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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
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1e étage, 609 rue Kumpf
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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 19, 2021	2020_739694_0031	018500-20, 021177-20, 021178-20, 023615-20	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Dufferin
151 Centre Street Shelburne ON L9V 3R7

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

Dufferin Oaks
151 Centre Street Shelburne ON L9V 3R7

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

AMANDA COULTER (694)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 10, 11, 14, 15, 16, and 17, 2020.

This inspection was conducted concurrently with complaint inspection #2020_739694_0032.

The following intakes were inspected during this critical incident (CI) system inspection;
Log #018500-20, change in condition,
Log #021178-20, a follow up inspection to CO #001 from inspection #2020_610633_0016, O. Reg. 79/10, s. 50 (2) (b), related to the home's skin and wound program,
Log #021177-20, a follow up inspection to CO #002 from inspection #2020_610633_0016, O. Reg. 79/10, s. 81, related to resident needs,
Log #023615-20, related to fall prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The inspectors also toured the home, observed the provision of care and services , reviewed relevant documents, including but not limited to clinical records, policies and procedures, internal investigation notes and training records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 81.	CO #002	2020_610633_0016	694

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,
(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).

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 failed to ensure that residents received a skin and wound assessment upon return from hospital.

a) A resident was transferred to hospital for further medical assessment and treatment after they sustained a fall. The resident sustained injuries as a result of the fall. There were no skin or wound assessments completed when the resident returned to the home with new skin tears and bruising that were sustained during the fall.

Sources: Resident's skin and wound assessment records, post fall assessment, progress notes and an interview with an RPN.

b) A resident was transferred to hospital for further medical assessment and treatment.

When they returned to the home there were no skin or wound assessments completed.

The resident had several wounds at the time of the hospitalization.

The resident was prone to skin breakdown and there was a risk that new wounds were not identified, and appropriate monitoring and treatments may not have been implemented by not completing skin and wound assessments on their return from hospital.

Sources: Resident's skin and wound assessment records, progress notes and an interview with an RPN. [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when they experienced a skin issue.

The inspector observed a skin issue on a resident and there were no skin assessments completed for this skin issue.

Due to a skin and wound assessment not being completed, appropriate monitoring was not implemented.

Sources: observations of a resident, resident's wound assessment records, progress notes and an interview with an RPN. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that weekly skin and wound assessments were completed for residents.

a) A resident's wound assessment records identified pressure ulcers.

There were incomplete or no weekly skin assessments completed for the resident's skin issues. One of the pressure areas did not include any measurements or staging and no assessment was completed for a two week period. No weekly assessments were completed for another skin issue for a week and there were no weekly assessments completed for a large laceration that was sustained as a result of a fall.

Sources: Resident's skin and wound assessment records, post fall assessment, progress

notes and an interview with an RPN.

b) A resident had a number of pressure ulcers that were to be assessed weekly by a registered staff member. During a one month period, weekly assessments were not completed for pressure ulcers at least four times.

Sources: Resident’s wound assessment records, progress notes and an interview with an RPN.

c) A resident had a number of pressure ulcers that were to be assessed weekly by a registered staff member.

During a one month period, assessments were incomplete. The stage of the pressure ulcers was not consistently identified and weekly assessments were not completed for the pressure ulcers on three occasions.

The resident's wound assessment records for some of the pressure ulcers said the wounds deteriorated, while others remained unchanged.

The gap in completed weekly assessments posed a risk that appropriate treatments may not have been provided which could have contributed to the worsening of wounds.

Sources: Resident’s wound assessment records, progress notes and an interview with an RPN. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

Issued on this 20th day of January, 2021

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) :	AMANDA COULTER (694)
Inspection No. / No de l’inspection :	2020_739694_0031
Log No. / No de registre :	018500-20, 021177-20, 021178-20, 023615-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 19, 2021
Licensee / Titulaire de permis :	Corporation of the County of Dufferin 151 Centre Street, Shelburne, ON, L9V-3R7
LTC Home / Foyer de SLD :	Dufferin Oaks 151 Centre Street, Shelburne, ON, L9V-3R7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Brenda Wagner

To Corporation of the County of Dufferin, 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)

Linked to Existing Order / Lien vers ordre existant: 2020_610633_0016, CO #001;

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 50 (2) (a) (ii), (b) (iv).

Specifically, the licensee must ensure that:

A) Resident #004 and #007 receive a skin and wound assessment upon return from hospital.
B) Resident #004 receives an initial skin assessment for skin and wound concerns using a clinically appropriate tool when clinically indicated.
C) Resident #004, #006 and #007 receive a weekly skin assessment for areas of skin and wound concerns using a clinically appropriate tool when clinically indicated.
D) An auditing process is developed and implemented to ensure compliance with the legislation and the home's process for the initial and weekly skin assessments of skin and wound concerns. The date, who is responsible for completing the audit, the residents audited, the results and actions taken in response must be documented and a record kept in the home. Audits are to be completed on a weekly basis until such time as staff are compliant with the legislation and the home's skin and wound policy.

Grounds / Motifs :

1. Compliance order #001 related to O. Reg. 79/10, s. 50 (2) (b) (i) (ii) (iv) from inspection 2020_610633_0001 issued on November 2, 2020, with a compliance due date of November November 13, 2020 is being re-issued.

The licensee failed to ensure that residents received a skin and wound assessment upon return from hospital.

a) A resident was transferred to hospital for further medical assessment and treatment after they sustained a fall. The resident sustained injuries as a result of the fall. There were no skin or wound assessments completed when the resident returned to the home with new skin tears and bruising that were sustained during the fall.

Sources: Resident's skin and wound assessment records, post fall assessment, progress notes and an interview with an RPN.

b) A resident was transferred to hospital for further medical assessment and

treatment. When they returned to the home there were no skin or wound assessments completed.

The resident had several wounds at the time of the hospitalization.

The resident was prone to skin breakdown and there was a risk that new wounds were not identified, and appropriate monitoring and treatments may not have been implemented by not completing skin and wound assessments on their return from hospital.

Sources: Resident's skin and wound assessment records, progress notes and an interview with an RPN. [s. 50. (2) (a) (ii)]
(694)

2. The licensee failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when they experienced a skin issue.

The inspector observed a skin issue on a resident and there were no skin assessments completed for this skin issue.

Due to a skin and wound assessment not being completed, appropriate monitoring was not implemented.

Sources: observations of a resident, resident's wound assessment records, progress notes and an interview with an RPN. [s. 50. (2) (b) (i)] (694)

3. The licensee has failed to ensure that weekly skin and wound assessments were completed for residents.

a) A resident's wound assessment records identified pressure ulcers.

There were incomplete or no weekly skin assessments completed for the resident's skin issues. One of the pressure areas did not include any measurements or staging and no assessment was completed for a two week period. No weekly assessments were completed for another skin issue for a

week and there were no weekly assessments completed for a large laceration that was sustained as a result of a fall.

Sources: Resident's skin and wound assessment records, post fall assessment, progress notes and an interview with an RPN.

b) A resident had a number of pressure ulcers that were to be assessed weekly by a registered staff member. During a one month period, weekly assessments were not completed for pressure ulcers at least four times.

Sources: Resident's wound assessment records, progress notes and an interview with an RPN.

c) A resident had a number of pressure ulcers that were to be assessed weekly by a registered staff member.

During a one month period, assessments were incomplete. The stage of the pressure ulcers was not consistently identified and weekly assessments were not completed for the pressure ulcers on three occasions.

The resident's wound assessment records for some of the pressure ulcers said the wounds deteriorated, while others remained unchanged.

The gap in completed weekly assessments posed a risk that appropriate treatments may not have been provided which could have contributed to the worsening of wounds.

Sources: Resident's wound assessment records, progress notes and an interview with an RPN. [s. 50. (2) (b) (iv)]

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

Severity: Lack of assessment and treatment may have contributed to worsening wounds.

Scope: This non-compliance was widespread as 3/3 residents reviewed were not assessed on a weekly basis and 2/3 were not assessed upon return from

hospital when they had pressure sores and skin tears.

Compliance history: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 50 (2) of O. Reg 79/10. This subsection was issued as a CO on November 2, 2020, during inspection #2020_610633_0016 with a compliance due date of November 13, 2020. The home had one other CO issued on September 18, 2020, during inspection #2020_610633_0016, failing to comply with s. 81 of O. Reg. 79/10 that is complied. (694)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 18, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 19th day of January, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amanda Coulter

Service Area Office /
Bureau régional de services : Central West Service Area Office