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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 10, 2018	2018_750539_0006	013891-18	Resident Quality Inspection

Licensee/Titulaire de permis

Corporation of the County of Bruce
41 McGivern Street P.O. Box 1600 WALKERTON ON N0G 2V0

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

Gateway Haven Long Term Care Home
671 Frank Street P.O. Box 10 WIARTON ON N0H 2T0

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

VALERIE GOLDRUP (539), MARIA MCGILL (728), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 11-13,16-20, 23-25, and July 30-August 3, 2018

The following intakes were completed during this inspection:
Log #014831-17, #005091-18 and # 00578-18- Critical Incidents related to Abuse and Neglect
Log #025260-17, and #011649-17- Critical Incidents related to two Falls
Log #026661-17 and #007060-18- Critical Incidents related to Resident to Resident Abuse

Log #023037-17 -Follow Up to Compliance Order #001 related to s. 24. (1) from RQI 2017_610633_0015 / 013758-17
Log #023038-17 –Follow Up to Compliance Order #002 related to s. 20. (1) from RQI 2017_610633_0015 / 013758-17 Upheld and altered with Director Review completed September 23, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator (s), the Director of Care, the Assistant Director of Care, the Recreation and Leisure Supervisor, the Environmental Supervisor, the Clinical Coordinator Registered Nurse, the Resident Assessment Instrument (RAI) Coordinator, the Administrative Assistant, Pharmacists, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers, Environmental Services Workers, a Registered Dietitian, a Receptionist, a Food Service Worker, a Registered Practical Nurse Student, Family Members and Residents.

During the course of the inspection the inspectors toured the home and observed resident care, services and activities. Clinical records and plans of care for identified residents were reviewed. Also, relevant documents were reviewed including but not limited to the home's documentation and procedures as related to the inspection. Additionally, the inspector(s) observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleanliness and condition of the home.

Inspector, Kim Byberg (729) attended this inspection.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1.The licensee has failed to protect residents from abuse by anyone.

1. The licensee has failed to protect a resident from sexual abuse by another resident.

O. Reg. 79/10 states that "sexual abuse" means,
(a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or
(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in April, 2018. It stated that a Personal Support Worker (PSW) witnessed one resident inappropriately touching another resident.

In an interview with the DOC, they said that the resident who was touched would be unable to provide consent.

The resident who touched the resident had a documented history of responsive behaviours prior to this incident and interventions in the plan of care.

The licensee has failed to protect a resident from sexual abuse by another resident.

2. The licensee has failed to protect a resident from abuse by staff.

O. Reg. 79/10 states that "physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain".

A CIS Report was submitted to the MOHLTC that stated an allegation of physical abuse by a PSW towards a resident in March, 2018. The CIS further stated that a PSW held the resident's arm up over their head and bent it at the elbow and they used excessive force during the resident's care. The CIS stated that when the resident was asked if pain was experienced they nodded their head yes.

Another PSW said they heard the resident screaming and they witnessed the PSW with the resident's arm up over their head pushing down on the headrest. They also said that the resident responded to having pain by nodding yes. A PSW and a Registered Practical Nurse said that it was unlike the resident to scream.

The PSW involved in the incident stated that they had lifted the resident's arm up to their shoulder level to wash underneath however they denied that they had bruised the resident.

The home's investigation records included two colour photos that showed an unknown body part with a bruise.The DOC confirmed that these photos were of the resident and they stated that it was a new bruise after the incident.

The licensee has failed to protect a resident from abuse by a PSW.

3. The licensee has failed to protect a resident from abuse by staff.

O. Reg. 79/10 states that "emotional abuse means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident"
.
O. Reg. 79/10 states that "verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

A CIS Report was submitted to the MOHLTC that stated an allegation of abuse by a RPN towards a resident that occurred in July, 2017. The CIS further stated that the RPN swore at the resident, raised their fist and placed paper towel in the resident's mouth while providing care.

The home's investigation records included a signed statement from a PSW that stated they witnessed the RPN yell, use profanity and shove paper towel in the resident's mouth to prevent the resident from spitting on them.

In interview, a RPN said that the PSW had reported to them that they observed paper towel in the resident's mouth and the RPN involved was verbal and aggressive towards the resident.

The Administrator confirmed that this incident was deemed to be resident abuse.

The licensee has failed to protect the resident from abuse by a Registered Practical Nurse.

The licensee has failed to ensure that the three residents were protected from abuse.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The licensee has failed to comply with Compliance Order #002 from inspection 2017_610633_0015 issued on September 22, 2017, with a compliance due date of December 29, 2017, related to 20. (1) of the Long Term Care Homes Act, 2007. The compliance order stated in part:
-"That the procedures within the policy for investigating alleged, suspected or witnessed abuse and neglect of residents is complied with".

The "RQI 2017- plans for non-compliance" dated October 2, 2017, stated that the home's new abuse policy contained templates for written statements from all witnesses and the alleged abuser plus a checklist for supervisors or the charge nurse at time of incident. These written statements and supervisor check lists would be forwarded to the Administrator to assist with the investigation. All documentation was to be kept.

The "Prevention of Abuse and Neglect of a Resident VII-G-10.00" was the current policy implemented at the home. The home's abuse policy stated in part:
-The Administrator/DOC or designate would initiate the investigation by requesting that anyone aware of, or involved in the situation, including the alleged abuser, would write, sign and date a statement that accurately described the event.
-The Administrator/DOC would interview the resident, other residents or persons who may have knowledge of the incident.
-If statements have been written, the Administrator/DOC interviews those persons after the statement had been written.

The home's abuse policy appendix (b) titled "Prevention of Abuse and Neglect of a Resident-Actual or Suspected VII-G-10.00 (b)" stated that this nursing checklist was to be used with any issues of suspected or actual abuse of a resident. This checklist also stated that the Charge Nurse, Clinical Care RN, DOC or Administrator would interview all possible witnesses before the shift ended and request written accounts of the incident. They would also refer to the investigation template VII-G-10.00 (c).

A) The home's investigation records related to Critical Incident System report (CIS) M526 -000011-18 that occurred in March, 2018, did not include a resident interview, a nursing checklist, investigation templates or signed statements from the alleged abuser and all witnesses or persons aware of the incident at the time that incident occurred. Two Registered Practical Nurses (RPNs) said they were aware of the incident and were not asked to write their statement related to this incident. A Registered Nurse (RN) said that they did not complete any documentation as their role was to inform the DOC to investigate. The investigation was not initiated and reported to the MOHLTC until four days after the incident.

B) The home's investigation records related to CIS Report M526-00009-18 did not include a resident interview, a nursing checklist, investigation templates or signed statements from all the witnesses at the time of the incident. Two RPNs said they were aware of the incident and they were not asked to write their statement. A RN said that their understanding was the nursing checklist was a guide.

A RN said that the expectation was that the registered staff or whoever was in charge would obtain the written statements at the time of the incident from the resident and all staff involved or aware of the situation which included the alleged abuser. The DOC confirmed that the home's abuse policy related to investigations and documentation was

not followed.

C) A CIS Report was submitted to the MOHLTC related to an incident of resident to resident sexual abuse that occurred in April, 2018, where a resident was found touching a resident.

The PSW who witnessed the event provided a written statement of the event. No other statements were collected related to the incident contained in the investigation records. In an interview with DOC, they said that their process was to get statements from staff members that witnessed the event and not others because they wanted to avoid getting hearsay. They said that obtaining statements from staff members who were aware of the incident and on shift, may have assisted in determining how the incident occurred.

The DOC said that the policy was not followed for the investigation of this incident.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with related to the investigation and documentation of the incidents.

2. Compliance Order #002 from inspection 2017_610633_0015 related to s. 20 (1) of the Long Term Care Homes Act, 2007 had a compliance due date of December 29, 2017. The compliance due date was not past due at the time of the incident and therefore, this is further evidence to support the compliance order that was issued on September 22, 2017.

A) A Critical Incident System Report (CIS) was submitted to the MOHLTC that stated an allegation of improper treatment of a resident by a RPN that had occurred in July, 2017.

The home's policy "Prevention of Abuse and Neglect" stated that a thorough investigation would be completed which included that all staff interviews and statements would be completed.

The home's investigation records did not include all statements from staff witnesses or with knowledge of the incident. This included the alleged abuser.

The Director of Care confirmed that the home's abuse policy was not followed.

B) A Critical Incident System Report (CIS) was submitted to the MOHLTC in November,

2017, for an incident that occurred where a Personal Support Worker reported that one resident was inappropriately touching another resident. The CIS completed by the home documents this incident as resident to resident sexual abuse.

The DOC said that a verbal statement was provided, that the situation had already been dealt with when they became aware of it, and that they made a decision that the progress note written by another registered staff was sufficient. The DOC said that in retrospect the policy related to investigating allegations of abuse was not followed.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may have occurred immediately reported the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to comply with Compliance Order #001 from inspection 2017_610633_0015 issued on September 22, 2017, with a compliance due date of December 29, 2017, related to 24. (1) of the Long Term Care Homes Act, 2007. The compliance order stated in part:
-"1. That a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident and abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident is immediately reported to the Director.
2. That all immediate mandatory reporting includes after business hours, on weekends and on statutory holidays."

A Critical Incident System Report (CIS) was submitted to the MOHLTC that stated an allegation of improper treatment of a resident by a RPN had occurred in March, 2018. This report was not submitted to the MOHLTC until four days later.

The CIS Report and the home's investigation records stated the RPN did not report to the Charge RPN until the next day. Both staff said this incident was potentially improper treatment of the resident. The Charge RPN also said that they had reported the incident to a RN the next day, and they had followed up with the DOC by email three days later. The RN said they notified the DOC verbally the day after the incident and had followed up with an email three days later.

The RPNs and a RN all said they did not report to the MOHLTC as this was the role of the DOC and management.

The home's policy confirmed that the expectation was that all allegations of improper treatment and abuse of a resident was to be reported to the MOHLTC immediately. The Administrator agreed that this incident was not reported to the MOHLTC immediately as required.

2. Compliance Order #002 from inspection 2017_610633_0015 related to 24 (1) of the Long Term Care Homes Act, 2007 had a compliance date of December 29, 2017. The compliance due date was not past due at the time of the incident and therefore, this is further evidence to support the compliance order that was issued on September 22, 2017.

A CIS Report was submitted to the MOHLTC that stated an allegation of improper treatment of a resident by a RPN had occurred in July, 2017. This CIS report was not submitted to the MOHLTC until two days later.

The DOC confirmed that this incident was not reported to the Director immediately as required and they acknowledged that this incident occurred prior to the compliance due date of December 29, 2017.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper treatment or care of a resident and/or abuse of the resident that had occurred or may have occurred was immediately reported with the suspicion and the information upon which it was based to the Director.

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

A record review for a resident noted that the resident exhibited altered skin integrity. A progress note on the following day indicated the area was foul smelling. No assessment was completed by the registered staff.

In an interview with a RN, they said that the initial assessments were documented in the progress notes of the chart.

In an interview with a RPN said that an initial assessment should have been completed for the concern related to the resident's skin integrity and that this was not completed.

The licensee has failed to ensure that the resident that exhibited altered skin integrity, 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.

2. The licensee has failed to ensure that a resident that exhibited altered skin integrity, that included skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered staff, if clinically indicated.

During Stage I of the Resident Quality Inspection, a resident was observed with altered skin integrity.

A weekly wound assessment was documented for the resident for one week in their plan of care and there were no other weekly wound assessments thereafter.

A RPN reviewed the plan of care for the resident and stated that weekly wound assessments should have been completed and were not. The DOC and the home's policy "Skin and Wound Care Management Protocol VII-G-10.80", confirmed that the expectation was that for altered skin integrity, weekly wound assessments were to be completed.

3. In March and April 2018, three progress notes documented a resident's altered skin integrity. In July, 2018 two other progress notes documented the altered skin integrity.

In an interview with a RN, they stated that there were no weekly assessments completed for the resident. A RPN confirmed that there was no weekly skin assessment for the altered skin integrity and that this should have been completed.

The licensee has failed to ensure that the two residents that exhibited altered skin integrity, were reassessed at least weekly by a member of the registered staff.

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system in relation to falls prevention was complied with.

O. Reg. 79/10 states that every licensee of a long-term care home shall ensure that the following interdisciplinary program is developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's policy entitled "Bruce County Falls Prevention", policy #: VII-G-30.00, stated that the registered staff would complete a thorough investigation of the fall incident including all contributing factors and complete the electronic post fall assessment.

Training documents provided to staff said that the post fall assessment should include the resident's level of consciousness, evidence of injury, vital signs, assessments and range of motion of joints, signs and symptoms of shock, pain level, assessment of the environment and the use of head injury routine, if appropriate.

A resident fell four times during a specified time in 2018. The resident chart did not further outline the post fall assessment results in the resident record.

A RN and DOC confirmed that it is the expectation of the home that a registered staff complete a detailed fall risk assessment note in progress notes in Point Click Care.

The home's policy entitled "Head Injury Routine", policy #: VII-G-10.40 stated that a Head Injury Routine (HIR) would be initiated so that registered staff could report any deviations from the resident's baseline vital signs, Glasgow Coma Scale, and/or level of cognition/

consciousness.

A resident fell three times during a specified time in 2018, and Head Injury Routines were initiated for the resident. A review of the forms indicated that the most recent form that included a Coma Scale and Limb Movement were not completed for two of the three falls.

A RN said that the registered staff had received training on the use of the new form and were to use the new form. The DOC stated it is the expectation of the home that a registered staff complete the new Head Injury Routine form when initiating the Head Injury Routine as it is a more comprehensive form for assessing the resident after a fall.

2. The home's policy entitled the "Falls Prevention and Management Program" directed nursing staff to complete a fall-risk assessment on a resident following a change in status.

A resident fell requiring a transfer to hospital. A Fall Risk Assessment was not completed upon return from the hospital.

A RN and a DOC confirmed it was the expectation of the home that the registered staff complete a fall risk assessment with a change of condition such as with a readmission from hospital after sustaining injury.

The licensee has failed to ensure that the home's plan, policy, protocol, procedure, strategy or system in relation to falls prevention for the two residents were complied with.

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 in relation to Falls Prevention that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty present at all times unless there is an allowable exception to this requirement.

A review of the schedules dated June 16, 2018 to July 27, 2018 showed that there was no RN coverage in the home for 14 shifts out of a total of 138 shifts, approximately 10 per cent.

The DOC confirmed that there was no RN in the home for the above noted shifts. They stated that after all RN options to cover shifts have been unsuccessful, an RPN will provide coverage and an RN will be on call but not in the home. The DOC said that there is not an RN on duty and present at all times.

The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty present at all times unless there is an allowable exception to this requirement.

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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, was immediately investigated, appropriate action was taken in response to every such incident and any requirements that were provided for in the regulations for investigating and responding as required were complied with.

During the RQI inspection a resident stated that they had been treated roughly by an employee. An inspector informed the Administrator of the allegation.

The Administrator stated that the resident was not interviewed at the time of the incident, there were no staff interviews completed and there were no incident or investigation records.

A RN stated that this incident was a form of abuse. The home's abuse policy "Prevention of Abuse and Neglect of a Resident" VII-G-10.00, confirmed that the expectation was that all incidents of alleged abuse of a resident were investigated and records were maintained.

The licensee has failed to ensure that the alleged incident abuse of a resident that was reported to the licensee was immediately investigated, appropriate action was taken in response to the incident and any requirements that were provided for in the regulations for investigating and responding as required were complied with.

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, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations; (b) appropriate action is taken in response to every such incident; and (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System Report (CIS) was submitted to the MOHLTC in March, 2018.

A PSW and a RPN said the resident's care plan was not followed by the PSW as two staff were required for safe transferring and positioning.

The PSW who provided the care agreed that they did not follow the resident's plan of care for safe transferring.

The DOC confirmed that the expectation was that the resident received their care as specified in their plan of care for safe transfers.

The licensee has failed to ensure staff used safe transferring and positioning devices or techniques when assisting the resident.

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours.

According to the clinical record, a resident had a number of incidents of responsive behaviour during a specified time in 2018.

A PSW, a RN and the DOC said that interventions or strategies related to responsive behaviours would be documented in the care plan.

A registered staff confirmed that the care plan did not contain strategies related to the resident's responsive behaviours. The DOC said that it was the expectation that strategies or interventions related to responsive behaviours would be documented and accessible for staff in the care plan.

The DOC confirmed that there were no written strategies and interventions related to responsive behaviours documented in the care plan for the resident.

The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident's responsive behaviours.

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, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure proper techniques to assist residents with eating, including safe positioning of residents who require assistance was implemented.

On three different dates during the RQI inspection, three residents were observed using assistive devices during meal service.

During interview with staff, they knew why they were using the assistive devices for the residents.

On record review the use of the assistive devices were not assessed or documented.

The licensee failed to ensure proper techniques to assist the three residents with eating, were in the resident's plan of care.

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 proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance.

The Professional Advisory Committee minutes noted there was a medication incident report related to a resident and a missing controlled substance.

The DOC and the inspector reviewed two medication incident reports for missing controlled substances.

A Critical Incident System Report (CIS) was not submitted to the MOHLTC for the missing or unaccounted controlled substances.

The Director of Care confirmed that they were unaware that the home was required to submit a CIS Report for a missing or unaccounted controlled substance.

The licensee failed to ensure that the Director was informed of missing or unaccounted for controlled substances.

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 the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance, to be implemented voluntarily.

WN #12: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident/SDM had been given an opportunity to participate fully in the development and implementation of the plan of care.

A resident's substitute decision maker (SDM) stated that they were not notified of the resident's change in health condition.

A "Family Note" progress note, stated that the SDM expressed a concern that they were not notified when the change had first occurred.

A RPN reviewed the plan of care for the resident and stated that the SDM may have been notified verbally, however they also stated that a progress note should have been made documenting this communication and was not. The DOC confirmed that the expectation was that the resident's SDM be notified and this be documented in the resident's plan of care.

The licensee has failed to ensure that a resident's SDM was given an opportunity to participate fully in the development and implementation of the plan of care.

2. The licensee has failed to ensure that the provision of the care as set out in the plan of care was documented.

At a specified date, a medication, was found during medication administration in a medication packet for a resident. The registered staff could not find the medication on the

Electronic Medication Administration Record (EMAR) for recorded signature of administration. A medication incident report was completed and faxed to the Pharmacy provider.

Upon review, it was determined that the orders for the medication were discontinued by the registered staff though the medication had been reordered.

A Pharmacist reviewed the processing of the medication from the Pharmacy provider and confirmed that the medication had been delivered to the home during the specified time for administration.

The registered staff failed to document on a daily basis that they had administered the medication.

The licensee failed to ensure that it was documented that the resident received their medication as set out in the plan of care.

Issued on this 21st day of November, 2018

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

Ministère 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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE GOLDRUP (539), MARIA MCGILL (728), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2018_750539_0006
Log No. / No de registre :	013891-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 10, 2018
Licensee / Titulaire de permis :	Corporation of the County of Bruce 41 McGivern Street, P.O. Box 1600, WALKERTON, ON, N0G-2V0
LTC Home / Foyer de SLD :	Gateway Haven Long Term Care Home 671 Frank Street, P.O. Box 10, WIARTON, ON, N0H-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tolleen Parkin

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

Ministère 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

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

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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee has failed to protect residents from abuse by anyone.

The licensee shall be compliant with s. 19(1) of the LTCHA.
Specifically the licensee shall:
a) Ensure that resident #020, and #026 and any other resident are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by anyone.

The licensee has failed to protect a resident from sexual abuse by another resident.

A Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in April, 2018. It stated that a Personal Support Worker (PSW) witnessed one resident inappropriately touching another resident.

In an interview with DOC, they said that the resident who was touched would be unable to provide consent.

The resident who touched the resident had a documented history of responsive behaviours prior to this incident and interventions in the plan of care.

2. The licensee has failed to protect a resident from abuse by staff.

A CIS Report was submitted to the MOHLTC that stated an allegation of physical abuse by a PSW towards a resident in March, 2018. The CIS further

stated that a PSW held the resident's arm up over their head and bent it at the elbow and they used excessive force during the resident's care. The CIS stated that when the resident was asked if pain was experienced they nodded their head yes.

Another PSW said they heard the resident screaming and they witnessed the PSW with the resident's arm up over their head pushing down on the headrest.

The home's investigation records included two colour photos that showed an unknown body part with a bruise.The DOC confirmed that these photos were of the resident and they stated that it was a new bruise after the incident.

3. The licensee has failed to protect a resident from abuse by staff.

A CIS Report was submitted to the MOHLTC that stated an allegation of abuse by a RPN towards a resident that occurred in July, 2017. The CIS further stated that the RPN swore at the resident, raised their fist and placed paper towel in the resident's mouth while providing care.

The home's investigation records included a signed statement from a PSW that stated they witnessed verbal and emotional abuse.

The Administrator confirmed that this incident was resident abuse.

The licensee has failed to ensure that the three residents were protected from abuse. The severity of this issue was determined to be a level 3 as there was actual harm/risk to the residents. The scope of the issue was a level 2 as it related to three out of five residents. The home had a level 5 compliance history as they had ongoing non-compliance within this section of the Act that included a Compliance Order for s. 20(1) issued November 9, 2017 (2017_610633_0015) and did not comply their order.

(728)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 08, 2019

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_610633_0015, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents is complied with.

The licensee shall be compliant with s. 20(1) of the LTCHA.
Specifically, the licensee shall ensure:
1. The procedures within the policy for investigating alleged, suspected or witnessed abuse and neglect of residents are complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The licensee has failed to comply with Compliance Order #002 from inspection 2017_610633_0015 issued on September 22, 2017, with a compliance due date of December 29, 2017, related to 20. (1) of the Long Term Care Homes Act, 2007. The compliance order stated in part:
-"That the procedures within the policy for investigating alleged, suspected or witnessed abuse and neglect of residents is complied with".

The "RQI 2017- plans for non-compliance" dated October 2, 2017, stated that the home's new abuse policy contained templates for written statements from all witnesses and the alleged abuser plus a checklist for supervisors or charge nurse at time of incident. These written statements and supervisor check lists

would be forwarded to the Administrator to assist with the investigation. All documentation was to be kept.

The "Prevention of Abuse and Neglect of a Resident VII-G-10.00" was the current policy implemented at the home. The home's abuse policy appendix (b) titled "Prevention of Abuse and Neglect of a Resident-Actual or Suspected VII-G-10.00 (b)" stated that this nursing checklist was to be used with any issues of suspected or actual abuse of a resident. This checklist also stated that the Charge Nurse, Clinical Care RN, DOC or Administrator would interview all possible witnesses before the shift ended and request written accounts of the incident. They would also refer to the investigation template VII-G-10.00 (c).

Only one PSW who witnessed the event provided a written statement of the event. In an interview with DOC, they said that their process was to get statements from staff members that witnessed the event. The DOC said that the policy was not followed for the investigation of this incident.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with related to the investigation and documentation of the incidents.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 2 as it related to three out of five currently reviewed residents. The home had a level 5 compliance history as they had ongoing non-compliance within this section of the Act that included a Compliance Order for s. 20(1) issued November 9, 2017 (2017_610633_0015) and did not comply their order.

(728)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 08, 2019

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

Ministère 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 : 003

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

Linked to Existing Order / Lien vers ordre existant: 2017_610633_0015, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall be compliant with s. 24(1) of the LTCHA.
The licensee shall ensure:
1. That a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident and abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident is immediately reported to the Director.
2. That all immediate mandatory reporting includes after business hours, on weekends and on statutory holidays.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may have occurred immediately reported the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to comply with Compliance Order #001 from inspection 2017_610633_0015 issued on September 22, 2017, with a compliance due date of December 29, 2017, related to 24. (1) of the Long Term Care Homes Act, 2007. The compliance order stated in part:
-"1. That a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident and abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident is immediately reported to the Director.
2. That all immediate mandatory reporting includes after business hours, on weekends and on statutory holidays."

A Critical Incident System Report (CIS) was submitted to the MOHLTC that stated an allegation of improper treatment of a resident by a RPN had occurred in March, 2018. This report was not submitted to the MOHLTC until four days later.

The RPNs and a RN all said they did not report to the MOHLTC as this was the role of the DOC and management.

The Administrator agreed that this incident was not reported to the MOHLTC immediately as required.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper treatment or care of a resident and/or abuse of the resident that had occurred or may have occurred was immediately reported with the suspicion and the information upon which it was based to the Director.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 1 as it related to one out of five residents reviewed. The home had a level 5 history as they had non-compliance within this section of the Act that included a Compliance Order for s. 24(1) issued September 22, 2017 (2017_610633_0015) and did not comply their order.

(633)

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

Ministère 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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 08, 2019

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

Ministère 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 : 004

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s. 50 (2).

The licensee shall ensure that resident #010 and any other residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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; and ensure resident's #009 and #010 and any other residents are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

A record review of a resident noted that the resident exhibited altered skin integrity. No assessment was completed by the registered staff.

The licensee has failed to ensure that the resident that exhibited altered skin integrity, 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.

2. The licensee has failed to ensure that a resident that exhibited altered skin integrity, that included skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered staff, if clinically indicated.

i) During Stage I of the Resident Quality Inspection, a resident was observed with altered skin integrity.

A weekly wound assessment was documented for the resident for one week in their plan of care and there were no other weekly wound assessments thereafter.

ii) In March and April 2018, three progress notes documented a resident's altered skin integrity. In July, 2018 two other progress notes documented the altered skin integrity.

In an interview with a RN, they stated there were no weekly assessments completed for the resident's altered skin integrity. A RPN confirmed that there was no weekly skin assessment for the altered skin integrity.

The licensee has failed to ensure that the two residents that exhibited altered skin integrity, were reassessed at least weekly by a member of the registered staff.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 2 as it related to two out of four residents. The home had a level 3 compliance history as they had non-compliance within this section of the Act that included a Voluntary plan of correction (VPC) issued for r. 50 (2) (b) (iv) on August 27, 2015 (2015_264609_0043).

(728)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 08, 2019

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 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, 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 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 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 de la Santé et 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 de la Santé et 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 10th day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Goldrup

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