.
4. Develop and implement a process for monitoring, tracking, and documentation of staff training to ensure all staff have completed the training.
5. Ensure that a written record related to the annual evaluation of the skin and wound care management program including the summary of changes made and the date those changes were implemented is completed.

Grounds / Motifs :

1. The licensee has failed to comply with Compliance Order #003 issued in Inspection #2016_303563_0042 on January 25, 2017 with a compliance date of March 1, 2017.

Compliance Order #003, issued in Inspection #2016_303563_0042 on January 25, 2017 with a compliance date of March 1, 2017 stated:
"Specifically, the home will ensure that there is a process to:
• Educate all nursing staff related to the types of altered skin integrity, roles and responsibilities related to recognition, reporting, documentation, assessments and appropriate strategies.
• Educate all registered staff related to the process for completing a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and the process for completing a skin assessment when the home's software for skin assessments is inaccessible;

• Develop and implement a process for tracking staff education to ensure completion.
• Ensure that a written record related to the annual evaluation of the skin and wound care management program including the summary of changes made and the date those changes were implemented is completed.

The education records for the home for 2017 and the home's skin and wound care management program evaluation were requested.

The Regional Manager (RM) provided the written Skin and Wound Care Management Program Evaluation for the period of January 1, 2016 to October 20, 2016. The date was initially dated October 20, 2016, but this date was crossed off with "completed: Jan 10, 2017" and initialed with the RM's initials. In the area "summary of changes made over the past year with dates of change", was written: "Assess residents on admission for improvements needed in seating, refer to OT, two air loss mattresses in January". There were no dates indicated other than "January". In the area "Indicators to Review (over past year): TAR documentation and follow-up assessments", was written: "assessments not always done as scheduled". The "Areas for Improvement" included: "continue with OT referrals, continue with nutrition referrals", there was no reference to improving assessments being done on time.

In an interview with the RM, they said that the evaluation had been started in 2016 and had not been completed, so they directed that it was completed in January and that was the reason for the date being changed. The RM agreed that the written record of the annual evaluation with the date of January 10, 2017 did not include dates that changes were made other than two air loss mattresses in January.

The RM provided a binder of education that included certificates of attendance. The certificate noted the staff name, attended the following in-services, TOPICS: Pixalere, Wound Care, Abuse & Neglect, Mandatory Reporting, Medication Administration, DATE: February 22, 2017, PROVIDED BY: Corporate Educator, Caressant Care Nursing and Retirement Home Limited. No documentation or record of monitoring or tracking of education completion was provided to the Inspector. There was no certificate for an identified Registered Practical Nurse.

In an interview with the RM, they said that the expectation was that all registered staff attend a four hour education session that included wound care and Pixilere.

The Regional Manager said that they did not have a monitoring or tracking tool, or a process for tracking staff education. The RM was not able to confirm if an identified RPN received the education related to wound care and Pixilere and said that they weren't sure why the RPN was missed.

In an interview with the RM and the Administrator, the RM stated that one of the Registered Nurses provided education related to skin and wound including observation, reporting and documentation for all personal support workers (PSWs). There was no documentation or record if the PSWs received the education or on what dates the education was received.

The licensee failed to comply with Compliance Order #003 issued in Inspection #2016_303563_0042 on January 25, 2017 with a compliance date of March 1, 2017 when no process tracking of staff education was developed or implemented, the home could not confirm the completion of education related to skin and wound care, and an annual evaluation of the skin and wound care management program did not include the summary of changes made and the date those changes were implemented. (213)

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Compliance Order #001 was issued January 25, 2017 in inspection #2016_303563_0042 with a compliance date of March 1, 2017. The order stated that the licensee shall ensure that three identified residents, and all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) An Incident Note in Point Click Care (PCC) for a resident on an identified date stated that the resident suffered an injury and altered skin integrity as a result. The injury was observed by the Inspector and a PSW shared that they were aware of the resident's injury and subsequent altered skin integrity.

In an interview, a Resident Care Coordinator (RCC) said that when a resident has an area of altered skin integrity it should be assessed and the assessment completed in the Pixalere electronic documentation system. The area of altered skin integrity should also be entered in PCC in the Treatment Administration Record (TAR) which would create the schedule to remind staff when the assessments should be completed in Pixalere. If there is a treatment to be done to the area of altered skin integrity this should also be entered in PCC in the TAR. The RCC said that there was nothing documented in Pixalere or on the TAR in PCC related to the resident's altered skin integrity. The RCC shared that the altered skin integrity should have been assessed using Pixalere and documented on the TAR in PCC.

b) An Incident Note in PCC for another identified resident stated that this resident suffered an injury resulting in altered skin integrity and treatment was provided.

In an interview, an RCC shared that when a resident has an area of altered skin integrity it should be assessed and the assessment completed in the Pixalere electronic documentation system. The area of altered skin integrity should also be entered in PCC in the TAR which would create the schedule to remind staff when the assessments should be completed in Pixalere. If there is a treatment to be done to the area of altered skin integrity this should also be entered in PCC in the TAR. The RCC shared that there was nothing documented in Pixalere or on the TAR in PCC related to the area of altered skin integrity for the resident. The RCC shared that the altered skin integrity should have been assessed using Pixalere and documented on the TAR in PCC.

The Caressant Care Nursing & Retirement Homes Ltd., Policy and Procedure Subject: Wound Assessment dated July, 2016 stated, "All residents with skin and wound issues shall have these appropriately treated and assessed by the Registered Staff in conjunction with the Wound Care Champion and Managers in the home. Registered staff shall utilize the E-TAR (Electronic Treatment Administration Record) on Point Click Care and the Pixalere wound assessment program to document and assess wound treatments and wound progress. All residents with skin and wound issues shall have these areas assessed by registered staff every 7 days".

The licensee failed to ensure that when two residents had altered skin integrity,

skin assessments were completed by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. (155)

3. The licensee has failed to ensure that the 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 if clinically indicated.

Compliance Order #001 was issued January 25, 2017 in inspection #2016_303563_0042 with a compliance date of March 1, 2017. The order stated that the licensee shall ensure that three identified residents and all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

An Incident Note in PCC for an identified resident stated that this resident suffered an injury resulting in altered skin integrity and treatment was provided.

A review of the resident's progress notes for a one month time period was completed. There was no documentation to support that there was any further treatment or assessment done for the resident's area of altered skin integrity.

The resident's Treatment Administration Record (TAR) for the month time period was reviewed and there was no documentation to reflect that the altered skin integrity was reassessed weekly or any other treatment was provided since the injury occurred.

In an interview, a Resident Care Coordinator (RCC) shared that when a resident has an area of altered skin integrity it should be assessed and the assessment completed in the Pixalere electronic documentation system. The area of altered skin integrity should also be entered in Point Click Care (PCC) in the Treatment Administration Record (TAR) which would create the schedule to remind staff when the assessments should be completed in Pixalere. If there is a treatment to be done to the area of altered skin integrity this should also be entered in PCC in the TAR. The RCC shared that there was nothing documented in Pixalere or on the TAR in PCC related to the resident's altered skin integrity. The

RCC shared that the altered skin integrity should have been assessed using Pixalere and documented on the TAR in PCC.

Review of Caressant Care Nursing & Retirement Homes Ltd., Policy and Procedure Subject: Wound Assessment dated July, 2016 states that "All residents with skin and wound issues shall have these appropriately treated and assessed by the Registered Staff in conjunction with the Wound Care Champion and Managers in the home. Registered staff shall utilize the E-TAR (Electronic Treatment Administration Record) on Point Click Care and the Pixalere wound assessment program to document and assess wound treatments and wound progress. All residents with skin and wound issues shall have these areas assessed by registered staff every 7 days".

The licensee failed to ensure that a resident's area of altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff.

The severity of this non-compliance is minimum harm/potential for actual harm and the scope was a pattern. The home does have a history of non-compliance in this subsection of the legislation, it was issued as a Written Notification during the Resident Quality Inspection December 8, 2014 and August 30, 2016 and as Compliance Order January 25, 2017 in Inspection #2016_303563_0042 with a compliance date of March 1, 2017. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 28, 2017

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_303563_0042, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Order / Ordre :

The licensee shall ensure that every alleged, suspected or witnessed incident of the
following that the licensee knows of, or that is reported to the licensee, is immediately
investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
appropriate action is taken in response to every such incident, and the results of every investigation are reported to the director.

Specifically, the licensee shall ensure that:
1. All staff are trained on the written policy to promote zero tolerance of abuse and neglect of residents; including mandatory reporting, roles and responsibilities, the process for investigating abuse and neglect and the immediate and long term appropriate actions to be taken.
2. The Administrator, the Director of Care, and all other management staff of the home are trained on the process for investigating abuse and neglect, roles and responsibilities, mandatory reporting, as well as immediate and long term appropriate actions to be taken.
3. There is a process for monitoring, tracking, and documentation of staff training to ensure all staff have completed the training and that all processes are completed and implemented.

Grounds / Motifs :

1. The licensee has failed to comply with Compliance Order #003, issued in Inspection #2016_303563_0042 on January 25, 2017 with a compliance date of

March 1, 2017.

Compliance Order #003, issued in Inspection #2016_303563_0042 on January 25, 2017 with a compliance date of March 1, 2017 stated:
"Specifically, the licensee shall ensure that:
• All staff are educated on the written policy to promote zero tolerance of abuse and neglect of residents; including mandatory reporting, roles and responsibilities, the process for investigating abuse and neglect and the immediate and long term appropriate actions to be taken;
• The Administrator, the Director of Care, and all other management staff of the home are educated on the process for investigating abuse and neglect, roles and responsibilities, mandatory reporting, as well as immediate and long term appropriate actions to be taken;
• There is a process for monitoring and tracking staff education to ensure all processes are completed and implemented."

The education records for the home for 2017 were requested. The home provided a binder of quizzes and "Abuse & Neglect Staff Acknowledgement Sheets". The purpose of the Staff Acknowledgement Sheets was to confirm that the staff received the training and understood the content. Some of the quizzes and acknowledgment sheets had staff names and dates, some had just a name and no date and some were blank. Some staff had a quiz completed and no acknowledgement sheet. There was not a quiz and staff acknowledgement sheet for every Personal Support Worker indicating that education was completed or when it was completed. Some of the acknowledgement sheets were signed and dated by the Resident Care Coordinators and some only had the staff signature. In reviewing the quizzes and acknowledgment sheets, an identified Personal Support Worker (PSW) did not have a signed Abuse & Neglect Staff Acknowledgement Sheet and had made a note on the sheet that they did not fully understand the policy and had questions. In reviewing the registered staff quizzes and acknowledgment sheets, there were three registered nurses (RN), and one registered practical nurse (RPN), who had no documentation at all related to the education being completed, the quiz or the acknowledgment sheet. No documentation or record of monitoring or tracking of education completion was provided to the Inspector.

Another binder was provided of education that included certificates of attendance. The certificate noted the staff name, attended the following in-services, TOPICS: Pixalere, Wound Care, Abuse & Neglect, Mandatory

Reporting, Medication Administration, DATE: February 22, 2017, PROVIDED BY: Corporate Educator, Caressant Care Nursing and Retirement Home Limited. There was no certificate for a Registered Practical Nurse. No documentation or record of monitoring or tracking of education completion was provided to the Inspector.

In an interview with the PSW, they said that they had questions related to the home's policy related to the prevention of abuse and neglect and with this, did not sign the acknowledgement sheet. The PSW said no one from the home had contacted or spoken to them related to their questions, that they still did not fully understand the entire policy and had still not signed the acknowledgement sheet.

In an interview with the Director of Nursing (DON), they said that the expectation was that all staff reviewed a binder of information related to the home's policy related to the prevention of abuse and neglect, completed a quiz related to the content and signed "Abuse & Neglect Staff Acknowledgement Sheet". The DON said both the quiz and acknowledgment sheet should have been dated with the staff member's name on each as well as the signature of the Resident Care Coordinator who reviewed the quiz with them. The DON said that they did not have a monitoring or tracking tool, or a process for tracking staff training and could not confirm if all staff had completed the training related to the written policy to promote zero tolerance of abuse and neglect of residents.

In an interview with the Regional Manager (RM), they said that the expectation was that all staff reviewed a binder of information related to the home's policy related to the prevention of abuse and neglect, completed a quiz related to the content and signed "Abuse & Neglect Staff Acknowledgement Sheet". They said both the quiz and acknowledgment sheet should have been dated with the staff member's name on each. The RM said that they did not have a monitoring or tracking tool, or a process for tracking staff training and could not confirm if all staff had completed the training related to the written policy to promote zero tolerance of abuse and neglect of residents. The RM was not able to confirm if all staff had received the training or which staff had received the training and which had not .

In another interview with the RM, they said that education was provided for management staff related to the process for investigating abuse and neglect, roles and responsibilities, mandatory reporting, as well as immediate and long

term appropriate actions to be taken. The RM said that there was no record or documentation of what management staff attended the training. The RM was not able to confirm if all management staff attended the training or which management had or had not attended the training.

The licensee failed to comply with Compliance Order #003, specifically that:
• All staff were trained on the written policy to promote zero tolerance of abuse and
neglect of residents; including mandatory reporting, roles and responsibilities, the process for investigating abuse and neglect and the immediate and long term appropriate actions to be taken;
• The Administrator, the Director of Care, and all other management staff of the home were trained on the process for investigating abuse and neglect, roles and responsibilities, mandatory reporting, as well as immediate and long term appropriate actions to be taken;
• There was a process for monitoring and tracking staff training to ensure all processes were completed and implemented. (213)

2. The licensee has failed to ensure that the results of every investigation of abuse of a resident by anyone or neglect of a resident by the licensee or staff, were reported to the Director.

Ministry of Health and Long Term Care Critical Incident Reports are the means in which homes report as required, under the Long Term Care Homes Act and Ontario Regulations, to the Director.

Critical Incident System (CIS) report #2636-000020-17, was submitted by the home related to an incident of alleged neglect towards a resident. The CIS report was last amended on an identified date, stating that the investigation had been initiated and will follow up. The results of the investigation were not reported to the Director in the amended CIS report as of the date of the inspection, months after the incident. The CIS report was amended by the home with the results of the investigations during the inspection after a meeting with the Administrator and Regional Manager.

Critical Incident System (CIS) report #2636-000027-17, was submitted by the home related to an incident of alleged neglect towards a resident. The CIS report had not been amended since the original report submitted stating, will determine at the conclusion of investigation. The results of the investigation

were not reported to the Director as of the date of the inspection. The CIS report was amended by the home with the results of the investigations after a meeting with the Administrator and Regional Manager.

Critical Incident System (CIS) report #2636-000029-17, was submitted by the home related to an incident of alleged neglect towards a resident. The CIS report had not been amended since the original report submitted stating, will determine at the end of investigation. The results of the investigation were not reported to the Director as of the date of the inspection. The CIS report was amended by the home with the results of the investigations after a meeting with the Administrator and Regional Manager.

In a meeting with the Administrator and Regional Manager, they agreed that the three CIS reports noted above had not been amended with the outcomes of the investigations and therefore were not reported to the Director.

The licensee failed to ensure that the results of every investigation of abuse of a resident by anyone or neglect of a resident by the licensee or staff, were reported to the Director.

The severity of this non-compliance is minimal risk and the scope is widespread. The home does have a history of non-compliance in this subsection of the legislation, it was issued as a Voluntary Plan of Correction during the RQI August 30, 2016 and as Compliance Order January 25, 2017 in Inspection #2016_303563_0042 with a compliance date of March 1, 2017. (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 28, 2017

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 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 29th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

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