Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 20, 2018	2018_752627_0014	013070-18	Resident Quality Inspection

Licensee/Titulaire de permis

IOOF Seniors Homes Inc.
20 Brooks Street BARRIE ON L4N 5L3

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

IOOF Seniors Home
10 Brooks Street BARRIE ON L4N 5L3

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

SYLVIE BYRNES (627), AMY GEAUVREAU (642), JENNIFER BROWN (647), SHANNON RUSSELL (692), TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 3-6, 9-13, 2018.

The following intakes were inspected during this Inspection:

-One intake related to CO #001 from Inspection report #2018_634513_0001, s. 6 (7) of the Long-Term Care Homes Act (LTCHA), 2007, specific to care not provided as per plan of care;
-One intake related to CO #001 from Inspection report #2018_638609_0006, s. 6 (4) of the LTCHA, 2007, specific to collaboration in the development and implementation of the plan of care;
-One intake related to alleged staff to resident physical abuse;
-One intake related to falls prevention and management, and
-Two intakes related to the Public Health Unit declaring Acute Respiratory Outbreaks (ARIs).

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Maintenance Manager, Assistant Director of Care (ADOC), Nurse Practitioner (NP), Nurse Manager (NM), Restorative Care Lead (RCL), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Maintenance Staff, residents and their family members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed internal investigation notes, licensee policies, procedures, programs, relevant training and resident health care records.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 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. 6. (4)	CO #001	2018_638609_0006	647
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_634513_0001	647

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) Resident #001 was identified as having impaired skin integrity from a health care record review and a staff interview.

Inspector #642 reviewed resident #001's progress notes which revealed a "Skin Assessment and Treatment" assessment, which indicated that resident #001 had areas of impaired skin integrity.

Inspector #642 reviewed the home’s policy titled “Skin and Wound Care Program”, #RMC 12-03-01, last revised June 6, 2018, which indicated that “when a resident was exhibiting altered skin integrity, registered staff were to initiate weekly skin assessments and evaluate the effectiveness of interventions and resident response to interventions”.

Inspector #642 interviewed RPN #132 who stated that resident #001 had areas of

impaired skin integrity and that an assessment of the areas was to be completed weekly or more frequently if required. The assessment was to be documented in Point Click Care (PCC).

Inspector #627 reviewed the weekly skin assessments documented in PCC under the focus of “Wound assessment” or “Skin assessment and Treatment” for a period of three months and identified that the assessments had not been completed weekly 58 per cent of the time.

b) Inspector #627 reviewed resident #015's progress notes which revealed a "Skin Assessment and Treatment" assessment, indicating that resident #015 had an area of altered skin integrity.

Inspector #627 reviewed resident #015’s assessments documented in PCC under the focus of “Wound assessment” or “Skin assessment and Treatment” for a specific period of time and noted that the assessments had not been completed weekly, 71 percent of the time.

c) Inspector #627 reviewed resident #016's progress notes and identified a "Wound Assessment" indicating that resident #016 had and area of altered skin integrity.

Inspector #627 reviewed the weekly skin assessments documented in PCC under the focus of “Wound assessment” or “Skin assessment and Treatment” for resident #016 and noted that the assessments had not been completed weekly, 33 per cent of the time.

Inspector #627 interviewed RPN #133 who stated that when residents had altered skin integrity, they were to receive a skin/wound assessment which was documented in PCC under the focus of “Wound assessment” or “Skin assessment and Treatment”. RPN #133 indicated that staff would be prompted to complete an assessment when the treatment was completed and documented in the electronic treatment administration record (ETAR). Upon a record review of residents #001's “Wound assessment” and “Skin assessment and Treatment” by RPN #133 and Inspector #627, the RPN acknowledged that weekly assessments had not been completed.

Inspector #627 interviewed RN #138 who stated that they were now the lead for the Skin and Wound Program. RN #138 stated that when a resident had impaired skin integrity, a weekly skin or wound assessment was to be completed and documented in PCC under the focus of “Wound assessment” or “Skin Assessment and Treatment”. The RN and

Inspector #627 reviewed the “Wound assessment” and “Skin assessment and Treatment” for residents #001, #015 and #016. RN #138 acknowledged that the assessments had not been completed weekly for the three aforementioned residents.

Inspector #627 interviewed the DOC who acknowledged that they recognized that the skin and wound assessments had not been completed weekly for all resident who had impaired skin integrity. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the Director, alleging an incident of staff to resident physical abuse between PSW #118 and resident #010.

Inspector #642 reviewed the internal investigation notes which indicated that resident #010 had sustained injuries as a result of the care PSW #136 provided to the resident. The home's investigation notes also revealed an interview with PSW #137, who had been working the evening of the incident. In the written record of the interview, PSW #137 described what they had heard and observed on the specific evening between PSW #118 and resident #010. The investigation concluded with identification that PSW #136 had received disciplinary action for not complying with the home's abuse policy.

Inspector #642 reviewed the home's policy titled "Preventing, Reporting and Eliminating Resident Abuse Policy", HR 03-00-07, last revised June 2017, which indicated that "the home had a zero tolerance for abuse and that abuse in any form was not tolerated or condoned".

Inspector #642 interviewed RPN #117 who indicated that they were working the evening of the incident. PSW #136 had reported to them that they were providing care to resident #010 and that the resident had accidentally injured themself. When RPN #117 assessed resident # #010, they noted minor injuries and that the resident appeared upset. The next day, RPN #117 re-assessed resident #010 and found the injuries to be more extensive.

Inspector #642 interviewed the DOC who indicated that PSW # 136 had received disciplinary action as a result of the investigation, based on the condition of the resident. The DOC indicated that PSW #136 had not complied with the home's Zero Tolerance for Abuse Policy. [s. 20. (1)]

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 that the home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours;
a) the behavioural triggers for the resident were identified where possible;
b) strategies were developed and implemented to respond to these behaviours, where possible; and
c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Inspector #627 observed that resident #002's bedroom door was closed on three occasions. Upon entering the room, the Inspector noted a change in the room temperature.

Inspector #627 interviewed PSW #114 who stated that resident #002 exhibited specific types of responsive behaviours which prevented staff to provide care as identified in the care plan.

Inspector #627 reviewed the home’s policy titled “Responsive Behaviours, # RCM #12-04-01, last reviewed October 2017, which defined responsive behaviours. Causes and triggers were to be identified to develop strategies for prevention”

a) During an interview with resident #002, Inspector #627 noted a change in the resident’s room temperature. On two other occasions, the Inspector noted resident #002’s bedroom door was closed.

Inspector #627 reviewed resident's care plan in effect at the time of the inspection for the focus of behaviours; the care plan identified a specific intervention for resident #002.

Inspector #627 interviewed PSW ##114 who stated that resident #002’s responsive behaviours were getting worse.

Upon entering resident #002’s room with the Inspector, RPN #118 acknowledged the change in the resident’s room temperature and that it could be a health hazard. The RPN asked the resident if they found it comfortable, to which the resident replied that it could be more comfortable.

Inspector #627 interviewed RPN #108 who stated that resident #002 was assessed to be at risk related to the temperature in the room.

b) Inspector #627 interviewed PSW #113 who stated that when a resident exhibited a specific responsive behaviour staff would respond with a specific intervention. They further stated that they had not seen any interdisciplinary approach to address the resident’s responsive behaviour.

Inspector #627 reviewed the electronic records in Point of Care (POC), where PSWs documented the care provided to residents, and noted that for for a specified period, resident #002 had exhibited a responsive behaviour 88% of the time.

Inspector #627 reviewed the resident’s plan of care in effect at the time of the inspection and noted that resident #002 had been exhibiting a specific responsive behaviour and a

specific intervention was identified.

Inspector #627 interviewed RPN #112 who stated that when a resident exhibited a responsive behaviour, staff responded with a specific intervention. When a resident continuously exhibited a responsive behaviour, different interventions were trialed. The concerns were discussed during report between the PSWs and RPNs, and management would be informed if the responsive behaviour continued. RPN #112 stated that they were unsure if management had been made aware of resident #002's responsive behaviour. They stated that they were unsure what other interventions had been trialed and that Behavioural Services Ontario (BSO) was not involved with this resident; BSO was usually involved when a resident exhibited different responsive behaviours than those exhibited by resident #002. They further stated that they had not informed management of the resident's responsive behaviours.

Inspector #627 interviewed the Nurse Practitioner (NP) who stated that if a resident's responsisve behaviours were due to physiology, such as pain or lack of ability to communicate, it was reported to them. The NP stated that behaviours such as responsive behaviours exhibited by resident #002 should have been followed up as it may have been a specific cause. They indicated that the responsive behaviours of resident #002 had not been brought to their attention. The NP further stated that the responsive behaviour might have been normalized.

Inspector #627 interviewed the ADOC who stated that when a resident exhibited responsive behaviours such as those exhibited by resident #002, the PSWs reported the responsive behaviour to the RPN. The ADOC went on to explain to the Inspector that staff should attempt to find the cause of the responsive behaviour. If the responsive behaviour continued, it was addressed at the risk management meeting. The ADOC stated that they had not been made aware of the resident's responsive behaviours. They acknowledged that the staff may have normalized the behaviour. They further stated that they should have been made aware via email or a telephone call, and should have been kept "in the loop" as the current intervention for the resident was not effective.

The licensee failed to comply with section 53 (4) of Ontario Regulation (O.Reg.) 79/10, as none of the triggers for resident #002's responsive behaviour had been identified. Although the home had attempted an intervention to address resident #002's responsive behaviours, this had not been effective and no further actions, assessments, reassessments or interventions had been completed. Resident's #002's increasing behaviours had not been addressed. [s. 53. (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 that for each resident demonstrating responsive behaviours;
a) the behavioural triggers for the resident are identified where possible; and
b) strategies are developed and implemented to respond to these behaviours, where possible;
c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented., to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

A CIS report was submitted to the Director on a specified date in 2018, regarding a specific outbreak in the home, which was declared on the previous day, by the Public Health Unit (PHU).

Inspector #627 reviewed the home's policy titled "Mandatory Reporting and Whistle Blowing Protection", #RCA 06-00-01, dated May 4, 2016, which indicated that "every licensee of a long-term care home shall ensure that the Director was immediately informed, in as much detail as was possible in the circumstances of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act" .

Inspector #627 interviewed RPN #126 who stated that when one or more residents presented with two or more symptoms of infection, they were placed on isolation precaution, and the RN, managers, and the Infection Control team would be made aware via email and telephone.

Inspector #627 interviewed RN #125 who stated that when they were made aware of one or more residents presenting with symptoms of infection, they verified if the symptoms and number of residents presenting with symptoms met the criteria for isolation and outbreak. RN #125 stated that they contacted the PHU if they were unsure, and followed up via email with the DOC, the management staff and all registered staff. They further stated that if the outbreak was declared in the evening, they called the on call manager, who in turn, reported the outbreak to the DOC.

Inspector #627 interviewed the DOC who stated that they reported an outbreak of a communicable disease to the Director immediately. The DOC acknowledged that the outbreak that was declared on a specified day in 2018, should have been reported on the same day instead of the following day. [s. 107. (1) 5.]

2. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident: a missing or unaccounted for controlled substance.

Inspector #692 reviewed a medication incident which indicated that a controlled substance medication for resident #013 was missing or unaccounted for.

Inspector #692 reviewed the Ministry of Health and Long-Term Care’s online critical incident reporting portal and noted that a CIS report had not been submitted to the Director regarding the missing controlled substance medication.

Inspector #692 reviewed two additional medication incidents regarding missing or unaccounted for controlled substance medication:

1) A medication incident report was completed which indicated that during narcotic shift count, the registered staff noted the medication card of resident #012 was missing a controlled substance medication tablet.

2) A medication incident report was completed as registered staff were unable to locate resident #014's controlled substance medication.

Upon review of the Ministry of Health and Long-Term Care online critical incident reporting portal, Inspector #692 noted that CIS reports had not been submitted to the Director regarding the above mentioned two incidents of unaccounted for controlled substance medications.

Inspector #692 reviewed the home's policy entitled "Medication Management – Security and Storage #07-10-11", last reviewed January 2017. The policy outlined that the DOC/ Designate was to complete the Ministry of Health Critical Incident Report using the electronic critical incident system (CIS) where applicable.

Inspector #692 interviewed the DOC who identified that the above mentioned medication incidents involving unaccounted for controlled substance medications were not reported to the Director. The DOC indicated that in any instances of unaccounted for controlled substance medications, a report should be submitted to the Director. [s. 107. (3) 3.] [s. 107. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is immediately informed, in as much detail as is possible of the circumstances of an outbreak of a reportable disease or communicable disease as defined by the Health Protection and Promotion Act; and,
to ensure that the Director is informed of a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4), to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Inspector #642 observed resident #001 as having a specific intervention in place on three separate occasions while in bed.

Inspector #642, reviewed resident #001's plan of care which included the most recent care plan and could not locate any mention of the intervention being utilized.

Inspector #642 interviewed RPNs #128, #132 and RN #138, who stated that the use of the intervention was to be documented in the residents care plan. RPN #132 further stated after looking through resident #001's care plan, the specific intervention was not documented in the most recent care plan and they were going to add it.

Inspector #642 interviewed the DOC who stated that the intervention should have been documented in resident #001's care plan. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the resident, and the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM were provided the opportunity to participate fully in the development and implementation of the plan of care.

During an interview with Inspector #642, resident #001's family member, who was resident #001's enacted SDM, stated that they had not been informed of the resident's change in health condition on two separate occasions. They stated that they had received a call about an outbreak in the home, however it had not identified resident #001's change in health condition.

Inspector #642 reviewed resident #001's progress notes for a period of six and a half months, and failed to identify progress notes indicating that resident #001's SDM had been notified of resident #001's above mentioned change in health condition.

Inspector #642 interviewed RPNs #128, #132, and RN #138, who stated that a resident's SDM was to be informed when there was a significant change in health condition, and there should be documentation in the progress notes indicating when the resident's SDM was notified.

Inspector #642 interviewed the Restorative Aid Lead #139 who stated that if a resident had declined in health, the nurses were to advise the resident's SDM with the change in the resident's health condition.

During an interview with Inspector #642, the DOC and the Inspector reviewed the progress notes for the period of six and a half months and failed to identify a progress note that indicated that resident #001's SDM had been informed of resident #001's

change in health condition.   The DOC acknowledged that resident #001's SDM had not had the opportunity to participate fully in the development of the plan of care for resident #001 by not being informed of the resident's change in health condition. [s. 6. (5)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident's SDM.

Inspector #692 reviewed a medication incident regarding a missing narcotic patch. Please see WN #4, item #2 for details.

Inspector #692 reviewed resident #013’s electronic progress notes for the above mentioned medication incident and failed to identify documentation which indicated that the resident's SDM had been informed of the incident.

Inspector #692 reviewed the home's policy titled “Medication Incidents”, last reviewed January 17, 2017, which indicated that "the error or adverse reaction was also to be reported to the resident and/or the SDM”.

Inspector #692 interviewed RPN #105 who stated that the residents' SDM was to be notified of all medication incidents at the time of the incident.

Inspector #692 interviewed RN #116, who identified that they were the charge nurse at the time of the medication incident. RN #116 stated all SDMs were to be notified of all medication incidents at the time of the incident. RN #116 reviewed the medication incident report and the progress note documentation of the above mentioned medication incident and identified that resident #013's SDM was not notified of the medication incident.

Inspector #692 interviewed the DOC who indicated that for all medication incidents, the residents' SDM was to be notified at the time of the incident. Upon reviewing the medication incident and the progress notes for resident #013, the DOC further stated there was no documentation to substantiate that resident #013's SDM had been notified of the medication incident. s. 135. (1) (b)]

Issued on this 10th day of August, 2018

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

Original report signed by the inspector.

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE BYRNES (627), AMY GEAUVREAU (642), JENNIFER BROWN (647), SHANNON RUSSELL (692), TRACY MUCHMAKER (690)
Inspection No. / No de l'inspection :	2018_752627_0014
Log No. / No de registre :	013070-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 20, 2018
Licensee / Titulaire de permis :	IOOF Seniors Homes Inc. 20 Brooks Street, BARRIE, ON, L4N-5L3
LTC Home / Foyer de SLD :	IOOF Seniors Home 10 Brooks Street, BARRIE, ON, L4N-5L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Garry Hopkins

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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with section 50 (2) (b) (iv) of the of the Ontario Regulation (O. Reg.) 79/10 of the Long Term Care Homes Act.

The licensee shall prepare, submit and implement a written plan to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered staff.

The written plan shall include, but not limited to, the following:
1) Identify who is accountable to ensure that all residents with altered skin integrity are reassessed at least weekly;
2) Develop an audit system to ensure that all residents with altered skin integrity are reassessed weekly.

Please submit the written plan, quoting Inspection #2018_752627_0014 and Inspector, Sylvie Byrnes, by email to SudburySAO.moh@ontario.ca by July 31, 2018.
Please ensure that the submitted written plan does not contain any Personal Information and/or Personal Health Information.

Grounds / Motifs :

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

a) Resident #001 was identified as having impaired skin integrity from a health care record review and a staff interview.

Inspector #642 reviewed resident #001's progress notes which revealed a "Skin Assessment and Treatment" assessment, which indicated that resident #001 had areas of impaired skin integrity.

Inspector #642 reviewed the home's policy titled "Skin and Wound Care Program", #RMC 12-03-01, last revised June 6, 2018, which indicated that "when a resident was exhibiting altered skin integrity, registered staff were to initiate weekly skin assessments and evaluate the effectiveness of interventions and resident response to interventions".

Inspector #642 interviewed RPN #132 who stated that resident #001 had areas of impaired skin integrity and that an assessment of the areas was to be completed weekly or more frequently if required. The assessment was to be documented in Point Click Care (PCC).

Inspector #627 reviewed the weekly skin assessments documented in PCC under the focus of “Wound assessment” or “Skin assessment and Treatment” for a period of three months and identified that the assessments had not been completed weeekly, 58 per cent of the time.

b) Inspector #627 reviewed resident #015's progress notes which revealed a "Skin Assessment and Treatment" assessment, indicating that resident #015 had an area of altered skin integrity.

Inspector #627 reviewed resident #015’s assessments documented in PCC under the focus of “Wound assessment” or “Skin assessment and Treatment” for a specific period of time and noted that the assessments had not been completed weekly, 71 percent of the time.

c) Inspector #627 reviewed resident #016's progress notes and identified a "Wound Assessment" indicating that resident #016 had and area of altered skin integrity.

Inspector #627 reviewed the weekly skin assessments documented in PCC under the focus of “Wound assessment” or “Skin assessment and Treatment” for resident #016 and noted that the assessments had not been completed weekly, 33 per cent of the time.

Inspector #627 interviewed RPN #133 who stated that when residents had altered skin integrity, they were to receive a skin/wound assessment which was documented in PCC under the focus of “Wound assessment” or “Skin assessment and Treatment”. RPN #133 indicated that staff would be prompted to complete an assessment when the treatment was completed and documented in the electronic treatment administration record (ETAR). Upon a record review of residents #001's “Wound assessment” and “Skin assessment and Treatment” by RPN #133 and Inspector #627, the RPN acknowledged that weekly assessments had not been completed.

Inspector #627 interviewed RN #138 who stated that they were now the lead for

the Skin and Wound Program. RN #138 stated that when a resident had impaired skin integrity, a weekly skin or wound assessment was to be completed and documented in PCC under the focus of “Wound assessment” or “Skin Assessment and Treatment”. The RN and Inspector #627 reviewed the “Wound assessment” and “Skin assessment and Treatment” for residents #001, #015 and #016. RN #138 acknowledged that the assessments had not been completed weekly for the three aforementioned residents.

Inspector #627 interviewed the DOC who acknowledged that they recognized that the skin and wound assessments had not been completed weekly for all resident who had impaired skin integrity.

The decision to issue this compliance order was based on the scope which was widespread and the risk level which was determined to be potential for actual harm. Although there was no compliance history related to this section of the legislation, the severity and scope of the non-compliance has the potential to cause negative impacts on all residents in the home. (642)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 24, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	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 20th day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Sylvie Byrnes

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