Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 26, 2015	2014_376594_0020	S-000436-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE KIRKLAND LAKE
155 GOVERNMENT ROAD EAST P.O. BAG 3900 KIRKLAND LAKE ON P2N 3P4

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

MONIKA GRAY (594), MARINA MOFFATT (595), SYLVIE LAVICTOIRE (603)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 27 - 31 and November 03 - 06, 2014

During the course of the inspection, the inspector(s) spoke with Residents, Housekeeping Staff, Health Care Aides (HCA), Personal Support Workers (PSWs), Bachelor of Science Nursing Student, Office Manager, Activity Coordinator, Physical Therapist Assistant, Dietitian, Dietary Manager, Registered Practical Nurses (RPNs), Registered Nurses (RNs); Director of Care and the Administrator.

The inspector(s) also reviewed various policies, health care records including plans of care and other documentation within the home, conducted daily walk through of the resident care areas, observed staff to resident interactions and the provision of care to residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #361 that set out clear directions to staff and others who provided direct care to the resident. On October 23, 2014, Inspector #603 reviewed resident #361's health care record and noted an order from the attending physician which stated; If eats less than half, offer a nutritional drink three times a day. The inspector reviewed the care plan, which stated; if refuses a meal, offer a nutritional drink.

Inspector #603 interviewed staff member #S-003 who stated that all physician orders are to be transcribed by nursing staff who would automatically transfer updated information in the written care plan. Given the physician order stated if eats less than half, offer the nutritional drink three times a day, and the care plan stated if refuses a meal offer a nutritional drink; the written plan of care failed to set out clear direction to staff and others who provide care to resident #361. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #388. Inspector #595 reviewed resident #388's health care record, where it was identified that the resident had six wounds, with two of the identified wounds located in the same anatomical position. The inspector reviewed the resident's care plan dated October 2014 which identified only four wounds.

Inspector #594 asked staff #S-018 for clarification between two wounds, which were documented in the same anatomical position. Staff #S-018 told the inspector that other staff would chart the same wound in two different descriptions.

Inspector #594 observed six wounds on resident #388. Inspector #594 spoke with staff #S-018 who confirmed that the care plan did not identify one wound observed by the inspector.

Inspector #595 reviewed the home's policy 'Skin Treatments' dated June 2010 which stated that the care plan is to be updated to indicate the location of skin alteration(s) and any interventions or treatment required.

The inspector reviewed the electronic treatment administration record (eTAR) for resident #388 where there were no interventions listed specifically for one of the observed wounds on resident #388.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #388, as the care plan was missing the identification of one wound, and identified the incorrect location of another. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #377 related to the use of bed rails. Inspector #594 observed resident #377 on October 28, November 04 and 05, 2014 with one quarter bed rail in use. The inspector interviewed resident #377 who stated one quarter bed rail is always in use. Staff #S-009 told the inspector that the resident has two quarter bed rails in use.
The inspector reviewed resident #377's electronic care plan and Kardex which failed to identify any use of bed rails.

Review of Bed Entrapment and Proper Use of Bed rail Devices policy #08-10-11 states registered staff are to conduct a needs assessment for bed rail devices with every resident and to use the Bed Rail Decision Tree. According to the document, identification of the bed system (including bed rail devices) currently being used by the resident, is to be documented in their care plan. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #402. Inspector #603 interviewed resident #402 who explained that staff clean their dentures once a day. Inspector #603 reviewed the resident's care plan and noted the focus pertaining to Oral/dental stated the resident will clean their own teeth. The care plan focus pertaining to the ADL-Personal hygiene stated that staff will brush the resident's dentures however the care plan failed to

identify how often the oral/denture care should be provided. Inspector #603 interviewed staff #S-005 who stated the resident is able to brush their own teeth, however the resident wants staff to brush their teeth. [s. 6. (1) (c)]

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. 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 #388, exhibiting altered skin integrity, had been reassessed at least weekly by a member of the registered nursing staff. Inspector #595 reviewed resident #388's care plan, when resident #388 was identified with wounds. The care plan identified that the resident had five wounds all greater than a stage 2.

Inspector #595 reviewed the home's Pressure Ulcers policy #03-07 dated June 2010. The policy outlines that any pressure wound greater than a stage 2 is to be assessed weekly by the Skin Care Coordinator or delegate. Inspector #594 spoke with the Administrator who stated that staff are expected to document the weekly wound assessments in PointClickCare (PCC) under the Assessments tab, and the assessment will trigger a progress note.

Inspector #595 reviewed 'EO Weekly Wound Care' assessments in PCC during a four month period when resident #388 was identified with wounds. It was determined that on two occasions there was no documentation of a weekly wound assessment by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 resident #388 and any other resident exhibiting altered skin integrity, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated and documentation is according to the home's documentation process, to be implemented voluntarily.

WN #3: 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. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff received retraining in infection prevention and control, on an annual basis. Inspector #594 reviewed the home's Infection Prevention and Control In-service Record of Content for 2013. Hand hygiene training was completed August 29, 2013 (For September 2013) with 95 out of a 105 (90%) attendance. Modes of infection transmission training was completed on September 18, 2013 with 117 of 121 (97%) attendance. Cleaning and Disinfecting training was completed on October 23 and 24, 2013 with 111 of 118 (94%) attendance. Use of personal protective equipment training was competed on November 14, 2013 with 15 out of 18 (84%) manager attendance and on November 14, 18 and 25, 2013 remainder of staff with 93% attendance. The licensee failed to ensure all staff received retraining annually. [s. 76. (4)]

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 all staff receive retraining in infection prevention and control practices annually, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program. On November 05, 2014 at the lunch service and on November 6th, 2014 at the breakfast service, Inspector #603 observed resident #391 sitting in the common hallway, outside of their room for meals. Inspector #603 interviewed staff #S-006 who stated that the resident was on contact and droplet precautions for symptoms of nausea/diarrhea, vomiting, nasal congestion, sore throat,

and coughing. The inspector observed a sign secured to the outside of the resident's room that stated Droplet Precautions and had an insert indicating: Resident to wear surgical mask when out of the room. Inspector #603 failed to observe any Contact Precautions signage.

The inspector reviewed the home's Isolation policy #INFE-03-01-12 which stated that isolation practices require that the resident not leave their room for any reason other than an emergency situation, that all care needs should be met in the resident's room with care staff wearing personal protective equipment (PPEs) and practicing routine/standard practice and where required, additional precautions. According to the document, a sign must be placed on the door to the resident's room requiring visitors to check with the nurse before entering the room. Inspector #603 reviewed the home's Contact Precautions policy #INFE-03-01-09 which stated a contact precautions sign is to be placed on the resident room door advising visitors to speak with a nurse before entering the room. Given that resident #391 was observed eating their meals in the common hallway, the licensee failed to ensure that staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

2. The licensee has failed to ensure staff participate in the implementation of the infection prevention and control program. On October 28, 2014 Inspector #594 observed, in a spa room, a used unlabelled hairbrush, used unlabelled razor, two used unlabelled deodorant sticks and a bag of used hair curlers under towels on a shelf. The inspector observed, in another spa room, a used unlabelled deodorant stick and used nail clippers on a shelf beside the tub. In another spa room the inspector observed a used unlabelled comb and five used and unlabelled nail clippers in a cupboard beside the tub.

Inspector #594 interviewed staff #S-019 who stated nail clippers are shared amongst the residents and cleaned with an alcohol wipe between use. The inspector reviewed the home's Cleaning Resident Care Equipment: Introduction Policy #RESI-06-02-01 which states to refer to specific sections in Activities of Daily Living. Review of the Activities of Daily Living Personal Hygiene/Grooming Nail Care: Hands Policy #RESI-05-07-16 and Foot Care- of Toenails Policy #RESI-05-07-18, by Inspector #594 states that after trimming fingernails/toenails, to clean the equipment and return to the appropriate place. The above policies did not specify how equipment is to be cleaned. In an interview with the inspector, the administrator and DOC stated nail clippers are not to be shared amongst residents. [s. 229. (4)]

3. The licensee has failed to ensure staff participate in the implementation of the infection

prevention and control program. On October 31, 2014 during a walk through of the home, Inspector #594 observed a cart with Personal Protective Equipment outside a resident room. Inspector #594 interviewed staff #S-007 and a Bachelor of Science Nursing student who stated the cart was there because the room is under isolation.

Review of the home's Infection Prevention and Control Isolation Policy #INFE-03-01-12 version 2013 states that once it is determined a resident requires isolation, the required PPE's will be placed outside the resident's door and a sign must be placed on the door to the resident's room requiring visitors to check with the nurse before entering the room. Signage will also include the kind of precaution and PPE's required to provide care for the resident. The DOC confirmed to inspector #594 that no sign was posted on the resident's room door and verified that the room was under isolation. [s. 229. (4)]

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 that all staff participate in the infection prevention and control program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed. Inspector #594 observed resident #377 on October 28, November 04 and 05, 2014 with one quarter bed rail in use. Inspector #594 interviewed resident #377 who stated one quarter bed rail is always in use and the other quarter bed rail they can adjust. Staff #S-009 told the inspector that the resident has two quarter bed rails in use.

The inspector reviewed resident #377's electronic care plan and Kardex which failed to identify any use of bed rails. Review of the most recent Minimum Data Set dated September 28, 2014 identified daily use of bed rails. Review of Bed Entrapment and Proper Use of Bed rail Devices policy #08-10-11 stated registered staff are to conduct a needs assessment for bed rail devices with every resident and to use the Bed Rail Decision Tree. According to the document, identification of the bed system (including bed rail devices) currently being used by the resident, is to be documented in their care plan.

During an interview with the inspector staff #S-009 stated that PSWs would access the Kardex to identify the bed rail used for a resident, and if the bed rail isn't listed "it is what it is". Staff #S-009 also stated to the inspector that there is no formal assessment of residents related to bed rail use. Inspector #594 provided a copy of the home's Bed Entrapment and Proper Use of Bed rail Devices policy #08-10-11 including Bed Rail Decision Tree Appendix II to staff #S-009 who stated it was not used to assess residents for bed rails.

During an interview with inspector #594, the administrator stated any use of bed rails are to be documented on the care plan. Inspector #594 provided a copy of the home's Bed Entrapment and Proper Use of Bed rail Devices policy #08-10-11 including Bed Rail Decision Tree Appendix II to the administrator who told inspector #594 that the Bed Rail Decision Tree is not used all the time. Therefore where bed rails were used in the case of resident #377 who had one quarter bed rail in use which was not documented in the care plan, the licensee failed to ensure that resident #377 had been assessed. [s. 15. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident received oral care, including mouth care and cleaning of dentures in the morning and evening. On November 3, 2014 Inspector #603 interviewed resident #402 who stated that they are unable to clean their dentures and requires staff to assist. The resident also explained that staff only clean their dentures once a day, usually in the morning or at night. Inspector #603 interviewed staff #S-005 who stated that the resident is capable to do their own teeth but chooses not too. In an interview with the inspector, staff #S-004 stated that staff only provide oral care as needed but is being done at least once a day.

Review of resident #402's care plan with focus on Oral/Dental care, identified that the resident will clean their own teeth. Review of care plan with focus to Personal hygiene, states the staff will brush the resident's dentures but fails to identify how often to provide denture care. [s. 34. (1) (a)]

2. The licensee has failed to ensure that resident #360 was offered an annual dental assessment. Inspector #594 reviewed resident #360 health care records for documentation pertaining to offering an annual dental assessment and was unable to locate any information. Inspector #594 interviewed staff #S-009 who stated documentation is located in the Interdisciplinary Team Care Conference Assessment and/or accompanying progress note. Upon review of resident #360 health care record, Staff #S-009 told the inspector that there was no documentation offering an annual dental assessment. Inspector #594 reviewed resident #355, #377 and #388 health care record's and there was no documentation offering annual dental assessments. [s. 34. (1) (c)]

Issued on this 27th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MONIKA GRAY (594), MARINA MOFFATT (595), SYLVIE LAVICTOIRE (603)
Inspection No. / No de l'inspection :	2014_376594_0020
Log No. / Registre no:	S-000436-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 26, 2015
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE KIRKLAND LAKE 155 GOVERNMENT ROAD EAST, P.O. BAG 3900, KIRKLAND LAKE, ON, P2N-3P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennifer Kasner

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the written plan of care sets out clear direction for Resident #361 with respect to their food intake; Resident #402 with respect to their oral care, Resident #377 with respect to their use of bed rails and Resident #388 with respect to their wound care.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #402. Inspector #603 interviewed resident #402 who explained that staff clean their dentures once a day. Inspector #603 reviewed the resident's care plan and noted the focus pertaining to Oral/dental stated the resident will clean their own teeth. The care plan focus pertaining to the ADL-Personal hygiene stated that staff will brush the resident's dentures however the care plan failed to identify how often the oral/denture care should be provided. Inspector #603 interviewed staff #S-005 who stated the resident is able to brush their own teeth, however the resident wants staff to brush their teeth. (603)

2. The licensee has failed to ensure that there was a written plan of care for resident #361 that set out clear directions to staff and others who provided direct care to the resident. On October 23, 2014, Inspector #603 reviewed resident #361's health care record and noted an order from the attending physician which stated; If eats less than half, offer a nutritional drink three times a day. The inspector reviewed the care plan, which stated; if refuses a meal, offer a nutritional drink.

Inspector #603 interviewed staff member #S-003 who stated that all physician orders are to be transcribed by nursing staff who would automatically transfer updated information in the written care plan. Given the physician order stated if eats less than half, offer the nutritional drink three times a day, and the care plan stated if refuses a meal offer a nutritional drink; the written plan of care failed to set out clear direction to staff and others who provide care to resident #361. (603)

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #388. Inspector #595 reviewed resident #388's health care record, where it was identified that the resident had six wounds, with two of the identified wounds located in the same anatomical position. The inspector reviewed the resident's care plan dated October 2014 which identified only four wounds.

Inspector #594 asked staff #S-018 for clarification between two wounds, which were documented in the same anatomical position. Staff #S-018 told the inspector that other staff would chart the same wound in two different descriptions.

Inspector #594 observed six wounds on resident #388. Inspector #594 spoke with staff #S-018 who confirmed that the care plan did not identify one wound observed by the inspector.

Inspector #595 reviewed the home's policy 'Skin Treatments' dated June 2010 which stated that the care plan is to be updated to indicate the location of skin alteration(s) and any interventions or treatment required.

The inspector reviewed the electronic treatment administration record (eTAR) for resident #388 where there were no interventions listed specifically for one of the observed wounds on resident #388.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #388, as the care plan was missing the identification of one wound, and identified the incorrect location of another. (595)

4. The licensee has failed to ensure that the plan of care set out clear directions

to staff and others who provide direct care to resident #377 related to the use of bed rails. Inspector #594 observed resident #377 on October 28, November 04 and 05, 2014 with one quarter bed rail in use. The inspector interviewed resident #377 who stated one quarter bed rail is always in use. Staff #S-009 told the inspector that the resident has two quarter bed rails in use.
The inspector reviewed resident #377's electronic care plan and Kardex which failed to identify any use of bed rails.

Review of Bed Entrapment and Proper Use of Bed rail Devices policy #08-10-11 states registered staff are to conduct a needs assessment for bed rail devices with every resident and to use the Bed Rail Decision Tree. According to the document, identification of the bed system (including bed rail devices) currently being used by the resident, is to be documented in their care plan. (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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M5S-2B1
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La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 26th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Monika Gray

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