Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
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Public Report

Report Issue Date: January 3, 2025

Inspection Number: 2024-1178-0004

Inspection Type:
Complaint
Critical Incident

Licensee: Omni Healthcare (Lambton) Limited Partnership, by its general partner, Omni Healthcare (Lambton) GP Ltd.

Long Term Care Home and City: Bear Creek Terrace, Petrolia

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 22, 23, 24, 25, 28, 29, 31, 2024 and November 1, 4, 5, 6, 2024

The following intake(s) were inspected:

- Intake: #00120710 Critical Incident #2673-000024-24 - Incident with injury to a resident for which the resident is taken to the hospital and which results in a significant change in health status.
- Intake: #00121069 Critical Incident #22673-000025-24 - Incident with injury to a resident for which the resident is taken to the hospital and which results in a significant change in health status.
- Intake: #00121172 Critical Incident #22673-000026-24 - Incident with injury to a resident for which the resident is taken to the hospital and which results in a significant change in health status.
- Intake: #00122063 Critical Incident #22673-000028-24 - Incident with injury to a resident for which the resident is taken to the hospital and which results in a significant change in health status.
- Intake: #00125505 Critical Incident #22673-000031-24 - Incident with injury to a resident for which the resident is taken to the hospital and which results in a significant change in health status.

- Intake: #00128949 Critical Incident #22673-000038-24 - Incident with injury to a resident for which the resident is taken to the hospital and which results in a significant change in health status.
- Intake: #00129131 Critical Incident #22673-000039-24 - Incident with injury to a resident for which the resident is taken to the hospital and which results in a significant change in health status.
- Intake: #00129751 Critical Incident #22673-000040-24 - Incident with injury to a resident for which the resident is taken to the hospital and which results in a significant change in health status.

- Intake: #00126047 Critical Incident #2673-000032-24 – Improper/Incompetent treatment or care of a resident that results in harm or risk to a resident.
- Intake: #00128758 Critical Incident #2673-000037-24 – Improper/Incompetent treatment or care of a resident that results in harm or risk to a resident.

- Intake: #00127958 Complaint concerns related to plan of care.
- Intake: #00128690 Complaint concerns related to nursing and personal support services, bathing, alleged neglect.
- Intake: #00123875 Complaint concerns related to care and services, availability of supplies, menu planning, staffing.
- Intake: #00124593 Complaint concerns related to staffing.
- Intake: #00129523 Complaint concerns related to nursing and personal support services and menu planning
- Intake: #00129737 Complaint concerns related to nursing and personal support services.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Responsive Behaviours
Staffing, Training and Care Standards

Reporting and Complaints
Palliative Care
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

The licensee failed to ensure that procedures were implemented and that resident's assistive devices/aides were cleaned as required.

RATIONALE AND SUMMARY:
An inspector observed two resident's assistive devices to be unclean and in poor condition.

During an interview the condition of the resident's assistive devices was brought to staff's attention. They indicated that the devices would be replaced immediately and that checking all resident's equipment would audited.

Date Remedy Implemented: November 6, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that the written plan of care for a resident set out clear directions to staff on management of a resident's personal items that should be secured.

RATIONALE AND SUMMARY:
A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care where a resident was taken to hospital with a change in their health status.

Review of the CIS indicated that a resident's care plan had been updated and that the home would inform the resident of a new safety intervention.

During a review of this resident's care plan on a specific date it did not state any direction to staff related to the safety intervention.

The Inspector observed the resident's room and found that the identified intervention was not in place.

During an interview with the Administrator it was stated that the Director of Care was tasked with updating the resident's care plan with the same information stated in the CIS report. During the Administrator's review of the resident's care plan, it was identified that the care plan was not updated to provide clear direction to staff on management of this resident's items that required secure storage.

By not having the resident's care plan updated with clear direction to staff, this posed a moderate risk to other residents on the home area who could potentially have access to the resident's items. There was low impact to the resident.

SOURCES: CIS report, resident's care plan, interviews with resident and the Administrator.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

RATIONALE AND SUMMARY:
A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care which documented that a resident stated that a Personal Support Worker (PSW) was alone when the resident was transferred. The resident's plan of care included that the resident required extensive assistance from two staff for safe transfers.

A PSW stated that they transferred the resident by themselves.

Not transferring the resident using two people as set out in the plan of care put the resident at risk for falling.

SOURCES: Critical Incident, resident's plan of care, and interview with the PSW.

WRITTEN NOTIFICATION: Powers of Residents' Council

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee failed to ensure that Residents' Council concerns were responded to in writing within 10 days.

RATIONALE AND SUMMARY:
During complaint inspections related to staffing concerns the inspector identified

that sufficient staffing and staffing challenges were documented during recent Residents' Council meetings at the home. Council concerns were not responded to in writing within 10 days of being received.

A review of the home's Residents' Council meeting minutes for the past four months from June - September 2024, found that the August 26, 2024, minutes and the September 30, 2024, meeting minutes under new business noted staffing concerns.

A written response from the Administrator accompanied the September 30, 2024, meeting minutes dated October 22, 2024, thus not within 10 days.

During an interview with the Administrator, they indicated that they were not aware that a written response to the Resident Council concerns, recommendations or advice was required within 10 days.

When the home did not provide a written response or a timely response to council's staffing concerns they potentially risked jeopardizing the relationship with council and that council concerns, recommendations or advice might not be taken seriously.

SOURCES: complaint intakes, Residents' Council Meeting minutes, interviews.

WRITTEN NOTIFICATION: Equipment Use

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to ensure that a Personal Support Worker (PSW) used a specific lift in accordance with the manufacturers' instructions when providing care to a resident.

RATIONALE AND SUMMARY:
A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care which stated in part that, a resident had manipulated the lift, they moved their body forward which caused an incident to occur.

A concern/complaint report submitted to the home by a PSW documented that during a conversation with another PSW, the first PSW forgot some safety features during a lift resulting in the resident having an incident.

The instructions for using the lift provided specifics when in use by a resident.

During an interview with the Administrator, they stated that, due to the resident's cognition they would not have been capable of manipulating the lift. The Administrator acknowledged that the safety measures were not used at the time of the incident.

Not using the equipment in accordance with the manufacturers' instructions caused the resident to have a incident.

SOURCES: Critical Incident, concern/complaint report, instructions for the lift, and interview with the Administrator.

WRITTEN NOTIFICATION: Bathing

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 37 (1)

Bathing

s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was provided two baths per week.

RATIONALE AND SUMMARY:

A resident was scheduled a bath two times per week. The resident's Point of Care (POC) charting was reviewed and the resident did not receive their bath on a specific date. The hard copy bath list on the unit was not signed for by staff. No progress notes were recorded to indicate why the resident's bath was not done or that it was made up for on another day.

During an interview with a Registered Practical Nurse (RPN) they stated that the resident's missed bath should be picked up the following day as per the home's missed bath procedure.

The Director of Care (DOC) confirmed that the resident did not receive their bath.

Not ensuring the resident was provided with two baths a week could have a potential negative impact on the resident relating to skin condition and dignity.

SOURCES: Resident's clinical records and staff interviews.

WRITTEN NOTIFICATION: Mouth Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)

Oral care

s. 38 (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;

The licensee failed to ensure that a resident received mouth care in the morning.

RATIONALE AND SUMMARY:

A resident was observed, following a rest period, with an unclean face. Point of Care documentation indicated that the resident was provided mouth care prior to the observation.

During an interview with the Director of Care (DOC) they stated that the mouth care was documented but was not done.

By failing to ensure that the resident received oral care in the morning, there was risk of the resident's oral tissues being compromised.

SOURCES: Observation, and interview with the DOC.

WRITTEN NOTIFICATION: Safe Transferring

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that safe transferring techniques were used when assisting a resident.

RATIONALE AND SUMMARY:
A Critical Incident System (CIS) report was submitted to The Ministry of Long-Term Care indicating that a resident had an incident. The home's investigation noted that a staff member had used a lift without a second staff member present.

The home's policy titled, "Mandatory Lift and Transfer Procedures", last reviewed January 12, 2024, instructed in part that, all mechanical lifts, including bath chairs, required two employees to be present while transferring a resident.

During an interview the Acting Director of Care (A/DOC) acknowledged that two staff should have been present while the lift was being used for this resident.

Not using a safe transferring technique when assisting the resident caused the resident have an incident and sustain an injury.

SOURCES: Critical Incident, the home's lift and transfer policy, the home's investigation notes, and interview with the A/DOC.

WRITTEN NOTIFICATION: Clean Clothing

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 44
Dress
s. 44. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their

own clean clothing and in appropriate clean footwear.

The licensee failed to ensure that a resident was dressed in clean clothing.

RATIONALE AND SUMMARY:
A resident was observed in their wheelchair with clothing that was unclean.

The following day the resident was observed to be wearing unclean clothes with dried food on them.

During an interview with the Director of Care (DOC) stated that if a resident's clothes are dirty then staff should change the residents clothing or the soiled area should be cleaned if it is possible.

SOURCES: Observations, and interview with the DOC.

WRITTEN NOTIFICATION: Clean Personal Equipment

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(ii) supplies and devices, including personal assistance services devices, assistive

aids and positioning aids, and

The licensee failed to ensure that procedures were implemented and a resident's wheelchair was cleaned following a meal.

RATIONALE AND SUMMARY:
A resident's wheelchair was not cleaned following a meal where the chair was soiled with food.

While the resident was in bed, their wheelchair was observed to be unclean. The resident's chair was later observed with the resident in the chair and remained unclean with the same debris.

During an interview with the Director of Care (DOC), they stated that the chair should have been cleaned following the meal.

A resident's wheelchair was observed following the scheduled cleaning and the resident's chair remained unclean.

The DOC and Administrator observed the chair and agreed that the resident's wheelchair was unclean and should have been cleaned on the scheduled cleaning day.

Not ensuring the resident's personal wheelchair was free from debris and potential bacteria posed a risk for infections to the resident.

SOURCES: Observations of the resident personal equipment, and interviews with staff.

WRITTEN NOTIFICATION: Dealing With Complaints

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to ensure that a written complaint concerning the care of a resident was investigated and resolved where possible, and a response was provided within 10 business days of the receipt of the complaint.

RATIONALE AND SUMMARY:

A complaint concerning the care of a resident was e-mailed to the Resident Services Coordinator (RSC) on a specific date. The RSC forwarded the complaint, on the same day, to the Director of Care (DOC) for follow up.

During an interview with the DOC, they were unable to produce documentation that the complaint was investigated or that a response was provided to the complainant within 10 business days. The DOC acknowledged that there was no record of investigation into the complaint or response to the complainant.

Not investigating the complaint or responding to the complainant posed minimal risk to the resident.

SOURCES: e-mail to RSC and interview with the DOC.

WRITTEN NOTIFICATION: Record of Complaints

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee failed to ensure that a record for the written/verbal complaint concerning the care of a resident was completed.

RATIONALE AND SUMMARY:
A complaint concerning the care of a resident was forwarded to the Director of Care (DOC). The date of the complaint was unknown.

During an interview with the DOC they were able to locate a complaint, but they were unable to produce a record of the complaint. The DOC acknowledged that the complaint process was not followed as there were no notes, dates, follow up or a response from the complainant.

Not keeping a record of the complaints received by the home impacts the resident as the concerns were not addressed and the home cannot conduct quality improvement by analyzing trends for complaints.

SOURCES: Complaint to DOC and interview with the DOC.

COMPLIANCE ORDER CO #001 Nursing and personal support services

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (a)
Nursing and personal support services
s. 35 (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1) Complete a review of the home's staffing mix for Personal Support Workers and Registered Nursing Staff to ensure all shifts are covered for the identified care needs of the residents, for each home area.

2) Conduct an analysis on the number of line vacancies and the manner in which the licensee is working to fill those gaps. This will include identifying who is responsible, for Personal Support Worker staff and Registered Nursing Staff, for each home area.
3) Complete a weekly analysis of the actual shifts worked compared to shifts that

were scheduled, and how many times the home's contingency plan was utilized. This will be completed until the order is complied.

4) The Administrator, Director of Care (DOC) or designate will complete a monthly analysis of staffing insufficiencies as it relates to monthly statistics for increased falls that occurred when the home was working short of nursing staff and monthly statistics of skin/wound concerns that have worsened or were acquired when the home was working short of nursing staff.

5) Ensure that all of the above reviews and analyses are documented, who participated and corrective actions taken, if any, to be produced to inspectors upon request.

Grounds

The licensee failed to ensure that the home's staffing mix was consistent with the resident's assessed care and safety needs when the residents did not receive care according to their assessed needs.

RATIONALE AND SUMMARY:
There were several complaints about staffing shortages that resulted in residents not receiving care and services according to their assessed needs and delays in resident's care.

The Administrator provided a document titled "Continuous Quality Improvement Initiative – Interim Report 2024." The document outlined Recruitment and Retention as the home's number one priority, with a goal to minimize the number of times units work without their allotted number of staff as per the Master Schedule by ensuring all positions are filled.
The Inspector noted an increase in fall and skin and wound care statistics for

specific quarters in 2024.

An interview with Restorative Coordinator/Falls Lead, and a review of the home's performance indicator report for falls found that the fall statistics in a specific month on a home area, that 10/12 falls occurred when the unit was working short of nursing staff, this was confirmed by Restorative Coordinator/Falls Lead.

An interview with the Skin and Wound Lead and review of the home's performance indicator report for skin and wound found an increase in skin concerns from the first to second quarter. The Lead could not discount that a potential increase could be directly related to the home working short of nursing shifts and expressed specific concerns related to care and service being done consistently when the home was working short nursing staff.

During Critical Incident reviews and resident interviews it was reported that residents expressed concerns with having to wait prolonged periods for staff assistance with their continence care.

A review of staffing schedules for two time periods showed significant staffing shortages on each of the days reviewed.
The Administrator acknowledged the nursing staffing shortages, where shifts not filled fell below the home's staffing complement and that the licensee had not been able to recruit and retain staff according to the licensee's staffing plan and that resident's did not receive care and services according to their assessed needs.

The licensee failed to ensure residents received timely and appropriate care when there were a number of registered nursing and personal support worker shifts not filled consistently, as per the homes staffing mix.

SOURCES: Several residents' clinical health records, staffing schedules, home's performance indicators and interviews with staff and residents.

This order must be complied with by March 21, 2025

COMPLIANCE ORDER CO #002 Skin and Wound Care

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:

1) Provide education to all registered staff, specific to the use of a clinically appropriate assessment instrument for new areas of altered skin integrity.

2) Maintain documentation of the education, including the names of the staff, their designation, date the training was provided and who provided the education.

3) Conduct weekly audits for four weeks on all units to ensure a clinically appropriate assessment instrument is being completed by registered staff for all new areas of altered skin integrity.

4) Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings and any corrective actions taken.

Grounds

The licensee failed to ensure that a resident who was exhibiting altered skin integrity, received a skin assessment using a clinically appropriate assessment instrument.

RATIONALE AND SUMMARY:
A review of the resident's progress notes indicated that they had an incident and sustained an injury.

During an interview with the Acting Director of Care (DOC) they stated that this would have been considered altered skin integrity and an initial assessment should have been completed in Point Click Care (PCC) within the skin and wound tab.

A review of the skin and wound tab in PCC did not include an initial assessment of the resident's altered skin integrity. The Acting DOC acknowledged that an initial assessment, using a clinically appropriate assessment, was not completed.

Not completing an initial assessment of the area of impaired skin integrity put the resident at risk of not receiving appropriate treatment of the area.

SOURCES: A resident's progress notes and skin and wound assessments, an

interview with the Acting DOC.

The licensee failed to ensure that an initial skin assessment using a clinically appropriate assessment instrument was completed when a resident exhibited altered skin integrity.

RATIONALE AND SUMMARY:
A resident had an incident in the home and sustained injuries, resulting in altered skin integrity.

During an interview with the Acting Director of Care (DOC), they stated that the expectation in the home was that an initial Skin and Wound Evaluation was completed in Point Click Care (PCC) for each area of altered skin integrity.

A review of the resident's Skin and Wound Evaluations did not include a clinically appropriate assessment instrument for the resident's skin tears in PCC. The Acting DOC acknowledged that an initial assessment, using a clinically appropriate assessment instrument, was not completed.

Not completing an initial skin and wound assessment for the resident placed them at a potential risk of undetected deterioration in their skin tears and a potential for a delay in treatment changes.

Sources: a resident's clinical records and interview with the Acting DOC.

This order must be complied with by February 21, 2025

COMPLIANCE ORDER CO #003 Skin and Wound Care

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: The licensee shall be compliant with O. Reg s. 55 (2) (b) (iv). Specifically, the licensee must:

1. Ensure that residents with areas of altered skin integrity are reassessed weekly by a member of the registered nursing staff, if clinically indicated, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

2. Complete for a specified home area, a weekly audit of all residents where a weekly wound assessment is clinically indicated. The audits are to be completed for a minimum of one month.

3. Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings and any corrective actions taken.

4. Conduct education on the licensee's Skin and Wound Program policies and the

use of a clinically appropriate assessment instrument specifically designed for skin and wound assessments, with any registered nursing staff designated to complete weekly wound assessments.

5. Maintain documentation of the education, including the names of the staff, their designation, and date training was provided.

Grounds

The licensee failed to ensure that a resident who exhibited altered skin integrity was reassessed at least weekly.

RATIONALE AND SUMMARY:
A resident sustained an injury of unknown cause resulting in an alteration in their skin integrity. Review of the Skin and Wound Evaluation for the resident in Point Click Care (PCC) showed documentation of an initial wound assessment on a specific date. Weekly wound and skin assessments were not completed consistently post incident.

An interview completed with an RPN indicated that the Skin and Wound Evaluation is to be completed weekly.

Not completing the Skin and Wound Evaluation reassessment posed a moderate risk to the resident by not monitoring the healing pattern.

SOURCES: a resident's clinical records, interview with an RPN.

The licensee failed to ensure that a resident's altered skin integrity was reassessed at least weekly.

RATIONALE AND SUMMARY:
A resident sustained an injury following an incident. A review of the residents Skin and Wound Evaluation within Point Click Care (PCC) showed documentation of the injury on a specific date. A subsequent reassessment using the Skin and Wound Application was due to be completed but this reassessment was not completed.

An interview with an RPN indicated that the Skin and Wound Application was to be completed weekly for all wounds.

Not having the resident's alteration in skin integrity reassessed could have had a potential negative impact on the resident relating to a delay in treatment if the assessment indicated.

SOURCES: Record review of assessments, and staff interview

The licensee failed to ensure that a resident had their alteration in skin integrity reassessed at least weekly.

RATIONALE AND SUMMARY:
The resident sustained an injury, with alteration in their skin integrity, cause of the injury was unknown. Review of the residents Skin and Wound Evaluation within Point Click Care (PCC) showed documentation of the initial wound assessment on a specific date. A subsequent reassessment using the Skin and Wound Application was due to be completed but this reassessment was not completed.

An interview with an RPN indicated that the Skin and Wound Evaluation was to be completed weekly.

The risk to the resident not having the reassessment completed was moderate due to not monitoring the healing pattern of the altered skin integrity.

SOURCES: a resident's clinical records, interview with an RPN.

This order must be complied with by February 21, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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