Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Aug 10, 2020	2020_560632_0008	004293-20, 011767-20	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

Hamilton Continuing Care
125 Wentworth Street South HAMILTON ON L8N 2Z1

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

YULIYA FEDOTOVA (632), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 16, 17, 18, 19, 22, 23, 24, 25, 26, July 2, 6, 7, 8, 2020, off-site and June 29, 30 and July 9 and 10, 2020, on-site.

The following intake was completed during this Complaint inspection:
log #011767-20 - related to Prevention of Abuse and Neglect, Falls Prevention, Continence Care and Bowel Management, Nutrition and Hydration, Personal Support Services, Skin and Wound Care.
The following Critical Incident System (CIS) inspection was completed concurrently with this Complaint Inspection:
log #012124-20 - related to prevention of abuse and neglect.
The following Compliance Order Follow Up (FU) inspection was completed concurrently with this Complaint Inspection:
log #004293-20 - related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), the Director of Nursing Care (DONC), Environmental Support, Registered Dietitian (RD), Physiotherapist (PT), Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Nursing Consultant, Dietary Aide (DA), Housekeeper, residents and their families.

During the course of the inspection, the inspector(s) interviewed staff, observed residents and staff, reviewed documentation, including, clinical health records, policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2020_556168_0008	632

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration was implemented.

A. Resident #003's clinical record was reviewed. On an identified date in April 2020, the resident experienced a fall that resulted in injury. The staff conducted a Skin and Wound Evaluation. The evaluation indicated the RD was not notified/referred to regarding the resident's newly acquired wound.

In an interview with RPN #116, who worked as the Skin and Wound Lead, they reported that it was the home's expectation to notify the RD through a referral when residents had new alterations in skin integrity and that it was to be done during the initial completion of a Skin and Wound Evaluation. In an interview the RD reported they expected to receive referrals immediately upon identification of any new area of altered skin integrity. The RD confirmed they did not receive any referral therefore, did not assess the resident when the skin alteration had been identified.

B. Resident #021's clinical record was reviewed. On an identified date in June 2020, registered staff conducted a Skin and Wound Evaluation which documented the

presence of altered skin integrity for resident #021. The evaluation indicated the RD was not notified/referred regarding the newly acquired altered skin integrity. Dietary assessment documentation was reviewed, showing the resident's most recent RD assessment occurred on an identified date in June 2020. In an interview the RD reported the home's expectation was to notify them through referrals when residents had new alterations in skin integrity. The RD reported they did not receive a referral to assess the resident and confirmed no assessment was completed.

C. Resident #020's clinical record was reviewed:

i) On an identified date in June 2020, registered staff conducted a Skin and Wound Evaluation for resident #020, which documented the presence of altered skin integrity. The evaluation indicated the RD was not notified/referred regarding the newly identified altered skin integrity.

ii) On an identified date in July 2020, registered staff conducted a Skin and Wound Evaluation for resident #020; which documented the presence of a new altered skin integrity. The evaluation indicated the RD was notified; however, no referral was found in the clinical record. On an identified date in July 2020, a Referral to Skin Care Lead was completed however, staff documented specified note.

Dietary assessment documentation for resident #020 was reviewed, which revealed the most recent RD assessment was conducted on an identified date in July 2020. The July 2020's assessment did not reference the new altered skin integrity. In an interview the RD confirmed they had not factored in the newly identified altered skin integrity in their assessment completed on an identified date in July 2020, as they had not received a referral to inform them about it. The RD also confirmed they did not receive a referral to assess altered skin integrity on an identified date in July 2020. In an interview with RPN #116, they reported that in recent weeks, gaps had been noted that not all staff were making referrals to the home's RD when any new skin alterations were identified. [s. 50. (2) (b) (iii)]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

A. Resident #022's clinical record was reviewed. On an identified date in July 2020, resident #022 experienced a fall and sustained no injury. Staff documented that a specified device would be implemented for use when the resident was in bed. The resident's plan of care was reviewed, which provided direction to staff related to two falls prevention interventions for the resident while they were in bed..

On an identified date in July 2020, the resident was observed in bed and the interventions identified in the plan of care were not implemented as per the plan. PSW #121 was interviewed and confirmed that the interventions were not in place as per the plan of care. When asked by the Inspector, where resident #022's specified device was, PSW # 121 was unable to locate it. Later in the day on an identified date in July 2020, LTCH Inspector #585 and RPN #122 observed the resident in bed. RPN #122 confirmed that no specified device was in place. In an interview with RPN #105, they reported they worked on shift(s) between an identified date range in July 2020 and had provided care to the resident. RPN #105 stated the resident did not have specified device in place when in bed as a fall intervention. In an interview with RPN # 116, who completed the Fall Incident Report on an identified date in July 2020, they reported the resident's plan of care identified the specified device was to be in place, when resident #022 was in bed

and another specified device was to be within reach.

The licensee failed to ensure the care set out in the plan of care related to falls prevention and management was provided to resident #022 as specified in their plan.

B. Resident #003's clinical record was reviewed. The plan of care stated they were at risk of falls and included fall intervention strategies, which included, but were not limited to the use of specified devices.

On an identified date in March 2020, the resident experienced a fall. The Fall Incident Report documented that the specified device was not in place at the time of the fall.

On an identified date in June 2020, the resident experienced a fall. The Fall Incident Report documented the specified device was not in place. Staff documented the resident sustained an injury following the fall. In an interview RN #108 confirmed the resident sustained an injury and the specified device was not in place at the time of the fall.

On an identified date in June 2020, the resident experienced a fall. The Fall Incident Report noted the specified device was not applied correctly. Staff documented an altered skin integrity on resident #003. Interview with RN #108 confirmed the resident sustained an injury and the specified device was not in place at the time of the fall.

During an interview with the DONC, they reported the expectation was for all fall intervention strategies to be in place to ensure resident safety. The DONC confirmed the home failed to ensure that fall interventions set out in resident #003's plan of care were provided to the resident as specified in the plan. [s. 6. (7)]

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

a) The resident #003’s written care plan included supports documented under the falls focus that included, but were not limited to specified intervention related to a specified ADL, effective on an identified date in June 2019. Another area of the care plan noted the resident required specified assistance with their ADL and to ensure specified device was within reach, effective on an identified date in October 2018.

On identified dates in March and June 2020, the home's Physiotherapist (PT) completed

assessments of the resident. In both assessments, the PT documented recommendations, however the clinical record failed to show that they were implemented. In an interview, the PT verified they made the recommendations; however, confirmed they did not update resident #003's care plan when they made recommendations in their assessments.

On an identified date in December 2019, a Continence Evaluation was completed, which noted a specified intervention as a treatment option for the resident's care. In interviews with PSW #103, PSW #104, PSW #110 and RPN #106, differing approaches on how staff provided assistance to the resident were reported in relation to their continence care and bowel management.

In a number of Fall Incident Reports from the identified period between March to June 2020, none referenced that the resident had attempted to use the specified device noted in their plan of care. RN #108, RPN #106 and PSW #104 reported the intervention was neither used or an effective approach for the specified ADL.

The DONC was interviewed and confirmed that the resident's plan of care was not reviewed and revised to meet their care needs in relation to their specified ADL, and that the use of a specified device was not adequate to meet the needs of the resident for their specified ADL.

b) On an identified date in April 2020, a progress note stated a specified device was put in place to prevent risk of fall; however, the plan of care did not include the use of the device until on an identified date in June 2020. Interview with the DONC who confirmed the plan of care was not revised to include the intervention of a specified device for over two months; and confirmed it should have been for the safety of resident #003.

c) On an identified date in April 2020, resident #003 sustained an injury to their skin. The Skin Assessment noted the resident received a specified intervention. The assessment did not list treatment or interventions to promote healing and prevent infection for the injury. The clinical record, including the resident's medication and treatment administration records for May and June 2020, did not indicate there was injury nor were there any intervention(s) in place for staff to follow. RPN #106 reported the resident refused treatment to the injury. On an identified date in June 2020 staff documented in a skin assessment that the altered skin integrity healed.

RPN #116, who served as the home's skin and wound program lead, confirmed resident

#003's plan of care had not been reviewed and revised to reflect the presence of the injury and that no interventions were listed for treatment to promote healing. RPN #116 reported that the home's expectation would be to include treatment and interventions in the resident's plan of care to promote healing and prevent infection, even if a resident refused treatment.

The licensee failed to ensure the resident was reassessed and the plan of care was reviewed at least every six months when the resident's care needs change or care set out in the plan was no longer necessary regarding falls prevention and management strategies, toileting and skin and wound care needs.

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 and ensuring that the resident is reassessed and the plan of care reviewed and revised at least every six months when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: 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 failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A. Resident #004's clinical record was reviewed. Their care plan stated they required specified assistance with transferring. The plan directed staff to provide specified assistance by a number of team members when transferring the resident, using specified device.

PSW #103 and PSW #104 were interviewed. Both PSWs reported resident #004

required the assistance by a number of staff with transfers, using specified transfer device. PSW #103 and PSW #104 reported that on unspecified dates in June 2020, they had transferred resident #004 using specified transfer device but had not applied the specified safety device. Both staff reported the home's expectation was to ensure that the specified safety device be applied; however, they did not always apply it as the resident expressed specified concerns. Both staff denied any occurrence where the resident sustained an injury as a result of the improper transfers.

The GM was interviewed and reported the that the expectation when transferring residents using a specified transfer device included ensuring the specified safety device be applied, for any transfer. The GM confirmed PSW #103 and PSW #104 had not used safe transferring techniques when assisting resident #004 using specified transfer device on unspecified dates in June 2020.

B. A Complaint was received by the MLTC related to not using a specified safety device when transferring resident #008 by using a specified transfer device. Review of investigation notes related to an identified critical system incident report indicated that on an identified date in June 2020, PSW #103 and PSW #104 transferred resident #008 using a specified transfer device without application of the specified safety device.

Review of resident #008's care plan (last revised on an identified date in February 2020) indicated that the resident required specified assistance with transfer by a number of team members. Resident #008 was to use specified transfer devices as per the resident's cooperation and health condition. Review of Physiotherapy Assessment (effective on identified date in February 2020) indicated that resident #008 was assessed to be transferred using a specified transfer device.

Review of User Manual specified instruction on using the specified safety device. Review of the home's Transfer Status Assessment Guide Policy (no date) indicated that team members were required to consider a resident's ability at time of transfer to determine if they might need to go up in transfer status for the safety of the resident and team member.

During the inspection, PSW #103 indicated that they did not remember the details about the transfer of resident #008 on an identified date in June 2020, but stated that there were times when the specified safety device was not applied to the resident during transfers. During the inspection, PSW #104 indicated that they probably did not apply the specified safety device as the resident did not want it to be applied.

The licensee failed to ensure that PSW #103 and PSW # 104 used safe transferring devices or techniques, such as application of the specified safety device or going up in transfer status for the safety of the resident and team members, when assisting resident #008, which was acknowledged by the GM.

C. A Complaint was received by the MLTC related to not using specified safety device when transferring resident #012 using the specified transfer device. Review of investigation notes related to an identified critical system incident report indicated that on an identified date in June 2020, PSW #103 and PSW #104 transferred resident #012 using a specified transfer device without application of a specified safety device.

Review of resident #012's care plan (last revised on an identified date in February 2018), indicated that the resident required the specified transfer device for transfer by a number of team members. Review of Kinesiology Program For Active Living Assessment (effective on an identified date in May 2020) indicated that resident #012 was assessed to be transferred using a specified transfer device.

During the inspection, PSW #103 recalled an incident, when they did not apply the specified safety device to resident #012, while using the specified transfer device to transfer due to resident #012 screaming and behaving aggressively. During the inspection, PSW #104 indicated that they did not fasten the safety belt as the resident exhibited some behaviors.

The licensee failed to ensure that PSW #103 and PSW #104 used safe transferring devices or techniques when assisting resident #012, which was acknowledged by the GM. [s. 36.]

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight changes that compromises the resident's health status. [s. 69]

A. A Complaint was received by the MLTC related to the nutrition concerns of resident #001, who was at identified nutrition risk (Dietary Profile/Assessment dated on an identified date in April 2020).

Weights and Vitals Summary review indicated that resident #001 had specified body weight on identified dates in February 2020 and in May 2020. During the specified period of time, the resident had specified body weight changes over a number of months. Review of the written plan of care indicated no nutrition assessment of specified body weight changes in May 2020 for resident #001.

During the inspection, the RD indicated that specified body weight changes were to be triggered by Point Click Care (PCC) for residents to be nutritionally assessed and there was no specified body weight triggers identified in PCC for resident #001 in May 2020.

Review of "Weight & Height Monitoring Policy" (no date) indicated that all weight/height

was to be documented electronically in Point of Care (POC). When a weight loss or gain of more than 2 kg or more than 5% was noted from the previous month, the Personal Care Aide (PCA) would reweigh the resident immediately to ensure the weight was correct. Review of “Weights - Body Weight of Resident Policy” (no date) indicated that working collaboratively, the designate and the RD were "to assess those residents triggered with a significant weight change and implement supportive strategies as required”.

The licensee failed to ensure that resident #001, with a change of 7.5 per cent of body weight, or more, over an identified number of months was assessed using an interdisciplinary approach, and that actions were taken, and outcomes were evaluated.

B. Resident #009 was at specified nutrition risk (Dietary Profile/Assessment dated on an identified date in April 2020).

Weights and Vitals Summary review indicated that resident #009's had specified body weight on identified dates in February 2020 and in May 2020. During the specified period of time, the resident had specified body weight chages. Review of written plan of care indicated no nutrition assessment of specified weight changes in May 2020 for resident #009.

During the inspection, the RD indicated that specified weight changes were to be triggered by PCC identifying residents' need to be nutritionally assessed and there was no specified weight trigger in PCC for resident #009 in May 2020.

Review of “Weight & Height Monitoring Policy” (no date) indicated that all weight/height was to be documented electronically in Point of Care (POC). When a weight loss or gain of more than 2 kg or more than 5% was noted from the previous month, the Personal Care Aide (PCA) would reweigh the resident immediately to ensure the weight was correct. Review of “Weights - Body Weight of Resident Policy” (no date) indicated that working collaboratively, the designate and the RD were "to assess those residents triggered with a significant weight change and implement supportive strategies as required”.

The licensee failed to ensure that resident #009, with a change of 7.5 per cent of body weight, or more, over an identified number of months was assessed using an interdisciplinary approach, and that actions were taken, and outcomes were evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 and ensuring that residents with a change of 7.5 percent of body weight, or more, over three months are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The Licensee failed to ensure that each resident was offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

A Complaint was received by the MLTC about not providing water to the residents during snack time. On an identified date in June 2020, the distribution of afternoon snack cart with drinks and snacks was observed in the home. Review of Nourishment menu (week two), which was in effect during the observation period, indicated that on an identified date in June 2020, lite tropical fruit drink, fresh fruit, assorted popsicles, coffee creamer and sugar were to be available on the cart. It was observed that a jar of water, coffee and tea, lite tropical fruit drink, fresh fruit, assorted popsicles, coffee creamer and sugar were on the afternoon snack cart on the above identified date in June 2020.

A. Resident #006 was provided a specified snack and no fluids were offered by staff #117. Care plan review (last updated on an identified date in March 2020) indicated that resident #006 was to be provided and encouraged fluid intake of specified number of milliliters (ml) per day.

B. Resident #012 was offered a specified snack only and no fluids were offered by staff #117. Care plan review (last updated on an identified date in November 2019) indicated that resident was to be provided and encouraged fluid intake of specified number of ml per day.

C. Resident #014 was provided specified snack and no fluids were offered by staff #117. Care plan review (last updated on an identified date in October 2019) indicated that resident was to be provided and encouraged specified number of ml of fluid per day.

D. Resident #017 was offered specified snack only and no fluids were offered by staff #117. Care plan review (last updated on an identified date in January 2020) indicated that resident had specific intervention related to fluids intake.

During the inspection, the GM indicated that snacks (including afternoon snacks) were to be provided according to the Nourishments Policy. Review of the Nourishments Policy (no date) indicated that it was the policy of Schlegel Villages that snacks were to be offered to all residents, regardless of diet order, at mid-afternoon and at bedtime. Beverages were to be offered to all residents between meals and at bedtime, unless contraindicated in the individual resident's plan of care.

The home failed to ensure that resident #006, resident #012, resident #014 and resident #017 were offered a minimum of, (b) a between-meal beverage in the afternoon. [s. 71. (3) (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 and ensuring that each resident is offered a minimum of, (b) a between-meal beverage in the afternoon, to be implemented voluntarily.

Issued on this 26th day of August, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	YULIYA FEDOTOVA (632), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2020_560632_0008
Log No. / No de registre :	004293-20, 011767-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 10, 2020
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	Hamilton Continuing Care 125 Wentworth Street South, HAMILTON, ON, L8N-2Z1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kelly Younger

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee must be compliant with r. 50. (2) of Ontario Regulation 79/10.

Specifically, the licensee must:
a) Ensure resident #003, resident #020, resident #021, and any other resident exhibiting altered skin integrity, including skin tears or wounds, are assessed by a registered dietitian who is a member of the staff of the home.
b) Ensure all registered nursing staff are re-educated on the requirement set out under Ontario Regulation 79/10 r. 50. (2) (b) (iii); and in part, ensure the education also includes how, as per the home's policies/processes, the Registered Dietitian is to be notified to ensure they are sufficiently made aware of any resident's need for assessment. A record of the training, including staff names of those who completed the training, shall be maintained.

Grounds / Motifs :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration was implemented.

A. Resident #003's clinical record was reviewed. On an identified date in April 2020, the resident experienced a fall that resulted in injury. The staff conducted a Skin and Wound Evaluation. The evaluation indicated the RD was not notified/referred to regarding the resident's newly acquired wound.

In an interview with RPN #116, who worked as the Skin and Wound Lead, they reported that it was the home's expectation to notify the RD through a referral when residents had new alterations in skin integrity and that it was to be done during the initial completion of a Skin and Wound Evaluation. In an interview the RD reported they expected to receive referrals immediately upon identification of any new area of altered skin integrity. The RD confirmed they did not receive any referral therefore, did not assess the resident when the skin alteration had been identified.

B. Resident #021's clinical record was reviewed. On an identified date in June 2020, registered staff conducted a Skin and Wound Evaluation which documented the presence of altered skin integrity for resident #021. The

evaluation indicated the RD was not notified/referred regarding the newly acquired altered skin integrity. Dietary assessment documentation was reviewed, showing the resident's most recent RD assessment occurred on an identified date in June 2020. In an interview the RD reported the home's expectation was to notify them through referrals when residents had new alterations in skin integrity. The RD reported they did not receive a referral to assess the resident and confirmed no assessment was completed.

C. Resident #020's clinical record was reviewed:

i) On an identified date in June 2020, registered staff conducted a Skin and Wound Evaluation for resident #020, which documented the presence of altered skin integrity. The evaluation indicated the RD was not notified/referred regarding the newly identified altered skin integrity.

ii) On an identified date in July 2020, registered staff conducted a Skin and Wound Evaluation for resident #020; which documented the presence of a new altered skin integrity. The evaluation indicated the RD was notified; however, no referral was found in the clinical record. On an identified date in July 2020, a Referral to Skin Care Lead was completed however, staff documented specified note.

Dietary assessment documentation for resident #020 was reviewed, which revealed the most recent RD assessment was conducted on an identified date in July 2020. The July 2020's assessment did not reference the new altered skin integrity. In an interview the RD confirmed they had not factored in the newly identified altered skin integrity in their assessment completed on an identified date in July 2020, as they had not received a referral to inform them about it. The RD also confirmed they did not receive a referral to assess altered skin integrity on an identified date in July 2020. In an interview with RPN #116, they reported that in recent weeks, gaps had been noted that not all staff were making referrals to the home's RD when any new skin alterations were identified.

The licensee failed to ensure that resident #003, resident #020 and resident #021 who were exhibiting altered skin integrity, including skin tears or wounds, were assessed by a registered dietitian who was a member of the staff of the

home.

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3, widespread, as it related to three of three residents reviewed. The home had a level 3 history as they had previous non-compliance to the same subsection of the LTCHA that included:

- voluntary plan of correction (VPC) issued December 4, 2018 (2018_543561_0018);
- voluntary plan of correction (VPC) issued January 2, 2018 (2017_573581_0024)

Additionally, the LTCH has a history of 2 other compliance orders in the last 36 months.
(585)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 14, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 10th day of August, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Yuliya Fedotova

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