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

London Service Area Office
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Amended Public Report (A1)

Report Issue Date May 4, 2022
Inspection Number 2022_1045_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Revera Long Term Care Inc.

Long-Term Care Home and City
Hillside Manor Stratford

Inspector who Amended
Melanie Northey (563)

Inspector who Amended Digital Signature
Melanie Northey
2022.05.09 15:25:57 -04'00'

AMENDED INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to reflect the correct inspection number and report issue date. The Critical Incident System inspection #2022_1045_0001 was completed on April 26, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 25 and 26, 2022

The following intake was inspected:
- 020086-21 for Critical Incident System (CIS) #1975-000025-21 related to care and services.

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (9) 2

The licensee has failed to ensure that the outcomes of the care related to the use of a specific skin care intervention for the resident as set out in the plan of care were documented.

Rationale and Summary

The Treatment Administrative Records (TARs) documented a specific preventative skin care intervention. Registered nursing staff documented in the TARs that the care intervention was implemented as planned, when the intervention was not provided to the resident as indicated.

The Documentation Survey Report documented a task for Personal Support Workers (PSWs) for customized care related to specific preventative skin care interventions. There were three shifts where the PSWs documented "Y" for yes that both interventions were in use when they were not.

The Director of Care (DOC) verified that the registered staff signed the TARs that the specific preventative skin care interventions were in place on two consecutive days when they were not. The DOC stated the expectation was that registered staff document the correct outcomes of care. The DOC stated the registered staff did not document the outcomes of the care provided on those two days.

The resident's application of the specific interventions was inaccurately documented at the outcome of care. There was low impact and risk to the resident.

Sources: Observations of the resident, clinical record review for the resident, and staff interviews. [563]

COMPLIANCE ORDER [CO#001] [PLAN OF CARE]

NC#002 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 6 (7)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1) (a)]

Licensee has failed to comply with s. 6 (7).

Specifically, the licensee shall:

a) Perform daily audits to ensure the skin care interventions set out in the plan of care are provided to the resident as specified in the plan, including but not limited to the use of specific preventative skin care interventions. Daily audits are to be completed until compliance is achieved for seven consecutive days.

b) Perform weekly audits for another four weeks to ensure the skin care interventions set out in the plan of care are provided to the resident as specified in the plan, including but not limited to the use of specific preventative skin care interventions.

c) Keep a written record of the audits and actions made based on the audit results.

Grounds

Non-compliance with: FLTCA, 2021 s. 6 (7)

The licensee has failed to ensure that the skin care intervention set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary
The care plan for the resident at the time of the incident and care plan at the time of the inspection identified a specific preventative skin care intervention. The resident was to have the intervention applied a all times. The plan of care included a task for customized care related to specific preventative skin care interventions. The resident was observed without the full use of the preventative interventions on two consecutive days.

The Registered Practical Nurse (RPN) shared that the interventions were partially implemented for the resident for two days. The RPN stated the resident should always have both preventative skin care interventions in place.

The Director of Care (DOC) stated the resident sustained a significant injury that required acute intervention offsite. The DOC verified that the resident had a supply of the specific intervention for use, but that some were lost.

There was a significant impact on the resident when the specific preventative skin care intervention was not in place to prevent injuries. The intervention was not applied and caused a significant skin injury that required immediate acute intervention offsite. The resident also developed a negative clinical outcome related to the injury. The injury could have been prevented. There was risk at the time of the inspection as the resident was observed multiple times without the use of the skin care intervention but did not sustain an injury.

Sources: Observations of the resident, clinical record review for the resident, and staff interviews. [563]

This order must be complied with by June 10, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The

licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

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

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

The written request for review must include,

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

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

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

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board **Director**

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Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

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

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