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
May 26, 2020	2020_797740_0007	022745-19, 022747-19, 023028-19, 023029-19, 023031-19, 023032-19, 023033-19	Follow up

Licensee/Titulaire de permis

Craigwiel Gardens
221 Main Street R. R. #1 AILSA CRAIG ON N0M 1A0

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

Craigholme
221 Main Street, R.R. #1 AILSA CRAIG ON N0M 1A0

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

SAMANTHA PERRY (740), CASSANDRA ALEKSIC (689), CHRISTINA LEGOUFFE (730)

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): February 25, 26, 27, 28, March 02, 03, 04 and 05.

The following Follow up intakes were completed within this inspection:
Log #022745-19 for Compliance Order (CO) #001 from inspection #2019_797740_0021 related to staff training;
Log #022747-19 for Compliance Order (CO) #002 from inspection #2019_797740_0021 related to 24hour admission care plan;
Log #023029-19 for Compliance Order (CO) #001 from inspection #2019_797740_0022 related to immediate investigation;
Log #023033-19 for Compliance Order (CO) #003 from inspection #2019_797740_0022 related to Skin and Wound management;
Log #023032-19 for Compliance Order (CO) #004 from inspection #2019_797740_0022 related to reporting of incidents to the Director in one business day;
Log #023028-19 for Compliance Order (CO) #005 from inspection #2019_797740_0022 related to Responsive Behaviours and Altercations and;
Log #023031-19 for Compliance Order (CO) #006 from inspection #2019_797740_0022 related to Falls Prevention.

Documentation of non-compliance related to Critical Incident Inspection #2020_797740_0009 for Log #00623-20 and Log #003577-20 as well as Complaint Inspection #2020_797740_0010
for Log #002467-20 have been documented within this Follow-Up Inspection Report.

During the course of the inspection, the inspector(s) spoke with members of the Board of Directors, the Chief Executive Office (CEO), the Director of Care (DOC), the Assistant Director of Care (ADOC), a Physiotherapist (PT), the Dietician, Registered Nurses (RNs), Registered Practical Nurses (RPN), Personal Support Workers (PSWs) and residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Training and Orientation

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

- **4 WN(s)**
- **0 VPC(s)**
- **3 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
O.Reg 79/10 s. 107. (3)	CO #004	2019_797740_0022	730
O.Reg 79/10 s. 24.	CO #002	2019_797740_0021	730
O.Reg 79/10 s. 49.	CO #006	2019_797740_0022	689
O.Reg 79/10 s. 54.	CO #005	2019_797740_0022	740

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) 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; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected, or witnessed incident of abuse of a resident by anyone that the licensee knows of was immediately investigated.

The licensee has failed to comply with Compliance Order (CO) #001 from inspection #2019_797740_0022 issued on November 18, 2019, with a compliance due date of February 10, 2020.

The licensee was ordered to ensure that they were compliant with LTCHA, 2007 S.O. 2007, c.8, s. 23. (1).

Specifically, the licensee was ordered to:

a) Ensure that every alleged, suspected, or witnessed incidents of abuse of resident #008, #009, #010, or any other resident by anyone that the licensee knows of, or is reported to the licensee, must be immediately investigated. The home must keep a documented record of this investigation.

b) Ensure all management, registered and non-registered staff working in the home, specific to their roles and responsibilities, receive training related to the home's policies and processes of completing an investigation related to Critical Incidents as per O.Reg. 104, including but not limited to, roles and responsibilities, appropriate actions, how to

conduct interviews with applicable persons, actions to prevent re-occurrence, follow up with residents and/or their substitute decision-makers and documentation required. A written record will be kept in the home of all training related to the process in completing an investigation, including staff names, dates and training content, to ensure that all management staff working in the home have received the training.

The licensee failed to complete parts a) and b) by the compliance due date of February 10, 2020.

A) Critical Incident System (CIS) report #2622-000016-20 was submitted to the Ministry of Long-Term Care (MLTC) ActionLine and was reviewed as part of this Follow-Up inspection. The report documented an incident of unlawful conduct between two residents, causing a risk of harm.

The home's policy "Investigation Process for Suspected Resident Abuse of Another Resident", with revision date December 19, 2019 stated the following under Procedure:
- "As soon as the Supervisor or Manager is made aware of an alleged/actual abuse, an investigation must be conducted immediately. All witnesses must be interviewed and the facts documented."

During an interview, Registered Nurse (RN) #116 stated that they were familiar with the incident as they were informed by PSW #120. The RN said that they assessed the residents, completed Risk Management in Point Click Care (PCC) and reported the incident to the Ministry via the after hours ActionLine. RN #116 said that they informed Assistant Director of Care (ADOC) #104 the day of the incident. When asked if they were interviewed about what had happened as part of an investigation, the RN stated no, but had provided the ADOC an email related to the incident details.

During an interview, Director of Care (DOC) #103 said that they were familiar with the incident and said that the process for conducting an investigation would be completed by the ADOC or the DOC, if warranted, and would include completing the "Craigwiel Gardens/Extendicare Internal Incident Report Form". Documents were reviewed and included the CI report, a copy of the head to toe assessment, copies of progress notes, and a copy of the Risk Management report. When asked if the home had a documented record of the investigation related to the incident, the DOC stated no, and that they would expect an investigation would have been completed.

The licensee failed to comply with part a) related to immediate investigations of critical

incidents.

B) The training records were reviewed related to the home’s policies and processes of completing investigations related to critical incidents as per CO #001. There were no documented records maintained in the home to ensure that registered practical nurses and personal support workers received the training.

During an interview, DOC #103 said that the home had written records that training, related to the investigation process, was provided to management and the registered nurses. There were no documents or records maintained in the home of training provided to registered practical nurses or personal support workers.

The licensee failed to comply with part b) related to training on the home's policies and processes of completing an investigation related to critical incidents. [s. 23. (1)]

2. C) The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report related to staff to resident care concerns.

The clinical records for resident #011 showed a progress note detailing the events of the care concerns reported in the CIS report.

Director of Care (DOC) #103 said they were familiar with resident #011 an had received an email from RN #106 regarding the incident and care concerns. DOC #103 said that ADOC #104 had conducted the investigation, and the written investigation notes should be attached to the CIS report and could be found in the CIS binder.

ADOC #104 said they were familiar with resident #011 and had received an email from RN #106 regarding the incident, they had interviewed resident #011 and the written notes of the interview should have been attached to the CIS report in the CIS binder. However, they were unable to interview any staff members involved in the incident and should have.

A review of the CIS binder showed a copy of the CIS report submitted to the MLTC; however, there were no investigation notes attached to the CIS report within the binder.

D) The Ministry of Long-Term Care (MLTC) received a complaint related to suspected staff to resident abuse.

The Board of Directors of Craigwiel Gardens Long-Term Care Home (LTCH) received a letter through email, which documented concerns regarding staff to resident abuse.

The Board of Directors Chair #117 said they were familiar with an email received by the Board, they had forwarded the email to the Chief Executive Officer of the home and it was their expectation that the concerns contained in the email would have been investigated.

The Chief Executive Officer (CEO) #102 said they were familiar with the email sent to the Board of Directors and they did not participate in an investigation.

The licensee failed to comply with part A) and B) of the order related to immediate investigation and training of the home's policies regarding the required completion of an investigation. Furthermore, the licensee has also failed to immediately investigate, when the home became aware of, an incident of harm or risk of harm involving resident #011, an incident of abuse involving resident #017 and #004 and an incident of suspected staff to resident abuse. [s. 23. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff who provided direct care to residents have received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. mental health issues, including caring for persons with dementia.
3. Behaviour management
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations
In accordance with O. Reg. 79/10, s. 219 (2), which states, “Despite subsection (1), retraining in an area described in paragraph 2 or 10 of subsection 76 (2) of the Act is not required for a person if, since the last training or retraining, there has been no change in the area that is relevant to the person’s responsibilities.”

O. Reg 79/10 s.221(1) states, “For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices,
training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

The licensee has failed to comply with Compliance Order (CO) #001 from inspection #2019_797740_0021, issued on November 18, 2019, with a compliance due date (CDD) of February 10, 2020. This CO included the following details:
The licensee must be compliant with s. 76 (7) of O. Reg. 79/10.

Specifically, the licensee must ensure:

A) All management of the home, including but not limited to the Administrator/ Chief Executive Officer, Director of Care, Assistant Director of Care, Quality Manager and Human Resources Manager, will receive training on the policies and procedures for all required programs in the home. A written record is kept of all training including staff names, dates and training content, to ensure that all management received the training.

B) All direct care staff (registered and non-registered) working in the home will receive education and training on the policies and procedures for all required programs, pursuant to s. 48 of the LTCHA. A written record is kept of all training including staff names, dates and training content, to ensure that all staff received the training.

C) The Chief Executive Officer/Director of Care/Assistant Director of Care will develop and implement an audit to assess the staff’s level of knowledge and application of the training materials, including processes and procedures as outlined in s. 76 of the LTCHA, to identify further training needs and will provide re-training as applicable. The audit must include who is responsible, audit dates, timelines, corrective actions taken and outcomes of the analysis. A written record is kept of all audit materials.

The licensee failed to complete steps A), B), and C) by the compliance due date of February 10, 2020.

Director of Care (DOC) #103 and Assistant Director of Care (ADOC) #104 provided inspectors with binders of materials related to the compliance orders that had been issued. Review of the binders included the following documents:

- “Craigwiel Gardens Education Logs- Received by Employees” Education: Skin and Wound Policy and included signatures and dates of review from management and direct care staff (registered and non-registered).

No written training records for management or staff (registered and non-registered) were maintained related to the policies and procedures as ordered for two of the required programs, Continence Care and Bowel Management and Pain Management.

“Education Summary Report” from Surge Learning, dated December 2019 was reviewed and indicated that staff had completed the following courses:
- “Continence Care for direct Care Staff: A Presentation by Surge Learning Inc.”
- “MODULE 1 The Pain Experience: A Module for direct Care Staff by Surge Learning.”
- “OANHSS Continence Care and Bowel Management Registered Staff”
- “Prevention of Constipation”

Upon review of the outlines for the “Surge Learning” courses, they did not include the specific policies and procedures of the home related to the Continence Care and Bowel Management and the Pain Management programs.

DOC #103 told inspectors that the education completed by staff on “Surge Learning,” related to the required programs of the home, was general education and not related to the policies and procedures of the home.

The DOC also said that management and direct care staff received training on the policies and procedures of the home related to the Falls Prevention and Skin and Wound care programs; however, training was not completed related to the policies and procedures of the home related to Continence Care and Bowel Management and the Pain Management programs.

When DOC #103 was asked about part c) of the order, and if the completion of an audit was done, including the documentation of who was responsible, the audit dates, timelines, corrective actions taken, and any outcomes of the analysis, the DOC said no.

The licensee has failed to comply with CO #001 from Inspection #2019_797740_0021 as

the training and education related to the home's policies and procedures for the Continence Care and Bowel Management and the Pain Management programs for management and direct care staff (registered and non-registered), development and implementation of an auditing process to assess the staff's level of knowledge and application of the training materials, was not completed as ordered by the Compliance Due Date (CDD) February 10, 2020. [s. 76. (7)]

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,
(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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin tears and pressure ulcers, received a skin assessment; immediate treatment to promote healing; was referred to the registered dietitian; and was reassessed at least weekly, if clinically indicated, by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The licensee has failed to comply with Compliance Order (CO) #003 from inspection #2019_797740_0022 issued on November 18, 2019, with a compliance due date of February 10, 2020.

The licensee was ordered to ensure that they were compliant with O. Reg. 79/10 s. 50 (2).
Specifically, the licensee was ordered to:

A) Ensure the home's “Skin and Wound Program: Wound Care Management” policies, including procedures and protocols are reviewed and revised to ensure they provide clear home-specific directions for all staff regarding the processes for residents who exhibit compromised skin integrity. This review must:
i) ensure the policy provides direction for registered nursing staff (RN’s and RPN’s) regarding their roles and responsibilities;
ii) ensure the policy provides direction for non-registered staff (PSW’s) regarding their roles and responsibilities;
iii) include input from the Registered Dietitian (RD) who provides service to the home;
iv) include at least one Personal Support Worker (PSW), one Registered Practical Nurse (RPN) and one Registered Nurse (RN), and the skin and wound lead working in the home to help determine if the policies and procedures provide clear direction for staff;
v) include a documented record of the review and the revisions made, revision date, and names of staff involved.

B) Ensure the Chief Executive Director (CEO), Director of Care (DOC), Assistant Director of Care (ADOC), Quality Manager, any applicable management staff, are trained on the revised skin and wound management policies. The home must keep a documented record of the training provided including: the names, designation and signature of staff who received the education; the staff or delegate who provided the education; the dates when it was provided; and the content that was covered during the education.

C) Ensure all registered and non-registered staff (RPNs, RNs and PSWs) are trained on the revised skin and wound management policies, specific to their roles and responsibilities, including but not limited to, monitoring of residents, documentation, and care planning. The home must keep a documented record of the training provided including: the names, designation and signature of staff who received the education; the staff or delegate who provided the education; the dates when it was provided; and the content that was covered during the education.

D) Ensure that there is a written plan of care for residents #007, #014, #016 and all other residents who have compromised skin integrity, that sets out clear directions to staff (registered and non-registered) and others who provide care to the resident including treatments or interventions and is reflective of the residents' current care needs.

E) Ensure the revised policies and procedures are fully implemented for resident #007, #014, and #016, and any other resident in the home who has compromised skin integrity, including but not limited to the following:
i) a skin assessment, if clinically indicated, by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. Documentation of the assessments must be maintained.
ii) immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection, as required. The treatment and interventions must be documented and updated in the resident’s plan of care.
iii) the resident is immediately referred to and assessed by a registered dietitian who is a member of the staff of the home. Documentation of the referral, nutritional assessment and interventions will be maintained.

F) The home must develop and implement monthly monitoring to ensure that D) and E) of the orders are reviewed for accuracy. The monitoring must include a list of residents to be monitored, who is responsible, dates, timelines, corrective actions taken and outcomes of the analysis. A written record must be kept of all monitoring materials.

The home completed steps A), B) & C).

The home’s revised policy “Skin and Wound Care Management”, last revised January 30, 2020 stated the following:
“Wound Care Lead”
-assesses wounds weekly and documents within the Bates Jensen Wound Assessment Tool (BWAT) within PCC for all pressure and stasis ulcers.
-ensures that resident’s care plan is updated and reflective of current treatment plan
-ensures referrals to OT/PT/Dietary/RD/ET Nurse and others as appropriate.

“The RN/RPN will develop a care plan and implement procedures according to, but not limited to, the following guidelines”:
2. Develop and implement an interdisciplinary plan of care for prevention/treatments.

-Document all skin issues under appropriate assessment.
-Enter treatment(s) and/or follow up onto Electronic record (eTAR)
-update care plan

“RN/RPN will complete required electronic documentation for impaired skin integrity"
-for any new skin issue document assessment under Skin-Weekly Wound Assessment – includes Bates-Jensen be sure to select NEW Wound – Initial Assessment
-Follow up assessments to be done weekly Skin – Weekly Wound Assessment – includes Bates-Jensen- weekly wound reassessment

“Registered Dietitian (RD) receives referrals from Registered Nursing staff for reassessment of diet/supplements”

A) The Care Plan for resident #007 was reviewed in Point Click Care (PCC) and showed that the resident had issues with the maintenance of their skin integrity and therefore was to be monitored closel by staff.

The Treatment Administration Records (TARs) were reviewed and showed specific direction for registered staff to follow to ensure the resident's skin integrity was maintained, as well as certain wound care directives to effectively manage the resident's current wounds. However, only certain and not all of the resident's wounds were reflected in the TARs.

Review of Assessments in PCC again were reflective of completed assessments for only some of the resident's altered areas of skin integrity and not all.

During an interview, Registered Nurse (RN) #106 stated that Registered Practical Nurse (RPN) #118 and the Assistant Director of Care (ADOC) #104 were the leads for the skin and wound program. The RN said that when a Personal Support Worker (PSW) informed them of an altered area of skin integrity, they would assess the resident and complete a skin and wound assessment. They said that if the altered area was a wound, the staff would initiate a “Bates-Jensen wound assessment – new wound” for the initial assessment, and then would complete a weekly assessment thereafter. RN #106 said that all other skin issues, including bruises, blisters, and skin tears, would require staff to complete a “weekly impaired skin integrity” assessment. RN #106 said that any registered staff could complete an assessment and update the monitoring records in the residents’ plans of care. The RN said that which ever registered staff was working that shift, would then complete the eTAR and that treatments and weekly monitoring

assessment reminders were documented in the eTAR for every skin or wound concern. They said that eTAR orders were considered part of the plan of care and would prompt the staff to complete the weekly skin and wound assessments. When asked when the registered staff would submit a referral to the registered dietitian (RD), the RN said that for any new wound, or any deteriorating wound a RD referral should be made and was completed through PCC.

During an interview, ADOC #104 stated that they were the lead of the skin and wound program. The ADOC said that the written plan of care consisted of the care plan, Kardex, progress notes, assessments, and the electronic medication administration and treatment administration records (eMAR/eTAR). When asked how the home ensured that the written plan of care set out clear direction for residents who have compromised skin integrity, including resident #007, the ADOC stated that each month, all residents with altered skin integrity were reviewed as an interdisciplinary team. They said that resident #007's care plan was updated to reflect their current care needs related to skin and wound. The ADOC stated that registered staff were updating the care plans, eTARs and completing assessments, and they would be reviewed. ADOC #104 said that treatments and interventions related to skin and wound were documented in the eTAR as per the home's policy. When asked how referrals were completed to the RD, the ADOC said that registered staff will make a custom progress note under "dietitian referral" and this was expected to be completed for every new altered area of skin integrity. The plan of care for resident #007 was reviewed and showed a physician order on a specific date to monitor areas of altered skin integrity. The ADOC stated that there was no eTAR, dietitian referral or weekly skin and wound assessments completed for the area of altered skin integrity and expected there should have been. [s. 50. (2)]

2. B) The Care Plan for resident #016 was reviewed in Point Click Care (PCC) and showed documentation of altered areas of skin integrity to be monitored and assessed by registered staff. The plan of care also referred to the TAR to provide direction for registered staff regarding treatment of the resident's altered areas of skin integrity; however, only certain altered areas of skin integrity and not all were referenced.

During an interview, RN #106 stated that they were familiar with resident #016's altered areas of skin integrity. The RN said that they would expect a weekly wound assessment to be documented in the eTAR and it was not. When asked how registered staff would know when to complete the weekly wound assessments if they were not documented in the eTAR, the RN said they were not sure. The Inspector and the RN reviewed resident #016's assessments in PCC, the RN said that the weekly wound assessments should

have been completed for all areas of altered skin integrity and that there were assessments missing. They said that the eTAR should have had the weekly wound assessments documented to prompt staff to complete the assessment.

During an interview, ADOC #104 stated that resident #016 had identified areas of altered skin integrity. The ADOC said there were no weekly wound assessments completed on a specified date and no weekly wound assessment completed on another specified date and expected there should have been. The ADOC said that there was no documentation in the eTAR related to the weekly wound assessments and expected there should have been. When asked if there was a RD referral for the areas of altered skin integrity, the ADOC said no.

C) During an interview, ADOC #104 stated that the home did not complete the monthly monitoring to ensure that D) and E) of the order was reviewed for accuracy. The home did not review the residents with altered skin integrity to ensure that a RD referral was completed or that the weekly assessments were completed. Therefore, did not take corrective actions or determine outcomes based on an analysis.

The home failed to ensure that resident #007 and #016 who exhibited altered skin integrity received a skin assessment; were referred to the registered dietitian; and was reassessed at least weekly, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident had occurred that the information upon which it was based was immediately reported to the Director.

On specified date the Ministry of Long-Term Care (MLTC) received a complaint regarding staff to resident suspected abuse.

The home's "Critical Incidents: Reporting of Incidents" policy, last revision date January 2020 stated the following under the heading "Reporting of Incidents": "A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Ministry of Health and Long Term Care:
- Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to a resident;
- Abuse of a resident by anyone or neglect of a resident by the Home or the staff that resulted in harm or a risk of harm to the resident and;
- Unlawful conduct that resulted in harm or a risk of harm to a resident.
The Administrator or designate shall notify the Ministry of Health and Long Term Care Regional Office of any Critical Incident according to the directive below:"
The "directive below" refers to a table, listing the types of incidents, the section of the Long-Term Care Homes Act with which it applies, the action to the be taken by the home

and the reporting time frame for each reportable incident.

A review of the Ministry of Long-Term Care (MLTC) Critical Incident reporting system showed that the home did not submit a corresponding critical incident system report related to the received complaint.

On a specified date Craigwiel Gardens Long-Term Care Home's (LTCH) Board of Directors received a letter, which documented concerns regarding staff to resident abuse.

The Board of Directors Chair #117 said they were familiar with the letter, that they forwarded the letter to the home and they expected that the concerns expressed in the letter would have been reported to the Ministry.

Chief Executive Officer (CEO) #102 said they were familiar with the letter received by the Board of Directors.

The licensee failed to ensure that when suspected abuse which resulted in harm or a risk of harm to residents and the information upon which it was based was immediately report

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Issued on this 27th day of May, 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) :	SAMANTHA PERRY (740), CASSANDRA ALEKSIC (689), CHRISTINA LEGOUFFE (730)
Inspection No. / No de l'inspection :	2020_797740_0007
Log No. / No de registre :	022745-19, 022747-19, 023028-19, 023029-19, 023031-19, 023032-19, 023033-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 26, 2020
Licensee / Titulaire de permis :	Craigwiel Gardens 221 Main Street, R. R. #1, AILSA CRAIG, ON, N0M-1A0
LTC Home / Foyer de SLD :	Craigholme 221 Main Street, R.R. #1, AILSA CRAIG, ON, N0M-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Wayne Williams

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

To Craigwiel Gardens, 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

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_797740_0022, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) 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;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

Specifically, the licensee must:

A) Ensure that every alleged, suspected, or witnessed incidents of abuse involving resident #004, #008, #011, #017 or any other resident by anyone that the licensee knows of, or is reported to the licensee, must be immediately investigated as per the home's investigation process and policies. The home must keep a documented record of this investigation.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected, or witnessed incident of abuse of a resident by anyone that the licensee knows of was immediately investigated.

The licensee has failed to comply with Compliance Order (CO) #001 from inspection #2019_797740_0022 issued on November 18, 2019, with a compliance due date of February 10, 2020.

The licensee was ordered to ensure that they were compliant with LTCHA, 2007 S.O. 2007, c.8, s. 23. (1).

Specifically, the licensee was ordered to:

a) Ensure that every alleged, suspected, or witnessed incidents of abuse of resident #008, #009, #010, or any other resident by anyone that the licensee knows of, or is reported to the licensee, must be immediately investigated. The home must keep a documented record of this investigation.

b) Ensure all management, registered and non-registered staff working in the home, specific to their roles and responsibilities, receive training related to the home's policies and processes of completing an investigation related to Critical Incidents as per O.Reg. 104, including but not limited to, roles and responsibilities, appropriate actions, how to conduct interviews with applicable persons, actions to prevent re-occurrence, follow up with residents and/or their substitute decision-makers and documentation required. A written record will be kept in the home of all training related to the process in completing an investigation, including staff names, dates and training content, to ensure that all management staff working in the home have received the training.

The licensee failed to complete parts a) and b) by the compliance due date of February 10, 2020.

A) Critical Incident System (CIS) report #2622-000016-20 was submitted to the Ministry of Long-Term Care (MLTC) ActionLine on February28, 2020 and was reviewed as part of this Follow-Up inspection. The report documented an incident of unlawful conduct between resident #017 and resident #004 causing risk of harm. The report documented that resident #004 reported to Personal Support Worker (PSW) #120 that co-resident #017 wandered into their room and punched them in the back of the head.

The home's policy "Investigation Process for Suspected Resident Abuse of Another Resident", with revision date December 19, 2019 stated the following under Procedure:
- "As soon as the Supervisor or Manager is made aware of an alleged/actual

abuse, an investigation must be conducted immediately. All witnesses must be interviewed and the facts documented."

During an interview, Registered Nurse (RN) #116 stated that they were familiar with the incident between resident #017 and resident #004. The RN said that they were informed by PSW #120 who said that resident #004 had informed them that resident #017 walked into their room and punched them in the back of the head. The RN said that they assessed the residents, completed Risk Management in Point Click Care (PCC) and reported the incident to the Ministry via the after hours ActionLine on February 28, 2020. RN #116 said that they informed Assistant Director of Care (ADOC) #104 the day of the incident. When asked if they were interviewed about what had happened as part of an investigation, the RN stated no, but had provided the ADOC an email related to the incident details.

During an interview, Director of Care (DOC) #103 said that they were familiar with the incident between resident #017 and resident #004. They said that the process for conducting an investigation would be completed by the ADOC or the DOC, if warranted, and would include completing the "Craigwiel Gardens/Extendicare Internal Incident Report Form". Documents were reviewed and included the CI report, a copy of the head to toe assessment completed on resident #004, copies of progress notes for resident #017 and #004, and a copy of the Risk Management report. When asked if the home had a documented record of the investigation related to the incident, the DOC stated no, and that they would expect an investigation would have been completed.

The licensee failed to comply with part a) related to immediate investigations of critical incidents.

B) The training records were reviewed related to the home's policies and processes of completing investigations related to critical incidents as per CO #001. There were no documented records maintained in the home to ensure that registered practical nurses and personal support workers received the training.

During an interview, DOC #103 said that the home had written records that training, related to the investigation process, was provided to management and the registered nurses. There were no documents or records maintained in the

home of training provided to registered practical nurses or personal support workers.

The licensee failed to comply with part b) related to training on the home's policies and processes of completing an investigation related to critical incidents.

C) The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report on January 10, 2020, related to staff to resident care concerns.

The clinical records for resident #011 showed the following:
-Cognitive Performance Scale indicated 2/6, mild impairment
-Progress note, dated January 9, 2020 documented that the resident asked the ward clerk to have Registered Nurse (RN) #106 go see them. The resident indicated to RN #106 that they did not like to complain but stated that they informed the Personal Support Worker (PSW) that they needed Ventolin treatment to which the night nurse (RN #121) administered. Resident #011 stated that the administration "was a bit rough". The note documented that the resident felt that they needed another Ventolin treatment, so they asked the PSW to let RN #121 know, and no one had returned or provided treatment. The note stated that reassurance was provided to resident #011 and that they could inform the staff if there was something that they did not feel good about.

On March 04, 2020, Director of Care (DOC) #103 said they were familiar with resident #011 an had received an email from RN #106 regarding an incident that occurred on the night of January 09, 2020. DOC #103 said that ADOC #104 had conducted the investigation, and the written investigation notes should be attached to the CIS report and could be found in the CIS binder.

On March 04, 2020, ADOC #104 said they were familiar with resident #011 and had received an email from RN #106 regarding an incident that occurred on the night of January 09, 2020. They had interviewed resident #011 and the written notes of the interview should have been attached to the CIS report in the CIS binder; however, they were unable to interview any staff members involved in the incident and should have.

A review of the CIS binder showed a copy of the CIS report submitted to the MLTC; however, there were no investigation notes attached to the CIS report

within the binder.

D) The Ministry of Long-Term Care (MLTC) received a complaint on February 07, 2020, related to suspected staff to resident abuse.

On January 10, 2020 the Board of Directors of Craigwiel Gardens Long-Term Care Home (LTCH) received a letter through email, which documented concerns regarding staff to resident abuse.

On March 04, 2020 the Board of Directors Chair #117 said they were familiar with an email received by the Board on January 10, 2020 and they had forwarded the email to the Chief Executive Officer of the home and it was their expectation that the concerns contained in the email would have been investigated.

On March 05, 2020 the Chief Executive Officer (CEO) #102 said they were familiar with the email sent to the Board of Directors on January 10, 2020, and that they did not participate in an investigation.

The licensee failed to comply with part A) and B) of the order related to immediate investigation and training of the home's policies regarding the required completion of an investigation. Furthermore, the licensee has also failed to immediately investigate, when the home became aware of, an incident of harm or risk of harm involving resident #011, an incident of abuse involving resident #017 and #004 and an incident of suspected staff to resident abuse.

During this inspection, this non-compliance was found to have a severity of minimal risk to the residents. The scope was widespread as it was found throughout the home and had the potential to impact a large number of residents. The home has a previous history of non-compliance in this area including:
-Written Notification (WN) and Compliance Order (CO) issued November 18, 2019, during inspection 2019_797740_0022. (689)

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 : Jul 31, 2020

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)

Linked to Existing Order / Lien vers ordre existant: 2019_797740_0021, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

Specifically, the licensee must ensure:

A) All management and direct care staff (registered and non-registered) working in the home receive in-person training regarding their roles and responsibilities related to O. Reg 79/10 s. 51 Continence Care and Bowel Management and s. 52 Pain Management programs, pursuant to s. 48 of the LTCHA. A written record will be kept of all training including staff names, dates and training content.

Grounds / Motifs :

1. The licensee has failed to ensure that staff who provided direct care to residents have received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. mental health issues, including caring for persons with dementia.

3. Behaviour management
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations
In accordance with O. Reg. 79/10, s. 219 (2), which states, "Despite subsection (1), retraining in an area described in paragraph 2 or 10 of subsection 76 (2) of the Act is not required for a person if, since the last training or retraining, there has been no change in the area that is relevant to the person's responsibilities."

O. Reg. 79/10 s.221(1) states, "For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices,
training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

The licensee has failed to comply with Compliance Order (CO) #001 from inspection #2019_797740_0021, issued on November 18, 2019, with a compliance due date (CDD) of February 10, 2020. This CO included the following details:
The licensee must be compliant with s. 76 (7) of O. Reg. 79/10.

Specifically, the licensee must ensure:

A) All management of the home, including but not limited to the Administrator/ Chief Executive Officer, Director of Care, Assistant Director of Care, Quality Manager and Human Resources Manager, will receive training on the policies and procedures for all required programs in the home. A written record is kept of all training including staff names, dates and training content, to ensure that all

management received the training.

B) All direct care staff (registered and non-registered) working in the home will receive education and training on the policies and procedures for all required programs, pursuant to s. 48 of the LTCHA. A written record is kept of all training including staff names, dates and training content, to ensure that all staff received the training.

C) The Chief Executive Officer/Director of Care/Assistant Director of Care will develop and implement an audit to assess the staff's level of knowledge and application of the training materials, including processes and procedures as outlined in s. 76 of the LTCHA, to identify further training needs and will provide re-training as applicable. The audit must include who is responsible, audit dates, timelines, corrective actions taken and outcomes of the analysis. A written record is kept of all audit materials.

The licensee failed to complete steps A), B), and C) by the compliance due date of February 10, 2020.

On February 25, 2020, Director of Care (DOC) #103 and Assistant Director of Care (ADOC) #104 provided inspectors with binders of materials related to the compliance orders that had been issued. Review of the binders included the following documents:

- "Craigwiel Gardens Education Logs- Received by Employees" Education: Skin and Wound Policy and included signatures and dates of review from management and direct care staff (registered and non-registered).

No written training records for management or staff (registered and non-registered) were maintained related to the policies and procedures as ordered for two of the required programs, Continence Care and Bowel Management and Pain Management.

"Education Summary Report" from Surge Learning, dated December 2019 was reviewed and indicated that staff had completed the following courses:
- "Continence Care for direct Care Staff: A Presentation by Surge Learning Inc."
- "MODULE 1 The Pain Experience: A Module for direct Care Staff by Surge

Learning."
- "OANHSS Continence Care and Bowel Management Registered Staff"
- "Prevention of Constipation"

Upon review of the outlines for the "Surge Learning" courses, they did not include the specific policies and procedures of the home related to the Continence Care and Bowel Management and the Pain Management programs.

On February 26, 2020, DOC #103 told inspectors that the education completed by staff on "Surge Learning," related to the required programs of the home, was general education and not related to the policies and procedures of the home.

The DOC also said that management and direct care staff received training on the policies and procedures of the home related to the Falls Prevention and Skin and Wound care programs; however, training was not completed related to the policies and procedures of the home related to Continence Care and Bowel Management and the Pain Management programs.

When DOC #103 was asked about part c) of the order, and if the completion of an audit was done, including the documentation of who was responsible, the audit dates, timelines, corrective actions taken, and any outcomes of the analysis, the DOC said no.

The licensee has failed to comply with CO #001 from Inspection #2019_797740_0021 as the training and education related to the home's policies and procedures for the Continence Care and Bowel Management and the Pain Management programs for management and direct care staff (registered and non-registered), development and implementation of an auditing process to assess the staff's level of knowledge and application of the training materials, was not completed as ordered by the Compliance Due Date (CDD) February 10, 2020.

During this inspection, this non-compliance was found to have a severity of minimal risk to the residents. The scope was pattern as it was found in a few areas throughout the home and had the potential to impact some residents. The home has a previous history of non-compliance in this area including:
-Written Notification (WN) and Compliance Order (CO) issued November 18,

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

2019, during inspection 2019_797740_0022. (730)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jul 31, 2020

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)

Linked to Existing Order / Lien vers ordre existant: 2019_797740_0022, CO #003;

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 :

Specifically, the licensee must:

A) Ensure that the written plan of care (including, but not limited to the eTAR) for residents #007, #016 and all other residents who have compromised skin integrity is updated to reflect the residents' current care needs related to each area of altered skin integrity. The home must keep a written record of all updates, including revision dates and persons responsible.

B) Ensure the skin and wound care program is implemented for resident #007, #016, and any other resident in the home who has altered skin integrity, including but not limited to the following:
i) a skin assessment, if clinically indicated, by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. Documentation of the assessments must be maintained.
ii) immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection, as required. The treatment and interventions must be documented and updated in the resident's plan of care.
iii) the resident is immediately referred to and assessed by a registered dietitian who is a member of the staff of the home. Documentation of the referral, nutritional assessment and interventions will be maintained.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin tears and pressure ulcers, received a skin assessment; immediate treatment to promote healing; was referred to the registered dietitian; and was reassessed at least weekly, if clinically indicated, by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The licensee has failed to comply with Compliance Order (CO) #003 from inspection #2019_797740_0022 issued on November 18, 2019, with a compliance due date of February 10, 2020.

The licensee was ordered to ensure that they were compliant with O. Reg. 79/10 s. 50 (2).

Specifically, the licensee was ordered to:

A) Ensure the home's "Skin and Wound Program: Wound Care Management" policies,
including procedures and protocols are reviewed and revised to ensure they provide clear home-specific directions for all staff regarding the processes for residents who exhibit compromised skin integrity. This review must:
i) ensure the policy provides direction for registered nursing staff (RN's and RPN's) regarding their roles and responsibilities;
ii) ensure the policy provides direction for non-registered staff (PSW's) regarding their roles and responsibilities;
iii) include input from the Registered Dietitian (RD) who provides service to the home;
iv) include at least one Personal Support Worker (PSW), one Registered Practical Nurse (RPN) and one Registered Nurse (RN), and the skin and wound lead working in the home to help determine if the policies and procedures provide clear direction for staff;
v) include a documented record of the review and the revisions made, revision date, and names of staff involved.

B) Ensure the Chief Executive Director (CEO), Director of Care (DOC), Assistant Director of Care (ADOC), Quality Manager, any applicable management staff, are trained on the revised skin and wound management policies. The home must keep a documented record of the training provided including: the names, designation and signature of staff who received the education; the staff or delegate who provided the education; the dates when it was provided; and the content that was covered during the education.

C) Ensure all registered and non-registered staff (RPNs, RNs and PSWs) are trained on the revised skin and wound management policies, specific to their roles and responsibilities, including but not limited to, monitoring of residents, documentation, and care planning. The home must keep a documented record of the training provided including: the names, designation and signature of staff who received the education; the staff or delegate who provided the education; the dates when it was provided; and the content that was covered during the education.

D) Ensure that there is a written plan of care for residents #007, #014, #016 and all other residents who have compromised skin integrity, that sets out clear directions to staff (registered and non-registered) and others who provide care to the resident including treatments or interventions and is reflective of the residents' current care needs.

E) Ensure the revised policies and procedures are fully implemented for resident #007, #014, and #016, and any other resident in the home who has compromised skin integrity, including but not limited to the following:
i) a skin assessment, if clinically indicated, by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. Documentation of the assessments must be maintained.
ii) immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection, as required. The treatment and interventions must be documented and updated in the resident's plan of care.
iii) the resident is immediately referred to and assessed by a registered dietitian who is a member of the staff of the home. Documentation of the referral, nutritional assessment and interventions will be maintained.

F) The home must develop and implement monthly monitoring to ensure that D) and E) of the orders are reviewed for accuracy. The monitoring must include a list of residents to be monitored, who is responsible, dates, timelines, corrective actions taken and outcomes of the analysis. A written record must be kept of all monitoring materials.

The home completed steps A), B) & C).

The home's revised policy "Skin and Wound Care Management", last revised January 30, 2020 stated the following:
"Wound Care Lead"
-assesses wounds weekly and documents within the Bates Jensen Wound Assessment Tool (BWAT) within PCC for all pressure and stasis ulcers.
-ensures that resident's care plan is updated and reflective of current treatment plan
-ensures referrals to OT/PT/Dietary/RD/ET Nurse and others as appropriate.

"The RN/RPN will develop a care plan and implement procedures according to, but not limited to, the following guidelines":
2. Develop and implement an interdisciplinary plan of care for prevention/treatments.
-Document all skin issues under appropriate assessment.
-Enter treatment(s) and/or follow up onto Electronic record (eTAR)
-update care plan

"RN/RPN will complete required electronic documentation for impaired skin integrity"
-for any new skin issue document assessment under Skin-Weekly Wound Assessment – includes Bates-Jensen be sure to select NEW Wound – Initial Assessment
-Follow up assessments to be done weekly Skin – Weekly Wound Assessment – includes Bates-Jensen- weekly wound reassessment

"Registered Dietitian (RD) receives referrals from Registered Nursing staff for reassessment of diet/supplements"

A) The Care Plan for resident #007 was reviewed in Point Click Care (PCC) and showed the following:
- encourage eating/drinking as per dietician restrictions. Will refer to dietitian as needed when issues of skin integrity arise.
- Has had a previous ulcer on coccyx. This area is at risk of further breakdown. Ensure all pressure removed from area, inspect area each shift for signs and symptoms of breakdown/pressure, apply barrier cream with care and notify nursing staff as soon as possible
- Follow treatment as per TAR [Treatment Administration Record]

The Treatment Administration Records (TARs) for February 2020 were reviewed and showed:
- "Complete weekly skin impairment assessment for rash at right breast" once daily every seven days. Records showed documentation of "administered" on February 16 and 23, 2020.
- "Monitor open areas to labia. Clean with N/S and apply barrier cream" twice daily every day. Records showed documentation of "administered" from

February 10, 2020 onward.

The TAR for February 2020 did not show an order for a weekly skin and wound assessment for the residents open areas to labia.

Review of Assessments in PCC showed:
-Skin-Weekly Impaired Skin Integrity Assessment, dated February 16, 2020 related to rash to the right breast fold.
-Skin-Weekly Impaired Skin Integrity Assessment, dated February 23, 2020 related to redness under the right breast.

There were no documented skin or wound assessments completed for the open areas to the labia.

During an interview, Registered Nurse (RN) #106 stated that Registered Practical Nurse (RPN) #118 and the Assistant Director of Care (ADOC) #104 were the leads for the skin and wound program. The RN said that when a Personal Support Worker (PSW) informed them of an altered area of skin integrity, they would assess the resident and complete a skin and wound assessment. They said that if the altered area was a wound, the staff would initiate a "Bates-Jensen wound assessment – new wound" for the initial assessment, and then would complete a weekly assessment thereafter. RN #106 said that all other skin issues, including bruises, blisters, and skin tears, would require staff to complete a "weekly impaired skin integrity" assessment. RN #106 said that any registered staff could complete an assessment and update the monitoring records in the residents' plans of care. The RN said that which ever registered staff was working that shift, would then complete the eTAR and that treatments and weekly monitoring assessment reminders were documented in the eTAR for every skin or wound concern. They said that eTAR orders were considered part of the plan of care and would prompt the staff to complete the weekly skin and wound assessments. When asked when the registered staff would submit a referral to the registered dietitian (RD), the RN said that for any new wound, or any deteriorating wound a RD referral should be made and was completed through PCC.

During an interview, ADOC #104 stated that they were the lead of the skin and wound program. The ADOC said that the written plan of care consisted of the

care plan, Kardex, progress notes, assessments, and the electronic medication administration and treatment administration records (eMAR/eTAR). When asked how the home ensured that the written plan of care set out clear direction for residents who have compromised skin integrity, including resident #007, the ADOC stated that each month, all residents with altered skin integrity were reviewed as an interdisciplinary team. They said that resident #007's care plan was updated to reflect their current care needs related to skin and wound. The ADOC stated that registered staff were updating the care plans, eTARs and completing assessments, and they would be reviewed. ADOC #104 said that treatments and interventions related to skin and wound were documented in the eTAR as per the home's policy. When asked how referrals were completed to the RD, the ADOC said that registered staff will make a custom progress note under "dietitian referral" and this was expected to be completed for every new altered area of skin integrity. The plan of care for resident #007 was reviewed and showed a physician order to monitor open areas on labia, which was initiated on February 2, 2020. The ADOC stated that there was no eTAR, dietitian referral or weekly skin and wound assessments completed for the open area and expected there should have been.

B) The Care Plan for resident #016 was reviewed in Point Click Care (PCC) and showed the following:
- "Focus: Skin alteration r/t [related to] pressure areas on bilateral hips"
- "Treatment: See TAR for treatment"

The Treatment Administration Records (TARs) for February 2020 were reviewed and showed:
- "Stage 2 [two] pressure area to bilateral hips" Start date: January 7, 2020. Treatment BID [twice daily] everyday. "Change dressing on bath days or when soiled. Cleanse with normal saline, cover with inadine and dry dressing, bath days are Wednesday days and Saturday evening."
- "Ensure dressing is intact on bilateral hips, resident often removes when in bed." Start date: January 7, 2020. Treatment TID [three times daily] everyday. "Reposition every 2 [two] hours more so when resident is in bed, to offload hips."

The TAR for February 2020 did not show an order for a weekly skin and wound assessment for the residents' stage two pressure areas on bilateral hips.

Assessments completed after February 10, 2020 related to skin and wound:
-Skin -Weekly Wound Assessment – includes Bates-Jensen, dated February 25, 2020 indicated a right hip stage two pressure ulcer
-Skin -Weekly Wound Assessment – includes Bates-Jensen, dated February 11 & 25, 2020 indicated a left hip stage two pressure ulcer

There were no documented weekly wound assessments completed for the right hip the week of February 11th or 18th, 2020; or for the left hip the week of February 18, 2020.

During an interview, RN #106 stated that they were familiar with resident #016's bilateral hip wounds. Resident #016's plan of care was reviewed and showed no orders related to weekly wound assessments for the bilateral hip wounds in their eTAR. The RN said that they would expect that a weekly wound assessment was documented in the eTAR and it was not in the resident's plan of care. When asked how registered staff would know when to complete the weekly wound assessments if they were not documented in the eTAR, the RN said they were not sure. The Inspector and the RN reviewed resident #016's assessments in PCC which identified that the right hip wound had been assessed on February 25, 2020, but not for the previous two weeks. The RN said that the weekly wound assessments should have been completed for all areas of altered skin integrity and that there were assessments missing. They said that the eTAR should have had the weekly wound assessments documented to prompt staff to complete the assessment.

During an interview, ADOC #104 stated that resident #016 had pressure ulcers on bilateral hips and were identified on January 5, 2020. The ADOC said that there were no weekly wound assessments completed on the right hip on February 11 and 18, 2020, and no weekly wound assessment completed on the left hip on February 18, 2020 and expected there should have been. The ADOC said that there was no documentation in the eTAR related to the weekly wound assessments and expected there should have been. When asked if there was a RD referral for the areas of altered skin integrity, the ADOC said no, as the wounds were identified prior to the roll out of the new skin and wound program policies and orders.

C) During an interview, ADOC #104 stated that the home did not complete the

monthly monitoring to ensure that D) and E) of the order was reviewed for accuracy. The home did not review the residents with altered skin integrity to ensure that a RD referral was completed or that the weekly assessments were completed. Therefore, did not take corrective actions or determine outcomes based on an analysis.

The home failed to ensure that resident #007 and #016 who exhibited altered skin integrity, including open wounds and pressure ulcers, received a skin assessment; were referred to the registered dietitian; and was reassessed at least weekly, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

During this inspection, this non-compliance was found to have a severity of minimal risk to the residents. The scope was widespread as it was found throughout the home and had the potential to impact a large number of residents. The home has a previous history of non-compliance in this area including:
-Written Notification (WN) and Compliance Order (CO) issued November 18, 2019, during inspection 2019_797740_0022. (689)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2020

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:

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

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 26th day of May, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Samantha Perry

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