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
Jan 22, 2020	2019_767643_0036	020976-19	Complaint

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

Cummer Lodge
205 Cummer Avenue NORTH YORK ON M2M 2E8

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

ADAM DICKEY (643)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 30, 31, 2019, January 2, 3, 7, 8 and 9, 2020.

The following complaint intakes were inspected during this inspection:
Log #020976-19 - related to skin and wound care and pain management.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Nursing (ADON), Nurse Manager - Clinical (NM), Physician (MD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and resident family member(s).

During the course of the inspection the inspector(s) conducted observation of staff to resident interactions and the provision of care, reviewed resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Pain
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with 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 :

1. The licensee has failed to ensure that resident #020 who was exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment tool that was specifically designed for skin and wound assessment.

a. A complaint was submitted to the Ministry of Long-Term Care (MLTC) from a family member of resident #020 regarding skin and wound care the resident received in the home. The complaint indicated that resident #020 developed an area of altered skin integrity which was being treated but continued to worsen.

Review of resident #020's progress notes showed that on an identified date, staff noted signs of potential skin breakdown and requested the physician to assess the area. A note from the resident's physician two days later, showed resident #020 had a specified area of altered skin integrity identified, with a treatment initiated and instruction to staff to monitor the area. Further review of the progress notes showed no additional documentation of the specified area of altered skin integrity until 12 days later when the area was noted to have increased in size; and had specified characteristics indicating the area was worsening.

Review of the assessments completed for resident #020 showed no assessment of the

specified area of altered skin integrity was completed between the date of assessment by the physician, until a weekly skin assessment form was initiated 12 days later.

In an interview, RN #118 indicated that the area as described in resident #020's physician progress note on the above identified date would be considered altered skin integrity. RN #118 indicated that when an area of altered skin integrity was discovered registered staff would complete a head to toe assessment and put a note in the physician book for the doctor to assess the resident.

In an interview, RPN #117 indicated that when an area of altered skin integrity was noted by staff, registered staff would take a look at the area and document in a progress note reporting the area was found. RPN #117 indicated they would leave a note in the physician book for assessment and not complete a formal assessment tool at that time.

In an interview, ADON #101 indicated that when an area of suspected altered skin integrity was noted by staff and reported to registered staff, the registered staff should assess the area. Upon confirmation that altered skin integrity was present the registered staff would be expected to complete an assessment using the home’s assessment tool for skin and wound assessment which they indicated was the weekly wound assessment form at the time. ADON #101 indicated that when the area of altered skin integrity was discovered for resident #020, a weekly assessment form should have been started by registered staff documenting the measurement and characteristics of the area in order to follow-up to assess the effectiveness of interventions in place. The ADON acknowledged that an assessment by the registered staff had not been completed for resident #020’s specified area of altered skin integrity and should have been.

b. As a result of identified noncompliance with resident #020, the sample of residents reviewed was expanded to include resident #022.

Review of resident #022’s progress notes showed on an identified date, a specified area of altered skin integrity was noted by RN #121, with a note left for the physician to assess. A progress note from the resident’s physician the following day, noted specified characteristics of the area of altered skin integrity, for which a treatment was initiated with the physician to follow-up in one week.

Review of resident #022’s assessments in the home's electronic documentation system did not show an assessment completed by registered staff related to the above specified area of altered skin integrity discovered on the above identified date.

In an interview, RN #119 indicated that when an area of altered skin integrity was identified, registered staff would need to complete a head to toe assessment in the electronic documentation system, document in the resident's progress notes and leave a note for the physician to assess. RN #119 indicated that a head to toe assessment was not completed until one week after the area of altered skin integrity was discovered for resident #022.

In an interview, RN #121 indicated that a head to toe assessment should be completed for a new area of altered skin integrity. RN #121 indicated that they had left a note for the physician to assess resident #022 on the above identified date, but on that day had not completed a head to toe assessment related to the specified area of altered skin integrity.

In an interview, NM – Clinical #109 indicated that the expectation of the home was for registered staff to complete an assessment of any new area of altered skin integrity using the head to toe assessment form in the electronic documentation system. The NM acknowledged that an assessment had not been carried out by registered staff for resident #022's above specified area of altered skin integrity when it was identified by registered staff. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that resident #020 who was exhibiting altered skin integrity was assessed by a registered dietitian who was a member of the staff of the home, and had any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

a. Review of resident #020's progress notes included a note from the resident's physician on an identified date, which showed resident #020 had a specified area of altered skin integrity identified, with a treatment initiated and instruction to staff to monitor the area. Progress notes showed a referral to the RD was noted to be sent 12 days later. An additional progress note two days later, showed a referral was sent to the RD related to the specified area of altered skin integrity. A progress note from 28 days after the physician's note, indicated RD #122 had addressed the referral(s) assessing the resident's intake to not likely meet resident #020's needs for healing; nutrition supplementation was to be started and the resident was to be monitored.

RD #122 was not available for interview at the time of inspection. In an interview, RD #120 indicated it was the expectation for a referral to be sent by the nursing staff for a

resident that was exhibiting altered skin integrity. RD #120 indicated they would review a resident with new areas of altered skin integrity to compare intake of food and fluid with estimated requirements for calories, protein and fluid to promote wound healing. RD #120 indicated they would implement individualized interventions including high calorie, high protein supplements, special snacks and or favored beverages to meet the nutrition and hydration needs of the resident.

In an interview, ADON #101 indicated that it was the expectation of the home for a resident exhibiting altered skin integrity to be referred to the RD for assessment. The ADON indicated that the RD would complete an assessment of the resident's nutrition and hydration needs and implement interventions according to the assessment. The ADON acknowledged that resident #020 had been exhibiting altered skin integrity, and had not been referred for assessment, nor was an assessment carried out by the RD at the time the altered skin integrity was discovered.

b. As a result of identified noncompliance for resident #020, the sample of residents reviewed was expanded to include resident #022.

Review of resident #022's progress notes showed on an identified date a specified area of altered skin integrity was noted by RN #121, with a note left for the physician to assess. A progress note from the resident's physician the following day, noted specified characteristics of the area of altered skin integrity, for which a treatment was initiated with the physician to follow-up in one week

In an interview, RN #121 indicated that resident #022 was exhibiting altered skin integrity and should have been referred to the RD for assessment. RN #121 acknowledged that a referral was not sent to the RD for assessment of resident #022.

Review of resident #022's assessments in PCC showed no referral to the RD was initiated. No assessment by a RD was identified for resident #022 related to the specified area of altered skin integrity.

In an interview, RD #120 indicated that the expectation would be for nursing staff to initiate a referral in PCC for the RD to assess resident #022's nutrition and hydration status for adequacy to promote wound healing. RD #120 acknowledged that a referral was not initiated and an assessment was not completed for resident #022's alteration in skin integrity. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that for resident #020 who was exhibiting altered skin integrity was assessed at least weekly by registered staff.

Review of resident #020's progress notes showed that on an identified date, staff noted signs of potential skin breakdown and requested the physician to assess the area. A note from the resident's physician two days later, showed resident #020 had a specified area of altered skin integrity identified, with a treatment initiated and instruction to staff to monitor the area. Further review of the progress notes showed no additional documentation of the specified area of altered skin integrity until 12 days later when the area was noted to have increased in size; and had specified characteristics indicating the area was worsening.

Review of the assessments completed for resident #020 showed no assessment of the specified area of altered skin integrity was completed during the above mentioned 12 day period until a weekly skin assessment form was initiated and noted the measurements and characteristics of the area.

In an interview, ADON #101 indicated that a weekly wound assessment form should be initiated when an area of altered skin integrity was identified in order to document on the wound and assess if the area was responding to the treatment interventions in place. ADON #101 acknowledged that for resident #020 a weekly wound assessment form was not initiated to monitor the progress of the resident's specified area of altered skin integrity when it was identified. ADON #101 indicated that a weekly assessment of resident #020's area of altered skin integrity should have been completed one week after the altered skin integrity was identified and no weekly assessment had been completed. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #020's pain was not relieved by initial interventions; the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) from a family member of resident #020. The complainant indicated that resident #020 had an area of altered skin integrity and their related pain was not being managed. In an interview, the complainant indicated that resident #020 was exhibiting specified responsive behaviours, and staff of the home told the complainant that it was related to the resident's dementia.

Review of resident #020's progress notes showed resident #020 was exhibiting altered skin integrity which was noted to have developed on an identified date. Further review of the progress notes showed that five days later the resident was exhibiting identified responsive behaviours. The progress note indicated resident #020 was re-assured and re-positioned with no effect. Resident #020 was administered an identified as needed (PRN) medication which had fair effect of reducing agitation. a progress note an additional two days later showed resident #020 was exhibiting specified behaviours. The resident was repositioned with no effect, and the above mentioned PRN medication was administered with some effect. The following day, resident #020 was again noted to be exhibiting the above identified behaviours, and the resident was repositioned with no effect. The above PRN medication was administered with little effect.

Review of resident #020's health records showed a pain assessment had been conducted the month prior to developing the area of altered skin integrity, which showed no pain was exhibited by the resident. No subsequent pain assessment was identified to have been conducted until two months after the area of altered skin integrity was discovered.

Review of enterostomal therapy (ET) assessment conducted 20 days after the area of

altered skin integrity was identified, noting the area was painful to the touch. The ET assessment showed a recommendation to review pain medication.

Review of resident #020's Medication Administration Record (MAR) for an identified month, showed that they were receiving a scheduled analgesic medication three times daily (tid) for generalized pain. Resident #020 did not have any PRN analgesic medication in place until the day following the assessment by the ET nurse; the physician implemented an additional analgesic medication order to be administered prior to dressing changes.

In interviews, RNs #117 and #118 indicated that resident's would be assessed quarterly for effectiveness of pain management during review of the resident's plan of care. The RNs indicated that when residents were showing signs of pain and had no PRN analgesic medication in place a pain assessment should be carried out to evaluate the type of pain experienced and the level of pain the resident was experiencing. The RNs indicated that the assessment form used in the home was called pain assessment and was based on the abbey pain assessment and could be used for residents who could not express their pain verbally. RN #117 and #118 indicated that a resident who was exhibiting the above mentioned responsive behaviours as identified in resident #020's progress notes would be considered to be triggered by pain symptoms and should be assessed for pain.

In an interview, ADON #101 indicated that a pain assessment would be carried out quarterly, with a significant change in condition and at any time that the resident's pain is not controlled by the interventions in place to treat pain. The ADON indicated that the progress notes documenting resident #020's behaviours on the three above identified dates, would potentially have been triggered by pain experienced from the area of altered skin integrity. The ADON indicated that as resident #020 was not receiving any PRN medication for pain, registered staff would be expected to carry out a pain assessment to evaluate resident #020's pain and refer to the physician for pain management interventions. The ADON indicated that the above identified medication would not treat pain and the agitation resident #020 was exhibiting was not managed by this intervention in combination with the scheduled analgesic order, as the resident was not prescribed anything for breakthrough pain. The ADON acknowledged that a pain assessment had not been carried out when resident #020's pain was not controlled by the initial interventions. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

Issued on this 29th day of January, 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) :	ADAM DICKEY (643)
Inspection No. / No de l'inspection :	2019_767643_0036
Log No. / No de registre :	020976-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 22, 2020
Licensee / Titulaire de permis :	City of Toronto c/o Seniors Services and Long-Term Care, 365 Bloor Street East, 15th Floor, TORONTO, ON, M4W-3L4
LTC Home / Foyer de SLD :	Cummer Lodge 205 Cummer Avenue, NORTH YORK, ON, M2M-2E8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tim Burns

To City of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 :

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 be compliant with s. 50. (2) of the Regulation (O. Reg. 79/10).

Specifically, the licensee must:

1.) Provide training to all members of the registered staff of the home to include but not be limited to the following:
a.) The definition of altered skin integrity, and what type of conditions should be treated as altered skin integrity;
b.) The assessment process for registered staff to complete an assessment of each area of altered skin integrity for residents and the initiation of weekly assessments until the area of altered skin integrity is noted to be healed; and
c.) The process for referral to a registered dietitian (RD) who is a member of the staff of the home for assessment of a resident exhibiting altered skin integrity for the adequacy of nutrition and hydration to promote wound healing.

2.) Maintain a written record of the training provided, which should include the name and signature of the registered staff member, the date the training was provided, the method of training provided and the materials presented;

3.) Implement an auditing system to ensure the registered staff of the home conduct assessment of altered skin integrity, refer to the interdisciplinary team including the RD, and the initiation and completion of weekly assessments of altered skin integrity. The auditing system should be conducted randomly for a period of three months following the service of this order;

4.) Maintain a written record of audits conducted including the resident reviewed, type of altered skin integrity, date of onset of the area of altered skin integrity; date of initial assessment by registered staff; date of referral to the RD, date of completion of assessment by the RD, whether weekly assessments were conducted until the area of altered skin integrity was resolved, the name of the person completing the audit and the result of the audit including any corrective action taken in response to the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #020 who was exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment tool that was specifically

designed for skin and wound assessment.

a. A complaint was submitted to the Ministry of Long-Term Care (MLTC) from a family member of resident #020 regarding skin and wound care the resident received in the home. The complaint indicated that resident #020 developed an area of altered skin integrity which was being treated but continued to worsen.

Review of resident #020's progress notes showed that on an identified date, staff noted signs of potential skin breakdown and requested the physician to assess the area. A note from the resident's physician two days later, showed resident #020 had a specified area of altered skin integrity identified, with a treatment initiated and instruction to staff to monitor the area. Further review of the progress notes showed no additional documentation of the specified area of altered skin integrity until 12 days later when the area was noted to have increased in size; and had specified characteristics indicating the area was worsening.

Review of the assessments completed for resident #020 showed no assessment of the specified area of altered skin integrity was completed between the date of assessment by the physician, until a weekly skin assessment form was initiated 12 days later.

In an interview, RN #118 indicated that the area as described in resident #020's physician progress note on the above identified date would be considered altered skin integrity. RN #118 indicated that when an area of altered skin integrity was discovered registered staff would complete a head to toe assessment and put a note in the physician book for the doctor to assess the resident.

In an interview, RPN #117 indicated that when an area of altered skin integrity was noted by staff, registered staff would take a look at the area and document in a progress note reporting the area was found. RPN #117 indicated they would leave a note in the physician book for assessment and not complete a formal assessment tool at that time.

In an interview, Acting Director of Nursing (ADON) #101 indicated that when an area of suspected altered skin integrity was noted by staff and reported to

registered staff, the registered staff should assess the area. Upon confirmation that altered skin integrity was present the registered staff would be expected to complete an assessment using the home's assessment tool for skin and wound assessment which they indicated was the weekly wound assessment form at the time. ADON #101 indicated that when the area of altered skin integrity was discovered for resident #020, a weekly assessment form should have been started by registered staff documenting the measurement and characteristics of the area in order to follow-up to assess the effectiveness of interventions in place. The ADON acknowledged that an assessment by the registered staff had not been completed for resident #020's specified area of altered skin integrity and should have been.

b. As a result of identified noncompliance with resident #020, the sample of residents reviewed was expanded to include resident #022.

Review of resident #022's progress notes showed on an identified date, a specified area of altered skin integrity was noted by RN #121, with a note left for the physician to assess. A progress note from the resident's physician the following day, noted specified characteristics of the area of altered skin integrity, for which a treatment was initiated with the physician to follow-up in one week.

Review of resident #022's assessments in the home's electronic documentation system did not show an assessment completed by registered staff related to the above specified area of altered skin integrity discovered on the above identified date.

In an interview, RN #119 indicated that when an area of altered skin integrity was identified, registered staff would need to complete a head to toe assessment in the electronic documentation system, document in the resident's progress notes and leave a note for the physician to assess. RN #119 indicated that a head to toe assessment was not completed until one week after the area of altered skin integrity was discovered for resident #022.

In an interview, RN #121 indicated that a head to toe assessment should be completed for a new area of altered skin integrity. RN #121 indicated that they had left a note for the physician to assess resident #022 on the above identified date, but on that day had not completed a head to toe assessment related to the

specified area of altered skin integrity.

In an interview, NM – Clinical #109 indicated that the expectation of the home was for registered staff to complete an assessment of any new area of altered skin integrity using the head to toe assessment form in the electronic documentation system. The NM acknowledged that an assessment had not been carried out by registered staff for resident #022's above specified area of altered skin integrity when it was identified by registered staff. (643)

2. The licensee has failed to ensure that resident #020 who was exhibiting altered skin integrity was assessed by a registered dietitian who was a member of the staff of the home, and had any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

a. Review of resident #020's progress notes included a note from the resident's physician on an identified date, which showed resident #020 had a specified area of altered skin integrity identified, with a treatment initiated and instruction to staff to monitor the area. Progress notes showed a referral to the RD was noted to be sent 12 days later. An additional progress note two days later, showed a referral was sent to the RD related to the specified area of altered skin integrity. A progress note from 28 days after the physician's note, indicated RD #122 had addressed the referral(s) assessing the resident's intake to not likely meet resident #020's needs for healing; nutrition supplementation was to be started and the resident was to be monitored.

RD #122 was not available for interview at the time of inspection. In an interview, RD #120 indicated it was the expectation for a referral to be sent by the nursing staff for a resident that was exhibiting altered skin integrity. RD #120 indicated they would review a resident with new areas of altered skin integrity to compare intake of food and fluid with estimated requirements for calories, protein and fluid to promote wound healing. RD #120 indicated they would implement individualized interventions including high calorie, high protein supplements, special snacks and or favored beverages to meet the nutrition and hydration needs of the resident.

In an interview, ADON #101 indicated that it was the expectation of the home for a resident exhibiting altered skin integrity to be referred to the RD for

assessment. The ADON indicated that the RD would complete an assessment of the resident's nutrition and hydration needs and implement interventions according to the assessment. The ADON acknowledged that resident #020 had been exhibiting altered skin integrity, and had not been referred for assessment, nor was an assessment carried out by the RD at the time the altered skin integrity was discovered.

b. As a result of identified noncompliance for resident #020, the sample of residents reviewed was expanded to include resident #022.

Review of resident #022's progress notes showed on an identified date a specified area of altered skin integrity was noted by RN #121, with a note left for the physician to assess. A progress note from the resident's physician the following day, noted specified characteristics of the area of altered skin integrity, for which a treatment was initiated with the physician to follow-up in one week

In an interview, RN #121 indicated that resident #022 was exhibiting altered skin integrity and should have been referred to the RD for assessment. RN #121 acknowledged that a referral was not sent to the RD for assessment of resident #022.

Review of resident #022's assessments in PCC showed no referral to the RD was initiated. No assessment by a RD was identified for resident #022 related to the specified area of altered skin integrity.

In an interview, RD #120 indicated that the expectation would be for nursing staff to initiate a referral in PCC for the RD to assess resident #022's nutrition and hydration status for adequacy to promote wound healing. RD #120 acknowledged that a referral was not initiated and an assessment was not completed for resident #022's alteration in skin integrity. (643)

3. The licensee has failed to ensure that for resident #020 who was exhibiting altered skin integrity was assessed at least weekly by registered staff.

Review of resident #020's progress notes showed that on an identified date, staff noted signs of potential skin breakdown and requested the physician to assess the area. A note from the resident's physician two days later, showed

resident #020 had a specified area of altered skin integrity identified, with a treatment initiated and instruction to staff to monitor the area. Further review of the progress notes showed no additional documentation of the specified area of altered skin integrity until 12 days later when the area was noted to have increased in size; and had specified characteristics indicating the area was worsening.

Review of the assessments completed for resident #020 showed no assessment of the specified area of altered skin integrity was completed during the above mentioned 12 day period until a weekly skin assessment form was initiated and noted the measurements and characteristics of the area.

In an interview, ADON #101 indicated that a weekly wound assessment form should be initiated when an area of altered skin integrity was identified in order to document on the wound and assess if the area was responding to the treatment interventions in place. ADON #101 acknowledged that for resident #020 a weekly wound assessment form was not initiated to monitor the progress of the resident's specified area of altered skin integrity when it was identified. ADON #101 indicated that a weekly assessment of resident #020's area of altered skin integrity should have been completed one week after the altered skin integrity was identified and no weekly assessment had been completed.

The severity of this issue was determined to be a level 3 as there was actual risk or actual harm to the residents affected. The scope of the issue was a level 2 as two out of three residents reviewed were affected. The home had a level 3 compliance history as the home had previous noncompliance in the last 36 months with O. Reg. 79/10, s. 50 (2) that included:
- Written notification (WN) and voluntary plan of correction (VPC) issued November 13, 2018 (2018_644507_0019); and
- WN and VPC issued August 6, 2019 (2019_780699_0017).
(643)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 22, 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:

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 22nd day of January, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Adam Dickey

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