Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 5, 2016	2016_226192_0002	035820-15	Resident Quality Inspection

Licensee/Titulaire de permis

GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC
704 EAGLE STREET NORTH P.O. BOX 3277 CAMBRIDGE ON N3H 4T3

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

GOLDEN YEARS NURSING HOME
704 EAGLE STREET NORTH P.O. BOX 3277 CAMBRIDGE ON N3H 4T3

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

DEBORA SAVILLE (192), DONNA TIERNEY (569), PATRICIA VENTURA (517), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 5, 6, 7, 8, 11, 12, 13 and 14, 2016.

This Resident Quality Inspection was conducted concurrently with Complaint Inspections: 034283-15 and 032778-15 related to medications; 000701-16 related to lifts and transfers and 025707-15 related to staffing.

During the course of the inspection, the inspector(s) spoke with the Vice President Clinical Services, Executive Director, Director of Policy and Legislation, Director of Resident Quality Outcomes, Director of Food and Environmental Services, Director of Resident Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Food Service Workers, Housekeepers, Director of Recreation, Office Manager, Social Worker and Maintenance.

The Inspectors toured the home, observed meal service, medication administration, medication storage areas, recreation activities, reviewed relevant clinical records, reviewed relevant policies and procedures, the provision of resident care, resident-staff interactions, posting of required information and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **8 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005 who was exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Resident #005 was identified in record review and confirmed by interview with Registered Practical Nurse (RPN) #104 to have a specified area of altered skin integrity.

Resident #005 was admitted to hospital and returned to the home.

Review of the medical record and interview with RPN #104 confirmed that no skin assessment by a member of the registered nursing staff was completed on return of resident #005 from hospital.

RPN #104 confirmed that the resident would have remained at risk of altered skin integrity at the time of return from hospital.

Review of the home's policy titled Skin and Wound Care Management Program, reference number 006020.00 confirmed that it was expected that a Head to Toe Assessment be completed by registered staff on a residents return from hospital.

Review of the Re-Admission from Hospital Checklist number 003160.00(a) confirmed that a Head to Toe Skin assessment was to be completed in the assessment section of the e-chart.

The licensee failed to ensure that resident #005 who exhibited altered skin integrity received a skin assessment by a member of the registered nursing on return from hospital. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that a 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.

Review of the progress notes identified resident #005 as having a specified area of altered skin integrity. The Registered Practical Nurse #104 confirmed that no assessment of the altered skin integrity was completed and recorded in Point Click Care using the designated clinically appropriate assessment instrument specifically designed for skin and wound assessment.

The licensee failed to ensure that resident #005, who was exhibiting altered skin integrity was assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Interview with Registered Practical Nurse #104 confirmed that it was the expectation that weekly wound assessments would be completed on Point Click Care for all areas of altered skin integrity.

Record review and interview with Registered Practical Nurse #104 confirmed that resident #005 had altered skin integrity and that no weekly assessment of the area of altered skin integrity was completed for a specified date in 2015. No further weekly wound assessments were completed and the record failed to identify when the area of altered skin integrity healed.

Record review identified that resident #005 had a new area of altered skin integrity. No further documentation related to this area of altered skin integrity could be identified and it was unclear when this area of altered skin integrity was resolved.

Record review identified that on a specified date in 2015, a new area of altered skin integrity was identified, however the location of the area was not identified. No weekly assessment was completed in relation to this altered skin integrity for a specified period in 2015.

Record review and interview with Registered Practical Nurse #104 confirmed that resident #005 had altered skin integrity that had been identified on a specified date in 2015. A specified weekly assessment identified additional areas of altered skin integrity that were assessed but did not include a description of the area. No weekly wound assessment was completed for the a specified period in 2015, in relation to ongoing altered skin integrity.

The licensee failed to ensure that resident #005 who exhibited altered skin integrity, had been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

4. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been reassessed as least weekly by a member of the registered nursing staff.

Resident #003 was identified as having an area of altered skin integrity that was assessed on specified dates. RN #125 and Director of Resident Care #112 confirmed that resident #003 had not been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 instituted or otherwise put in place was complied with.

The home's policy titled Re-Admission from Hospital Checklist, reference number 003160.00 indicated that all the requirements identified on the checklist were to be completed and initialed within three days of return of a resident from hospital and the completed checklist was to be forwarded to the Director of Resident Care for signature and filing.

Resident #005 was admitted to hospital and returned to the home. Record review identified a progress note indicating that the Re-Admission from Hospital Checklist was to be completed.

Interview with Director of Resident Care #112, confirmed that the Re-Admission from Hospital Checklist was to be completed and that the completed checklist would be forwarded to the Nursing Office for review, signature and filing. The Director of Resident Care was unable to provide a completed checklist from the return from hospital of resident #005.

Interview with Registered Practical Nurse #104 confirmed that the Head to Toe skin assessment identified on the Re-Admission from Hospital Checklist had not been completed for resident #005 in relation to their return from hospital.

The licensee failed to ensure that the Re-Admission from Hospital Checklist policy was complied with in relation to resident #005's return from hospital. [s. 8. (1) (a),s. 8. (1) (b)]

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 ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During stage 1 of this Resident Quality Inspection it was identified that the home was not being maintained in a good state of repair.

Door frames and doors at the entrance to specified rooms and bathrooms in those rooms were observed to be paint chipped with scrapes in the doors, raw metal and wood were showing which would impede the ability to clean these surfaces.

Baseboard in specified rooms was observed to be peeling off. In one specified room the baseboard extended into the room at the entrance to the room and may have presented a trip hazard to ambulatory residents in the room. It was noted that baseboard in the room had been identified by staff and entered in the maintenance binder on specified date in 2015. Interview with Maintenance #127 confirmed that the baseboard had not been repaired and that they had not looked at the concern to identify if a risk existed.

The closet door in a specified room was off and was observed in the bathroom.

Walls in rooms and bathrooms in specified rooms were observed to have wall damage including holes in the drywall, wall repairs not painted, and damaged walls. Interview with the Executive Director #101 and Maintenance #127 confirmed that painting was not being completed in the home. A deficiency list that had been created by the Housekeeping staff related to rooms requiring painting, was shared with the inspector. The list indicated rooms requiring painting as of September 2015. It was confirmed with the Executive Director #101 and Maintenance #127 that these deficiencies had not been addressed.

The licensee failed to ensure that the home was maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

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 ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

The home's policy titled Deep Cleaning Resident Room Long Term Care, reference number 003040.00 indicated that a Preventive Maintenance Audit would be completed quarterly (including a plumbing/toilet inspection). Outstanding issues were to be put in the maintenance log book for attention by Maintenance.

During stage I of this inspection, it was noted that in specified rooms drains in bathroom sinks were corroded and worn. In the bathroom in a specified room, liquid was observed around the base of the toilet with a black ring around the toilet base and caulking around the sink was dry and cracked. In a specified room, the bathroom taps were observed to have some corrosion.

Interview with the Manager of Environmental Services #107 confirmed that it would be the expectation that housekeeping staff auditing a room would identify plumbing concerns and record them in the maintenance binder.

Review of audits conducted identified that on Oct 10, 2015, staff identified that the flooring in the bathroom in room a specified room required replacement. No other plumbing concerns were identified in audits conducted from August 2015 to January 2016.

Interview with Maintenance #127 confirmed that they do not audit rooms in relation to plumbing fixtures, toilets, sinks, grab bars and washroom fixtures.

The licensee failed to ensure that procedures were implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks. [s. 90. (2) (d)]

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 ensuring that procedures were developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76(7) of the Act, that all staff who provide direct care to the residents, are provided training related to skin and wound care.

The home's policy titled Skin and Wound Management Program indicated that all staff would receive education on skin and wound care annually.

Interview with the Director of Resident Care #112 on January 11, 2016, with the training records, identified that 37.5% (three of eight) of the Registered Nurses had failed to receive training on skin and wound care in 2015; that 31% (five of twelve) of the registered practical nurses had failed to receive training on skin and wound care in 2015, and that 49% (37 of 75) of the Personal Support Workers had failed to receive training on skin and wound care in 2015.

The licensee failed to ensure that all staff who provide direct care to the residents, were provided training related to skin and wound care. [s. 221. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all staff who provide direct care to the residents, are provided training related to skin and wound care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

During observation of the medication pass it was noted that a Registered Practical Nurse failed to complete hand hygiene routinely.

It was observed that the RPN provided medication to resident #032 and refilled the water cup used by the resident at the bathroom sink. The RPN returned to the medication cart, signed off the medication using a pen/stylus, unlocked the medication cart and proceed to prepare medication for resident #033 without completing hand hygiene. The RPN applied topical medication using a gloved hand. The glove was removed, no hand hygiene was observed before the RPN returned to the medication cart to prepare medication for resident #031. The staff member was observed to assist the resident to position their head and wiped the resident's eye with a tissue. The RPN then returned to the medication cart and completed documentation of the medication given using a pen/stylus to access the tablet, unlocking the medication cart and then proceeding to prepare the next residents medication. No hand hygiene was observed.

During interview conducted on January 14, 2016, the Director of Resident Care #112 confirmed that it would be the expectation that registered staff completed hand hygiene between administration of medications, and especially after having contact with residents or surfaces that may be contaminated.

The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program when hand hygiene was not completed during the medication pass. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

On January 7, 2016, it was observed that a ladder and bag containing a variety of tools and other sharp items was left unattended in the corridor leading from the lounge to the entrance to the pharmacy for a period of greater than five minutes. The inspector sought out the Executive Director #101 who confirmed that the ladder and bag of tools and other sharps had the potential to provide a risk to residents of the home who use the corridor to access their home area and that these items should not be left unattended where resident's might access them.

The licensee failed to ensure that the home was a safe and secure environment for its residents. [s. 5.]

WN #8: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

Staff interview in stage one of the Resident Quality inspection revealed that resident #007 had a fall.

Record review of a Physiotherapy assessment concluded that the resident was to be supervised for transfers and their ambulation status was; supervised using a specified device.

Record review of the care plan under interventions indicated the resident was to walk with one person supervising using the specified device. Further review of the kardex identified that the resident was to have supervision-extensive assistance with transfers as well as one person supervision with walking using the specified device.

Observations revealed the resident was using a specified device unsupervised.

Interview with Personal Support Worker #120 revealed resident #007 transferred and ambulated predominately independently. Interview with Registered Nurse #125 verified that the resident’s mobility status was independent using a specified device unsupervised.

Interview with the Vice President of Clinical Services (VPCS) #100 verified there were no additional documented assessments that would indicate a change in the residents mobility status from supervised assistance to independent.

The licensee failed to ensure that resident #007 was reassessed and the plan of care reviewed and revised when care set out in the plan was no longer necessary. [s. 6. (10) (b)]

Issued on this 5th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192), DONNA TIERNEY (569), PATRICIA VENTURA (517), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2016_226192_0002
Log No. / Registre no:	035820-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 5, 2016
Licensee / Titulaire de permis :	GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC 704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3
LTC Home / Foyer de SLD :	GOLDEN YEARS NURSING HOME 704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Donna McLeod

To GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC, 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) (b)

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 prepare, submit and implement a plan to ensure that residents #003 and #005 and all other residents who exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receive weekly wound assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument.

The plan is to be submitted electronically to Long Term Care Homes Inspector Debora Saville of the London Service Area Office, Ministry of Health and Long Term Care, Long-Term Care Inspections Branch, Long-Term Care Homes Inspection Division, 130 Dufferin Avenue, London, Ontario N6A 5R2 at debora.saville@ontario.ca by February 16, 2016.

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 had been reassessed as least weekly by a member of the registered nursing staff.

Resident #003 was identified as having an area of altered skin integrity that was assessed on specified dates. RN #125 and Director of Resident Care #112 confirmed that resident #003 had not been reassessed at least weekly by a member of the registered nursing staff. (155)

2. Interview with Registered Practical Nurse #104 confirmed that it was the expectation that weekly wound assessments would be completed on Point Click Care for all areas of altered skin integrity.

Record review and interview with Registered Practical Nurse #104 confirmed that resident #005 had altered skin integrity and that no weekly assessment of the area of altered skin integrity was completed for a specified date in 2015. No further weekly wound assessments were completed and the record failed to identify when the area of altered skin integrity healed.

Record review identified that resident #005 had a new area of altered skin integrity. No further documentation related to this area of altered skin integrity could be identified and it was unclear when this area of altered skin integrity was resolved.

Record review identified that on a specified date in 2015, a new area of altered skin integrity was identified, however the location of the area was not identified.

No weekly assessment was completed in relation to this altered skin integrity for a specified period in 2015.

Record review and interview with Registered Practical Nurse #104 confirmed that resident #005 had altered skin integrity that had been identified on a specified date in 2015. A specified weekly assessment identified additional areas of altered skin integrity that were assessed but did not include a description of the area. No weekly wound assessment was completed for the a specified period in 2015, in relation to ongoing altered skin integrity.

The licensee failed to ensure that resident #005 who exhibited altered skin integrity, had been reassessed at least weekly by a member of the registered nursing staff.

Previously issued as a VPC January 20, 2015. Two of three resident's reviewed failed to have weekly wound assessments completed. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBORA SAVILLE

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