Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 23, 2020	2020_648741_0020	021010-20, 021146-20	Critical Incident System

Licensee/Titulaire de permis

Copper Terrace Limited
284 Central Avenue London ON N6B 2C8

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

Copper Terrace
91 Tecumseh Road Chatham ON N7M 1B3

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

AYESHA SARATHY (741), AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 23, 24, 25, 26 and 27, 2020

The following Critical Incident Systems (CIS) were inspected as a part of this inspection:

CIS #1115-000042-20/Log #021146-20 related to falls prevention and management
CIS #1115-000041-20/Log #021010-20 related to responsive behaviours and prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Assistant Directors of Care (ADOC), the Director of Care (DOC) and residents.

The Inspectors also observed residents, reviewed relevant policies and procedures and reviewed clinical records for identified residents.

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee has failed to ensure that three residents' plans of care were revised when their transfer and mobility status changed.

A. A resident had a fall and sustained an injury as a result. Due to the fall, the resident had a change in their transfer status and required more assistance and the use of a lift to be transferred.

The resident's plan of care and transfer logo included information about their transfer status that was not up to date.

A Registered Practical Nurse (RPN) said that the resident's care plan had not been updated to reflect the change in their transfer and mobility status. The Director of Care (DOC) said that the floor nurse, Resident Assessment Instrument (RAI) Coordinator and Assistant Director of Care (ADOCs) were able to update the plan of care and that the resident's plan of care and transfer logo should have been updated within seven days of their readmission from hospital.

There was a risk of injury to the resident as a result of their plan of care not being updated when their transfer status changed.

Sources: Critical Incident System report, Safe Lift and Transfer (S.A.L.T.) Assessment, the resident's clinical record, including care plan, kardex, transfer logo, and interviews with an RPN, the DOC and other staff.

B. A resident had a fall and sustained an injury as a result. Due to the fall, the resident had a change in their transfer status and required more assistance and the use of a lift to be transferred.

The resident's plan of care and transfer logo included information about their transfer status that was inconsistent and not up to date.

The Director of Care (DOC) said that if there were any significant changes with a resident, the plan of care should be changed immediately to prevent injury. They said that the resident's care plan, kardex and transfer logo were not up to date.

There was a risk of injury to the resident as a result of their plan of care not being revised when their transfer status changed.

Sources: A Rehabilitation assessment, a Safe Lift and Transfer (S.A.L.T.) Assessment, resident's clinical record, including progress notes, care plan, kardex, transfer logo, and interviews with DOC and other staff.

C. A resident had a fall and sustained injuries as a result. Since the fall, the resident had been reassessed and had a change in their transfer status.

The resident's plan of care and transfer logo included information about their transfer status that was inconsistent and not up to date.

A Personal Support Worker (PSW) provided inaccurate information about the resident's current transfer status when asked. The Director of Care (DOC) said that the resident's plan of care and transfer logo should have been updated when their transfer status changed.

There was a risk of injury to the resident as a result of their plan of care not being revised when their transfer status changed.

Sources: Safe Lift and Transfer (S.A.L.T.) Assessments, the resident's clinical record, including progress notes, care plan, Kardex, transfer logo, and interviews with a PSW,

DOC and other staff.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the Head Injury Routine policy included in the required Falls Prevention Program was complied with for three residents.

Ontario Regulation 79/10 s. 48(1)(1) requires an interdisciplinary program of falls prevention and management to reduce the incidence of falls and the risk of injury.

Ontario Regulation 79/10 s. 30(1)(1) requires that the program include relevant policies, procedures and protocols related to falls prevention and management.

Specifically, staff did not comply with the home's policy and procedure "Fall Prevention

Program – Head Injury Routine", section 6.2, dated June 2017.

A. The home's Fall Prevention Program - Head Injury Routine (HIR) policy and procedure directed staff to initiate HIR for all resident falls that were not witnessed and to chart them in the Neurological Flow Sheet in Point Click Care (PCC). Staff were to complete HIR assessments at the following frequency: every 15 minutes for the first hour; every hour for two hours; and, every four hours for 24 hours.

A resident had an un-witnessed fall and required HIR to be initiated. Six out of 12 HIR assessments that were required to be completed were documented by staff. One Neurological Flow Sheet documented by staff stated that the HIR was not completed due to the resident being asleep at the time.

A Registered Practical Nurse (RPN) said that they initiated HIR for the resident on their shift but that no HIR assessments were completed for the resident during the shift that followed. An Assistant Director of Care (ADOC) said that staff did not complete HIR assessments for the resident as required and that it was unacceptable for to skip an assessment if the resident was sleeping. The Director of Care (DOC) said that staff had been trained on the HIR policy and did not comply with it for the resident.

There was a risk that the resident could have suffered negative neurological outcomes as a result of staff not following the home's HIR policy.

Sources: the resident's clinical record, including progress notes, Neurological Assessments in PCC, the home's "Fall Prevention Program – Head Injury Routine" policy, section 6.2, dated June 2017, and interviews with an ADOC and the DOC.

B. A resident had an un-witnessed fall required HIR to be initiated. Four out of nine HIR assessments that were required to be completed were documented by staff prior to the resident being transferred to the hospital for assessment.

The Director of Care (DOC) said that staff did not comply with the home's HIR policy for the resident.

There was a risk that the resident could have suffered negative neurological outcomes as a result of staff not following the home's HIR policy.

Sources: the resident's clinical record, including progress notes, Neurological

Assessments in PCC, the home's "Fall Prevention Program – Head Injury Routine" policy, section 6.2, dated June 2017, and an interview with the DOC.

C. A resident had an un-witnessed fall required HIR to be initiated. Nine out of 12 HIR assessments that were required to be completed were documented by staff and three were documented as not completed due to the resident being asleep at the time.

The Director of Care (DOC) said that staff did not comply with the home's HIR policy for the resident.

There was a risk that the resident could have suffered negative neurological outcomes as a result of staff not following the home's HIR policy.

Sources: the resident's clinical record, including progress notes, Neurological Assessments in PCC, the home's "Fall Prevention Program – Head Injury Routine" policy, section 6.2, dated June 2017, and an interview with the DOC.

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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when two residents exhibited altered skin integrity, they were reassessed at least weekly by a member of the registered nursing staff.

A. A resident sustained a wound as a result of a fall they had at the home. There was no documented evidence that staff had completed two out of four required weekly wound assessments for the resident.

The Director of Care (DOC) said that staff received education on skin and wound assessments and that weekly wound assessments should have been completed for resident #001's wound.

There was a risk that the resident's wound could have worsened as a result of it not being reassessed at least weekly.

Sources: the resident's clinical record, including progress notes, orders, eTAR, skin and wound assessments in Point Click Care (PCC), and interviews with the DOC and other staff.

B. A resident sustained areas of altered skin integrity as a result of a fall they had at the home. There was no documented evidence that the resident received weekly skin assessments for the altered skin integrity.

The Director of Care (DOC) said that staff should have completed weekly skin assessments of the resident's areas of altered skin integrity using the Weekly Wound Assessment tool in PCC.

There was a risk that the resident's areas of altered skin integrity could have worsened as a result of them not being reassessed at least weekly.

Sources: the resident's progress notes, orders, skin and wound assessments in PCC and an interview with the DOC.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 24th day of December, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AYESHA SARATHY (741), AMIE GIBBS-WARD (630)
Inspection No. / No de l'inspection :	2020_648741_0020
Log No. / No de registre :	021010-20, 021146-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 23, 2020
Licensee / Titulaire de permis :	Copper Terrace Limited 284 Central Avenue, London, ON, N6B-2C8
LTC Home / Foyer de SLD :	Copper Terrace 91 Tecumseh Road, Chatham, ON, N7M-1B3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shannon Snelgrove

To Copper Terrace Limited, you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must comply with s. 6 (10) of the LTCHA, 2007.

Specifically, the licensee must:

A. Ensure that when there is a change in a resident's transfer status, they are reassessed and their plans of care reviewed and revised.

B. Provide education to all registered staff on the home's process for revising care plans and resident transfer logos, including who is responsible for updating them. Keep a written record of the education, including the name, signature and designation of staff members who attended the training; the date of their attendance; and, the person who provided the training.

C. Develop and implement a weekly auditing process to ensure that resident plans of care are being revised when there is a change in their transfer status. The audits must include the name of the person who conducted the audit, the resident's name, the outcome and actions taken, if required. The audits must be documented and maintained in the home until compliance with the legislation is achieved.

Grounds / Motifs :

1. The licensee has failed to ensure that three residents' plans of care were

revised when their transfer and mobility status changed.

A. A resident had a fall and sustained an injury as a result. Due to the fall, the resident had a change in their transfer status and required more assistance and the use of a lift to be transferred.

The resident's plan of care and transfer logo included information about their transfer status that was not up to date.

A Registered Practical Nurse (RPN) said that the resident's care plan had not been updated to reflect the change in their transfer and mobility status. The Director of Care (DOC) said that the floor nurse, Resident Assessment Instrument (RAI) Coordinator and Assistant Director of Care (ADOCs) were able to update the plan of care and that the resident's plan of care and transfer logo should have been updated within seven days of their readmission from hospital.

There was a risk of injury to the resident as a result of their plan of care not being updated when their transfer status changed.

Sources: Critical Incident System report, Safe Lift and Transfer (S.A.L.T.) Assessment, the resident's clinical record, including care plan, kardex, transfer logo, and interviews with an RPN, the DOC and other staff.

B. A resident had a fall and sustained an injury as a result. Due to the fall, the resident had a change in their transfer status and required more assistance and the use of a lift to be transferred.

The resident's plan of care and transfer logo included information about their transfer status that was inconsistent and not up to date.

The Director of Care (DOC) said that if there were any significant changes with a resident, the plan of care should be changed immediately to prevent injury. They said that the resident's care plan, kardex and transfer logo were not up to date.

There was a risk of injury to the resident as a result of their plan of care not being revised when their transfer status changed.

Sources: A Rehabilitation assessment, a Safe Lift and Transfer (S.A.L.T.) Assessment, resident's clinical record, including progress notes, care plan, kardex, transfer logo, and interviews with DOC and other staff.

C. A resident had a fall and sustained injuries as a result. Since the fall, the resident had been reassessed and had a change in their transfer status.

The resident's plan of care and transfer logo included information about their transfer status that was inconsistent and not up to date.

A Personal Support Worker (PSW) provided inaccurate information about the resident's current transfer status when asked. The Director of Care (DOC) said that the resident's plan of care and transfer logo should have been updated when their transfer status changed.

There was a risk of injury to the resident as a result of their plan of care not being revised when their transfer status changed.

Sources: Safe Lift and Transfer (S.A.L.T.) Assessments, the resident's clinical record, including progress notes, care plan, Kardex, transfer logo, and interviews with a PSW, DOC and other staff.

An order was made by taking the following factors into account:

Severity: The home failed to revise three residents' plans of care when they had a change in their transfer status, resulting in minimal harm.

Scope: The home's failure to revise plans of care related to transfer status was widespread as the home did not update the plans of care for all three residents reviewed.

Compliance History: 52 Written Notifications (WN), 25 Voluntary Plans of Correction (VPC), and 19 Compliance Orders (CO) were issued to the home related to the different sections of the legislation in the past 36 months. (741)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 26, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must comply with s. 8 (1) of the Ontario Regulation 79/10.

Specifically, the licensee must:

A. Ensure that the home's head injury routine policies and procedures are complied for residents, when head injury routine is required.

B. Provide re-training to all registered staff on the home's head injury routine policy, including education on the expectation for completing head injury routine when residents are asleep. Document the re-training and include the name, signature and designation of staff members who attended the training; the date of the attendance; and the person who provided the training.

Grounds / Motifs :

1. The licensee has failed to ensure that the Head Injury Routine policy included in the required Falls Prevention Program was complied with for three residents.

Ontario Regulation 79/10 s. 48(1)(1) requires an interdisciplinary program of falls prevention and management to reduce the incidence of falls and the risk of injury.

Ontario Regulation 79/10 s. 30(1)(1) requires that the program include relevant policies, procedures and protocols related to falls prevention and management.

Specifically, staff did not comply with the home's policy and procedure "Fall Prevention Program – Head Injury Routine", section 6.2, dated June 2017.

A. The home's Fall Prevention Program - Head Injury Routine (HIR) policy and procedure directed staff to initiate HIR for all resident falls that were not witnessed and to chart them in the Neurological Flow Sheet in Point Click Care (PCC). Staff were to complete HIR assessments at the following frequency: every 15 minutes for the first hour; every hour for two hours; and, every four hours for 24 hours.

A resident had an un-witnessed fall and required HIR to be initiated. Six out of 12 HIR assessments that were required to be completed were documented by staff. One Neurological Flow Sheet documented by staff stated that the HIR was not completed due to the resident being asleep at the time.

A Registered Practical Nurse (RPN) said that they initiated HIR for the resident on their shift but that no HIR assessments were completed for the resident during the shift that followed. An Assistant Director of Care (ADOC) said that staff did not complete HIR assessments for the resident as required and that it was unacceptable for to skip an assessment if the resident was sleeping. The Director of Care (DOC) said that staff had been trained on the HIR policy and did not comply with it for the resident.

There was a risk that the resident could have suffered negative neurological outcomes as a result of staff not following the home's HIR policy.

Sources: the resident's clinical record, including progress notes, Neurological Assessments in PCC, the home's "Fall Prevention Program – Head Injury Routine" policy, section 6.2, dated June 2017, and interviews with an ADOC and the DOC.

B. A resident had an un-witnessed fall required HIR to be initiated. Four out of nine HIR assessments that were required to be completed were documented by staff prior to the resident being transferred to the hospital for assessment.

The Director of Care (DOC) said that staff did not comply with the home's HIR

policy for the resident.

There was a risk that the resident could have suffered negative neurological outcomes as a result of staff not following the home's HIR policy.

Sources: the resident's clinical record, including progress notes, Neurological Assessments in PCC, the home's "Fall Prevention Program – Head Injury Routine" policy, section 6.2, dated June 2017, and an interview with the DOC.

C. A resident had an un-witnessed fall required HIR to be initiated. Nine out of 12 HIR assessments that were required to be completed were documented by staff and three were documented as not completed due to the resident being asleep at the time.

The Director of Care (DOC) said that staff did not comply with the home's HIR policy for the resident.

There was a risk that the resident could have suffered negative neurological outcomes as a result of staff not following the home's HIR policy.

Sources: the resident's clinical record, including progress notes, Neurological Assessments in PCC, the home's "Fall Prevention Program – Head Injury Routine" policy, section 6.2, dated June 2017, and an interview with the DOC.

An order was made by taking the following factors into account:

Severity: The home failed to comply with their head injury routine policy for three residents, resulting in minimal harm.

Scope: The home's failure to comply with their head injury routine policy was widespread as the policy was not complied for all three residents reviewed.

Compliance History: Four Written Notifications (WN) and two Voluntary Plans of Correction (VPC) were issued to the home related to the same subsection of the legislation in the past 36 months. In the past 36 months, two Compliance Orders (CO) were issued to the home for the same subsection, which have been complied. (741)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Feb 26, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must comply with s. 50 (2) (b) of the Ontario Regulation 79/10.

Specifically, the licensee must:

A. Ensure that when residents exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, they are reassessed at least weekly and that registered nursing staff document the assessment using the home's clinically appropriate assessment tool for skin and wound assessments.

B. Provide education to all registered staff on:
- When weekly skin and wound assessments are required to be completed,
- Timelines for completing weekly skin and wound assessments and,
- The minimum amount of information that must be included in a weekly skin and wound assessment.

C. Ensure that the education is documented, including the name, signature and designation of registered staff members who received the education, the date they received the education and the person who provided the education.

D. Develop and implement an auditing process to ensure that all residents exhibiting altered skin integrity receive weekly skin and wound assessments by a member of registered nursing staff. The audit must be conducted weekly and include the name of the person performing the audit, the name of the resident, the date, outcome and actions taken to address the outcome, if required. The audits must be documented and maintained until compliance with the legislation is achieved.

Grounds / Motifs :

1. The licensee has failed to ensure that when two residents exhibited altered skin integrity, they were reassessed at least weekly by a member of the registered nursing staff.

A. A resident sustained a wound as a result of a fall they had at the home. There was no documented evidence that staff had completed two out of four required weekly wound assessments for the resident.

The Director of Care (DOC) said that staff received education on skin and

wound assessments and that weekly wound assessments should have been completed for resident #001's wound.

There was a risk that the resident's wound could have worsened as a result of it not being reassessed at least weekly.

Sources: the resident's clinical record, including progress notes, orders, eTAR, skin and wound assessments in Point Click Care (PCC), and interviews with the DOC and other staff.

B. A resident sustained areas of altered skin integrity as a result of a fall they had at the home. There was no documented evidence that the resident received weekly skin assessments for the areas of altered skin integrity.

The Director of Care (DOC) said that staff should have completed weekly skin assessments of the resident's areas of altered skin integrity using the Weekly Wound Assessment tool in PCC.

There was a risk that the resident's areas of altered skin integrity could have worsened as a result of them not being reassessed at least weekly.

Sources: the resident's progress notes, orders, skin and wound assessments in PCC and an interview with the DOC.

An order was made by taking the following factors into account:

Severity: The home failed to complete weekly wound assessments for two residents, resulting in minimal harm.

Scope: The home's failure to complete weekly wound assessments was a pattern as the home did not complete weekly wound assessments for two out of three residents reviewed with altered skin integrity.

Compliance History: One Written Notification (WN) and one Voluntary Plan of Correction (VPC) was issued to the home related to the same subsection of the legislation in the past 36 months. (741)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Feb 26, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 23rd day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ayesha Sarathy

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