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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2018	2018_621547_0032 (A1)	028991-17, 012621-18, 026082-18, 028565-18	Complaint

Licensee/Titulaire de permis

The Ottawa Jewish Home for the Aged
10 Nadolny Sachs Private OTTAWA ON K2A 4G7

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

Hillel Lodge
10 Nadolny Sachs Private OTTAWA ON K2A 4G7

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

Amended by LISA KLUKE (547) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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*

The Licensee requested an extension to compliance order CO #001 regarding r.50 Skin and wound care to March 15, 2019. This extension request has been approved.

Issued on this 29th day of November, 2018 (A1)

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

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*

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

Amended by LISA KLUKE (547) - (A1)

Amended 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): October 11, 12, 15, 16, 18, 23, 2018

The following intakes were completed in this complaint inspection:

Logs #028991-17, #028565-18, CIS #C601-000010-18 and #026082-18 related to concerns regarding skin and wound care management

Log #012621-18 related to concerns related to withholding admission of an applicant.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the home's Resident Assessment Instrument (RAI) Coordinator, the Registered Dietician, a private sitter, the reception attendants, the Social Worker, the Director of Care (DOC) and the Administrator.

In addition the inspector reviewed resident health care records, documents related to the home's investigations into critical incidents submitted by the Licensee and policies and procedures related to Skin and Wound. The inspector observed the delivery of resident care and services and staff to resident as well as resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Skin and Wound Care

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

5 WN(s)
2 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	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 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 is specifically designed for skin and wound assessment.

This issue is related to log #026082-18.

The Director under the Ministry of Health and Long-Term Care received a complaint on a specified date regarding resident #001's skin and wound care management that was not adequate to the resident's care needs while living in the Long-term Care home. The Complainant indicated resident #001 was receiving treatment for a specified skin condition that became infected in the home and was sent to hospital and died. The documents shared by the home to the hospital indicated specified skin interventions for the resident.

The Director of Care indicated to inspector #547 that the resident was receiving wound care management for this skin condition to a specified location on the resident regularly prior to the infection being identified on a specified date. RPN #104 indicated to inspector #547 to have seen the resident's wound the day earlier during a specified intervention whereby there was no infection noted. RPN

#104 also observed the resident's wound on a specified date and noted the infection to be definitely apparent and then sent the resident to hospital. RPN #104 indicated the resident had wound, that was difficult to cover properly due to the size and location however they cleaned the resident's skin, and covered the wound with a dry type dressing and closed it with paper tape. RPN #104 indicated that the seal of this wound dressing was not complete, as it was impossible with paper tape to seal completely to this location and for the size of the wound whereby it was possible the wound could have become contaminated. RPN #104 developed the treatment plan on a specified date as per an assessment completed and documented in the resident's progress notes. The assessment indicated the resident's wound required dressing change every shift and as required. RPN #104 indicated having entered the treatment plan into the Treatment Administration Record (TAR) as required. The TAR was reviewed indicated dressing changes as required three times a day. RPN #104 indicated that this information was not the same and made this intervention confusing as it was different than the assessment. RPN #104 indicated that wound care assessments should be completed weekly to review the resident's plan of care and noted upon review of the resident's health care records, that these assessments were not completed.

The Director of Care indicated to inspector #547 that an initial skin assessment should have been completed in the chart, whether it be in assessments or in the progress notes with a good description of the wound and dressing interventions.

As such, the registered nursing staff in the home did not complete a skin assessment using the Licensee's clinically appropriate assessment instrument specifically designed for skin and wound assessments for resident #001's skin wound that was infected and later deteriorated on a specified date that required resident #001 to be sent to hospital for further assessment and treatment of this wound. [s. 50. (2) (b) (i)]

2. The Director of Care (DOC) indicated the home's clinically appropriate assessment instrument used in the home is the wound assessment form in the home's electronic documentation system. The DOC indicated resident #003 has had a long standing wound to a specified area.

Inspector #547 reviewed resident #003's health care records for the last four months, that indicated the resident continues to have a wound to a specified area that requires skin and wound care dressings. The last wound assessment form in

the resident's electronic documentation system was dated seven months earlier for this same wound to a specified area.

The DOC indicated that these wound assessment forms are required to be completed for each resident with a wound in the home as per their Skin and Wound care program. [s. 50. (2) (b) (i)]

3. This issue is related to log #028991-17.

On a specified date, an incident occurred with resident #002 who sustained a skin wound to a specified area.

Inspector #547 reviewed the resident's health care records that indicated in the progress notes that the resident's wound required specified treatment and intervention. The resident was re-assessed later by the Director of Care and RPN #106 on the specified date of this incident. The resident was sent to hospital three days later related to further assessment and treatment of the wound was required. The resident returned to the Long-Term Care home on the same day with recommended treatment and interventions as well as prescribed medications for treatment of infection.

The Director of care indicated the skin and wound assessment form is to be used as the home's assessment instrument for all new alteration of skin integrity issues, new admissions and for all residents returning from hospital. Resident #002 had an incident occur on another specified date that caused an open wound that required treatment and intervention. Upon review of the resident's health care records with the DOC, inspector #547 was unable to locate any skin assessment forms related to the resident's specified wound.

As such, resident #002 exhibiting skin wounds to a specified area, did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wounds. [s. 50. (2) (b) (i)]

4. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

This issue is related to log #028991-17.

Resident #002's health care records were reviewed. Resident #002's had an incident that occurred on a specified date and time that caused an injury to a specified area to the resident that required specified treatment and interventions. This incident was communicated to the oncoming registered nursing staff for further follow up. RPN #106 and the Director of Care (DOC) assessed the resident's wound and specified treatment was provided. No further treatment or interventions to reduce or relieve pain, promote healing and prevention of infection were identified in the resident's plan of care. The complainant indicated the resident's treatment after the DOC completed it on the date of the incident, after which resident #001 was bathed and the treatment product became wet. The resident's Substitute Decision Maker (SDM) reported to the complainant over the next three days that the resident's dressing remained unchanged.On a specified date, three days after the incident occurred, the resident's SDM made a complaint to the DOC regarding the resident's skin and wound care management for the specified wound. Resident #002 was transferred to hospital that day for further assessment and treatment of the specified skin wound. Resident #002 returned to the home on the same day, after assessment and treatment was provided to the resident's skin wound in the hospital and diagnosed with a wound infection and began antibiotic therapy.

The DOC indicated to inspector #547 that the resident's skin wound to the specified area should have been assessed on each nursing shift in the home, and the area treated as required by specified interventions. The DOC indicated that the nursing assessment and treatment plan should have been added to the Treatment Administration Record (TAR) on the day the incident occurred. The DOC further indicated that a reassessment of the resident's plan of care related to pain assessment needs and Activities of Daily Living (ADL's) such as bathing, was required after this injury occurred.

As such, resident #002 exhibited altered skin integrity related to an incident that caused a wound to the resident that required immediate treatment however no interventions to reduce or relieve pain, promote healing or prevention of infection as required to the resident's plan of care. As a result, the resident's wound became infected and was required to be transferred to hospital. [s. 50. (2) (b) (ii)]

5. This issue is related to log #026082-18.

Resident #001 was admitted to the home on a specified date with several medical diagnoses. Resident #001 has had a private caregiver that was assisting the resident daily.

The Director of the Ministry of Health and Long-Term Care received a complaint regarding concerns related to resident #001's skin and wound care management by the home. The Complainant indicated resident #001 was receiving treatment for skin condition to a specified area that became infected in the home and was sent to hospital and died.

Inspector #547 reviewed the resident's health care records for a two and half month period prior to the resident's death. The resident's progress notes identified a deterioration in the resident's chronic skin condition on a specified date when the private caregiver informed the registered nursing staff that the resident's skin condition demonstrated possible signs of infection.

RPN #104 indicated to inspector #547 that this chronic skin condition began to erupt after an incident when the caregiver requested the RPN to complete a specified treatment to the skin wound and intervention. RPN #104 reported having reviewed the resident's plan of care after this request and noted there was no wound care instructions for this intervention. RPN #104 requested that the caregiver not perform this treatment and intervention to the resident's skin wound. The sitter stated to RPN #104 that care for the resident's skin wound prior to the resident moving to the specified unit was to complete this treatment and intervention when living on another specified unit. RPN #104 referred to a progress note written on a specified date in the resident's progress notes regarding this incident. The resident's progress notes indicated that RPN #104 went to the resident's room and found remnants of a treatment performed on the resident and intervention was applied to the resident after the sitter left. RPN #104 reported this to the DOC in person however did not make any further assessment of the resident's skin wound or add any interventions related to this incident.

Inspector #547 interviewed resident #001's caregiver regarding this treatment and intervention performed to the resident's skin wound and denied this incident. The DOC and RPN #104 indicated to inspector #547 that the caregiver in question was the caregiver involved in the incident that occurred on a specified date.

The DOC reported to inspector #547 having spoken to resident #001's caregiver after being made aware of this incident by RPN #104. The DOC informed the

caregiver that they are not to touch the resident's skin wound, or perform any treatment or intervention to this chronic skin wound. The DOC indicated not having reported this to the resident's POA as the DOC managed it directly with the caregiver. The DOC was also not aware if the physician was ever made aware of this incident to the resident's skin wound for further medical assessment or that no assessment of the skin wound was ever completed after this incident, or any additions to the resident's plan of care related to this incident.

As such, resident #001 exhibited altered skin integrity to a specified area after an incident occurred, however no immediate treatment, interventions to promote healing or prevention of infection as required. On a specified date after this incident, the resident's skin wound was diagnosed with an infection. [s. 50. (2) (b) (ii)]

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

This issue is related to log #026082-18.

The Director under the Ministry of Health and Long-Term Care received a complaint regarding resident #001's skin and wound care management that was not adequate to the resident's care needs while living in the Long-term Care home. The Complainant indicated resident #001 was receiving treatment for a specified skin condition to a specified area on the resident that became infected in the home and was sent to hospital. The documents shared with the hospital indicated the wound was being treated with interventions daily.

Resident #001 health care records were reviewed by inspector #547 and noted the resident's physician identified on a specified date that the resident had a specified skin condition to a specified area that was dry and long standing. The resident's health care records indicated resident #001 had this skin condition to other areas that required a specified treatment and procedure while living in the Long-Term Care home. Resident #001's progress notes indicated on a specified date a week later that this skin condition changed, with possible specified infection symptoms present that required treatment and interventions. No other skin assessment or treatment assessment was documented until two days later, when RPN #104 added the resident's treatment plan to the TAR. The next skin and

wound assessment on file was documented 19 days later when resident #001 was discovered to have an infection to the skin wound and was sent for further treatment and follow-up in hospital.

The Director of Care indicated that the registered nursing staff are expected to complete a wound assessment form electronically at least weekly with supporting documentation in the resident's progress notes after each treatment and intervention. As such, resident #001 that was exhibiting an infected wound to a specified area was not reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

7. Resident #003 was identified by the Director of Care (DOC) as a resident that had a long standing skin wound. Upon review of the resident's health care records, the last wound assessment was completed seven months earlier. The resident's progress notes for the last four months indicated the following gaps of weekly wound assessments for the resident's skin wound completed only nine times on specified dates.

RN #105 indicated to inspector #547 that registered nursing staff should be documenting their assessment of the skin wound after each treatment and intervention that is performed which should then be twice a week for resident #003 on specified days after the resident's shower. RN #105 indicated that if the assessment was not documented, it is considered that the assessment was not completed.

As such, the DOC indicated to inspector #547 upon review of the resident's health care record documentation, that a weekly re-assessment of the resident's skin wound was not completed as required. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the following strategies are developed to meet the needs of residents with responsive behaviours: written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

This issue is related to logs #028991-17 and #028565-18 for resident #002.

The Director under the Ministry of Health and Long-Term Care received a complaint on a specified date regarding resident #002's skin and wound care needs being inadequate after an incident occurred causing a skin wound to the resident.

Upon review of the resident's health care records, inspector #547 noted that the incident occurred on a specified date and time with a specified behaviour that resulted with a specified injury to resident #002. The resident's behaviour was not added to the resident's plan of care. The resident's progress notes indicated that the resident's Power of Attorney (POA) brought in a specified item to use for resident #002 for preventative measures related to this behaviour. This specified item was not identified in the resident's plan of care after this incident occurred. The resident's progress notes further indicated the POA also brought in other specified items as interventions to assist the resident with this behaviour as preventative measure, however these strategies were not added to the resident's plan of care.

RPN #106 indicated to inspector #547 that another incident had occurred on a later specified date with the same behaviour that resulted with altered skin integrity. RPN #106 further indicated that the resident was observed with this specified behaviour recently without injury at this time. Resident #002's health care records revealed that this responsive behaviour was not part to the resident's plan of care to date.

The Director of Care (DOC) indicated that these strategies developed by the resident's POA and the nursing staff in the home, should have been added to the resident's plan of care and that the techniques and interventions related to prevention of the resident's behaviour causing injury should be identified in the plan of care. [s. 53. (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 to ensure that the written strategies are developed to meet the needs of residents with responsive behaviours including techniques and interventions, to prevent, minimize or respond to the responsive behaviours, to be implemented voluntarily.

WN #3: 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):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure to inform the Director no later than one business day after the occurrence of an incident that caused an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

This issue is related to log #026082-18.

The Director of the Ministry of Health and Long-Term Care received a complaint on a specified date regarding concerns related to resident #001's skin and wound care management by the home. The Complainant indicated resident #001 was receiving treatment for a specified skin condition that became infected in the home and was sent to hospital with a change in the resident's health condition.

On October 11, 2018 the Director of Care indicated to inspector #547 that no critical incident was reported to the Director related to this incident as the resident died. [s. 107. (3) 4.]

2. This issue is related to log #028991-17.

The Director under the Ministry of Health and Long-Term care received a complaint on a specified date regarding concerns related to resident #002's skin and wound care management by the home, after an incident that occurred that caused an injury to the resident. The complainant indicated the resident was transferred to the hospital related to an injury that required further assessment and treatment. The resident returned to the home on the same day with treatment and medication management related to this skin wound.

On October 12, 2018 inspector #547 interviewed the Director of Care (DOC) regarding this incident, whereby resident #002 went to hospital related to an incident that caused an injury that resulted in a significant change in the care of resident's skin, pain, personal hygiene and responsive behaviours. The DOC indicated the Director was not informed of this incident as required by this section. [s. 107. (3) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure to inform the Director no later than one business day after the occurrence of an incident that caused an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The Director of Care (DOC) indicated to inspector #547 that resident #003 has had a long standing skin wound for review during this inspection. Inspector #547 reviewed the resident's current care plan that identified the resident had a specified skin wound that required monitoring, documentation and treatment as per the facility protocol. The DOC indicated the facility protocol would be the home's skin and wound care program, by entering the resident's assessed treatment plan in the Treatment Administration Record (TAR). The DOC also expected a progress note after the treatment and interventions are completed if there is any change in the wound state from the previous assessment.

RN #105 indicated on a specified unit, they identify the resident's that require skin treatments on a white board inside the nursing station. RN #105 indicated that there should be documentation in the progress notes for each treatment and intervention completed on the resident, to document that the treatment was completed and that if the documentation is not completed, that meant the care was not done. RN #105 indicated this unit did not add skin treatments to the TAR, however was not sure why.

Upon review of the resident's TAR with the DOC, it was noted that the resident did not have any plan in place for treatment of this long standing skin wound. Resident #003's progress notes were reviewed for a four month period related to skin and wound care that identified the resident's skin wound was not improving on a specified date four months earlier and the physician was informed. Assessments were documented sporadically throughout these four months reviewed with new skin and wound areas identified. Inspector #547 was unable to identify documented treatment and interventions provided to resident #003 for this long standing skin wound during this four month period, to demonstrate the treatment and interventions were completed twice weekly as required. Documentation and assessments reviewed with the DOC, who indicated that the unit's protocol will have to be updated with the current skin and wound practice in the home. [s. 30. (2)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The Licensee has failed to ensure that when withholding approval for admission, the licensee shall give the persons described in subsection (10) a written notice setting out; c) an explanation of how the supporting facts justify the decision to withhold approval; and d) contact information for the Director.

This issue is related to log #012621-18.

LTCHA 2007 stipulates in s.44(7) whereby the appropriate placement coordinator gave the Licensee copies of the assessments and information that were required to have been taken into account, under subsection 43(6), and the Licensee is to review these assessments and information and shall approve the applicant's admission to the home unless:

a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or
c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

The written notice provided by the Licensee was dated on a specified date. In this written notice, the Licensee did identify the ground on which the Licensee is withholding approval to be the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements. However the Licensee did not provide an explanation of the supporting facts associated with the identified ground in order to justify the decision to withhold approval. In this letter, the Licensee did not set out the contact information for the Director as required by this section. [s. 44. (9)]

Issued on this 29th day of November, 2018 (A1)

[redacted]

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

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LISA KLUKE (547) - (A1)
Inspection No. / No de l'inspection :	2018_621547_0032 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	028991-17, 012621-18, 026082-18, 028565-18 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 29, 2018(A1)
Licensee / Titulaire de permis :	The Ottawa Jewish Home for the Aged 10 Nadolny Sachs Private, OTTAWA, ON, K2A-4G7
LTC Home / Foyer de SLD :	Hillel Lodge 10 Nadolny Sachs Private, OTTAWA, ON, K2A-4G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ted Cohen

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

To The Ottawa Jewish Home for the Aged, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

Order # / Ordre no : 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 O.Reg.79/10, s.50.(2).

Specifically, the licensee shall complete the following:

a. Ensure that residents exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff as required,

b. Ensure that these skin assessments are documented on the Licensee's clinically appropriate assessment instrument designed for skin and wound assessments,

c. Ensure that each resident exhibiting altered skin integrity is immediately treated and interventions are implemented in the resident's plan of care as required,

d. Ensure that each resident with a wound or exhibiting altered skin integrity is reassessed at least weekly,

e. Ensure that each assessment or reassessment is documented, and

f. Ensure registered nursing staff review the Licensee's skin and wound care program. Records must be completed by the Licensee to attest that the required review was completed.

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 is specifically designed for skin and wound assessment.

This issue is related to log #026082-18.

The Director under the Ministry of Health and Long-Term Care received a complaint on a specified date regarding resident #001's skin and wound care management that was not adequate to the resident's care needs while living in the Long-term Care home. The Complainant indicated resident #001 was receiving treatment for a

specified skin condition that became infected in the home and was sent to hospital and died. The documents shared with the hospital indicated specified skin interventions for the resident.

The Director of Care indicated to inspector #547 that the resident was receiving wound care management for this skin condition to a specified location on the resident regularly prior to the infection being identified on a specified date. RPN #104 indicated to inspector #547 to have seen the resident's wound the day earlier during a specified intervention whereby there was no infection noted. RPN #104 also observed the resident's wound on a specified date and noted the infection to be definitely apparent and then sent the resident to hospital. RPN #104 indicated the resident had wound, that was difficult to cover properly due to the size and location however they cleaned the resident's skin, and covered the wound with a dry type dressing and closed it with paper tape. RPN #104 indicated that the seal of this wound dressing was not complete, as it was impossible with paper tape to seal completely to this location and for the size of the wound whereby it was possible the wound could have become contaminated. RPN #104 developed the treatment plan on a specified date as per an assessment completed and documented in the resident's progress notes. The assessment indicated the resident's wound required dressing change every shift and as required. RPN #104 indicated having entered the treatment plan into the Treatment Administration Record (TAR) as required. The TAR was reviewed indicated dressing changes as required three times a day. RPN #104 indicated that this information was not the same and made this intervention confusing as it was different than the assessment. RPN #104 indicated that wound care assessments should be completed weekly to review the resident's plan of care and noted upon review of the resident's health care records, that these assessments were not completed.

The Director of Care indicated to inspector #547 that an initial skin assessment should have been completed in the chart, whether it be in assessments or in the progress notes with a good description of the wound and dressing interventions.

As such, the registered nursing staff in the home did not complete a skin assessment using the Licensee's clinically appropriate assessment instrument specifically designed for skin and wound assessments for resident #001's skin wound that was infected and later deteriorated on a specified date that required resident #001 to be sent to hospital for further assessment and treatment of this wound. [s. 50. (2) (b) (i)]

(547)

2. The Director of Care (DOC) indicated the home's clinically appropriate assessment instrument used in the home is the wound assessment form in the home's electronic documentation system. The DOC indicated resident #003 has had a long standing wound to a specified area.

Inspector #547 reviewed resident #003's health care records for the last four months, that indicated the resident continues to have a wound to a specified area that requires skin and wound care dressings. The last wound assessment form in the resident's electronic documentation system was dated seven months earlier for this same wound to a specified area.

The DOC indicated that these wound assessment forms are required to be completed for each resident with a wound in the home as per their Skin and Wound care program. [s. 50. (2) (b) (i)]
(547)

3. This issue is related to log #028991-17.

On a specified date, an incident occurred with resident #002 who sustained a skin wound to a specified area.

Inspector #547 reviewed the resident's health care records that indicated in the progress notes that the resident's wound required specified treatment and intervention. The resident was re-assessed later by the Director of Care and RPN #106 on the specified date of this incident. The resident was sent to hospital three days later related to further assessment and treatment of the wound was required. The resident returned to the Long-Term Care home on the same day with recommended treatment and interventions as well as prescribed medications for treatment of infection.

The Director of care indicated the skin and wound assessment form is to be used as the home's assessment instrument for all new alteration of skin integrity issues, new admissions and for all residents returning from hospital. Resident #002 had an incident occur on another specified date that caused an open wound that required treatment and intervention. Upon review of the resident's health care records with the DOC, inspector #547 was unable to locate any skin assessment forms related to the resident's specified wound.

As such, resident #002 exhibiting skin wounds to a specified area, did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wounds. [s. 50. (2) (b) (i)]
(547)

4. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

This issue is related to log #028991-17.

Resident #002's health care records were reviewed. Resident #002's had an incident that occurred on a specified date and time that caused an injury to a specified area to the resident that required specified treatment and interventions. This incident was

communicated to the oncoming registered nursing staff for further follow up. RPN #106 and the Director of Care (DOC) assessed the resident's wound and specified treatment was provided. No further treatment or interventions to reduce or relieve pain, promote healing and prevention of infection were identified in the resident's plan of care. The complainant indicated the resident's treatment after the DOC completed it on the date of the incident, after which resident #001 was bathed and the treatment product became wet. The resident's Substitute Decision Maker (SDM) reported to the complainant over the next three days that the resident's dressing remained unchanged.On a specified date, three days after the incident occurred, the resident's SDM made a complaint to the DOC regarding the resident's skin and wound care management for the specified wound. Resident #002 was transferred to hospital that day for further assessment and treatment of the specified skin wound. Resident #002 returned to the home on the same day, after assessment and treatment was provided to the resident's skin wound in the hospital and diagnosed with a wound infection and began antibiotic therapy.

The DOC indicated to inspector #547 that the resident's skin wound to the specified area should have been assessed on each nursing shift in the home, and the area treated as required by specified interventions. The DOC indicated that the nursing assessment and treatment plan should have been added to the Treatment Administration Record (TAR) on the day the incident occurred. The DOC further indicated that a reassessment of the resident's plan of care related to pain assessment needs and Activities of Daily Living (ADL's) such as bathing, was required after this injury occurred.

As such, resident #002 exhibited altered skin integrity related to an incident that caused a wound to the resident that required immediate treatment however no interventions to reduce or relieve pain, promote healing or prevention of infection as required to the resident's plan of care. As a result, the resident's wound became infected and was required to be transferred to hospital. [s. 50. (2) (b) (ii)] (547)

5. This issue is related to log #026082-18.

Resident #001 was admitted to the home on a specified date with several medical diagnoses. Resident #001 has had a private caregiver that was assisting the resident daily.

The Director of the Ministry of Health and Long-Term Care received a complaint regarding concerns related to resident #001's skin and wound care management by the home. The Complainant indicated resident #001 was receiving treatment for skin condition to a specified area that became infected in the home and was sent to hospital and died.

Inspector #547 reviewed the resident's health care records for a two and half month period prior to the resident's death. The resident's progress notes identified a deterioration in the resident's chronic skin condition on a specified date when the private caregiver informed the registered nursing staff that the resident's skin condition demonstrated possible signs of infection.

RPN #104 indicated to inspector #547 that this chronic skin condition began to erupt after an incident when the caregiver requested the RPN to complete a specified treatment to the skin wound and intervention. RPN #104 reported having reviewed the resident's plan of care after this request and noted there was no wound care instructions for this intervention. RPN #104 requested that the caregiver not perform this treatment and intervention to the resident's skin wound. The sitter stated to RPN #104 that care for the resident's skin wound prior to the resident moving to the specified unit was to complete this treatment and intervention when living on another specified unit. RPN #104 referred to a progress note written on a specified date in the resident's progress notes regarding this incident. The resident's progress notes indicated that RPN #104 went to the resident's room and found remnants of a treatment performed on the resident and intervention was applied to the resident after the sitter left. RPN #104 reported this to the DOC in person however did not make any further assessment of the resident's skin wound or add any interventions related to this incident.

Inspector #547 interviewed resident #001's caregiver regarding this treatment and intervention performed to the resident's skin wound and denied this incident. The DOC and RPN #104 indicated to inspector #547 that the caregiver in question was the caregiver involved in the incident that occurred on a specified date.

The DOC reported to inspector #547 having spoken to resident #001's caregiver after being made aware of this incident by RPN #104. The DOC informed the caregiver that they are not to touch the resident's skin wound, or perform any treatment or intervention to this chronic skin wound. The DOC indicated not having

reported this to the resident's POA as the DOC managed it directly with the caregiver. The DOC was also not aware if the physician was ever made aware of this incident to the resident's skin wound for further medical assessment or that no assessment of the skin wound was ever completed after this incident, or any additions to the resident's plan of care related to this incident.

As such, resident #001 exhibited altered skin integrity to a specified area after an incident occurred, however no immediate treatment, interventions to promote healing or prevention of infection as required. On a specified date after this incident, the resident's skin wound was diagnosed with an infection. [s. 50. (2) (b) (ii)]
(547)

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

This issue is related to log #026082-18.

The Director under the Ministry of Health and Long-Term Care received a complaint regarding resident #001's skin and wound care management that was not adequate to the resident's care needs while living in the Long-term Care home. The Complainant indicated resident #001 was receiving treatment for a specified skin condition to a specified area on the resident that became infected in the home and was sent to hospital. The documents shared by the home with the hospital indicated the wound was being treated with interventions daily.

Resident #001 health care records were reviewed by inspector #547 and noted the resident's physician identified on a specified date that the resident had a specified skin condition to a specified area that was dry and long standing. The resident's health care records indicated resident #001 had this skin condition to other areas that required a specified treatment and procedure while living in the Long-Term Care home. Resident #001's progress notes indicated on a specified date a week later that this skin condition changed, with possible specified infection symptoms present that required treatment and interventions. No other skin assessment or treatment assessment was documented until two days later, when RPN #104 added the resident's treatment plan to the TAR. The next skin and wound assessment on file was documented 19 days later when resident #001 was discovered to have an infection to the skin wound and was sent for further treatment and follow-up in hospital.

The Director of Care indicated that the registered nursing staff are expected to complete a wound assessment form electronically at least weekly with supporting documentation in the resident's progress notes after each treatment and intervention. As such, resident #001 that was exhibiting an infected wound to a specified area was not reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

(547)

7. Resident #003 was identified by the Director of Care (DOC) as a resident that had a long standing skin wound. Upon review of the resident's health care records, the last wound assessment was completed seven months earlier. The resident's progress notes for the last four months indicated the following gaps of weekly wound assessments for the resident's skin wound completed only nine times on specified dates.

RN #105 indicated to inspector #547 that registered nursing staff should be documenting their assessment of the skin wound after each treatment and intervention that is performed which should then be twice a week for resident #003 on specified days after the resident's shower. RN #105 indicated that if the assessment was not documented, it is considered that the assessment was not completed.

As such, the DOC indicated to inspector #547 upon review of the resident's health care record documentation, that a weekly re-assessment of the resident's skin wound was not completed as required. [s. 50. (2) (b) (iv)]

Thus, the issuance of Written Notification (WN) #4 as well as the severity of this issue was determined to be level 2 as there was potential for actual harm to residents in this report related to skin and wound care management. The scope of the issue was widespread as there was 3 residents out of 3 residents reviewed related to skin and wound care issues. The home has a level 3 history as they have 1 or more related issues in last 36 months to the same area of non-compliance in the home's RQI 2016_287548_0014. (547)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 15, 2019(A1)

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:

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

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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 29th day of November, 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by LISA KLUKE (547) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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