Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 9, 2021	2021_866585_0008	003057-21, 006078-21, 006544-21, 009200-21, 010033-21, 010917-21	Critical Incident System

Licensee/Titulaire de permis

Six Nations of the Grand River
1745 Chiefswood Road P.O. Box 5000 Ohsweken ON N0A 1M0

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

Iroquois Lodge Nursing Home
1755 Chiefswood Road P.O. Box 309 Ohsweken ON N0A 1M0

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

LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 5, 6, 7, 8, 9, 13, 15, 21, 22 and 23, 2021 (on-site) and July 14, 19 and 20, 2021 (off-site).

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log #003057-21, CIS #2724-000004-21 related to skin and wound,
Log #006078-21, CIS #2724-000006-21 related to falls,
Log #006544-21, CIS #2724-000008-21 related to a significant change in condition,
Log #009200-21, CIS #2724-000009-21 and Log #010917-21, CIS #2724-000015-21 related to abuse; and,
Log #010033-21, CIS #2724-000011-21 related to personal support services.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), maintenance staff, the Unit Clerk, Social Worker, Environmental Supervisor (ES), Food Services Manager (FSM), Office Manager, Registered Dietitian, Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Coordinator, Assistant Director of Care (ADOC), Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector toured resident home areas, observed resident and staff interactions, reviewed relevant home policies and procedures, clinical health records, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Food Quality
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care

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

8 WN(s)
2 VPC(s)
2 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when three residents had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

The home's post-fall assessment instrument, "FALLS MANAGEMENT - Post Fall Assessment - V4" was expected to be initiated after any fall. The instrument noted if head injury routine (HIR) initiated, record vital signs on the "FALLS MANAGEMENT - Clinical Monitoring Record".

The Director of Care (DOC) reported staff were expected to complete a Post Fall Assessment after each fall and HIR was to be completed at all scheduled times using the Clinical Monitoring Record or a Neurological Flow Sheet for unwitnessed falls.

A) A resident had an unwitnessed fall and sustained injury. HIR was initiated but was not completed at all required times.

B) A resident had an unwitnessed fall and sustained injury. A Post Fall Assessment was not completed.

C) A resident had an unwitnessed fall. A Post Fall Assessment was partially completed. HIR was not completed at all required times.

The DOC confirmed post-fall assessments and/or HIR were not fully completed for the three residents.

Failure to complete all parts of the post-fall assessment increased potential risk to the residents as it was used to monitor their condition and evaluate the effectiveness of their plan of care.

Sources: residents clinical records, interview the DOC. [s. 49. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 when two residents exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Section 50. (3) of Ontario Regulation 79/10, states: in this section, "altered skin integrity" means potential or actual disruption of epidermal or dermal tissue.

Two residents were noted to have new areas of altered skin integrity. Skin assessments were not completed by a member of the registered nursing staff using the home's clinically appropriate assessment instrument when the alterations were first identified. This was confirmed by the DOC and registered nursing staff.

Sources: two residents clinical records, interviews with registered nursing staff and the DOC. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that when two residents had altered skin integrity, they were reassessed at least weekly by a member of the registered nursing staff, when it was clinically indicated.

The home's Skin and Wound Program: Wound Care Management policy required registered nursing staff to reassess altered skin integrity at minimum every seven days.

Registered nursing staff failed to re-assess two residents weekly when they had altered skin integrity. Both residents did not receive assessments on four occasions, when it was clinically indicated.

Sources: Skin and Wound Program Wound Care Management policy (#RC-23-01-32, dated August 2019), interviews with registered nursing staff and the DOC, two resident clinical records. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that annual evaluations of interdisciplinary programs required under section 48 of this Regulation were completed as required.

The home was unable to provide written records of annual evaluations for the falls prevention and management program and the skin and wound care program. The Administrator confirmed 2020 evaluations had not been completed for the two programs.

Sources: interview with the Administrator. [s. 30. (1) 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 and ensure that in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation, 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home had a dining and snack service that included, at a minimum, fluids served at a temperature that was safe to the residents.

Incidents occurred where two residents were served beverages at unsafe temperatures. Registered nursing staff reported there had been issues with hot beverages being too hot.

At the time of the inspection, the home did not have an established process to ensure hot beverages were served at a safe temperature for residents, as confirmed by the Food Services Manager (FSM).

Sources: two resident clinical records, interview with registered nursing staff and the FSM. [s. 73. (1) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that the home has a dining and snack service that includes, at a minimum, the following elements: food and fluids being served at a temperature that is both safe and palatable to the residents, 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of residents collaborated with each other in the assessment of two residents in relation to skin condition so that their assessments were consistent with and complemented each other.

Two residents had areas of altered skin integrity. Documentation completed by PSWs noted the residents did not have skin issues; however, registered nursing staff identified the residents did have altered skin integrity.

The DOC confirmed the assessments of both residents skin condition were inconsistent with and did not complement each other.

Sources: two resident clinical records, interview with the DOC. [s. 6. (4) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their Skin and Wound policy was complied with.

The home's Skin and Wound policy directed the Monthly Skin Issues Tracking Form be completed to ensure that all residents are being monitored and that the information is shared with the interdisciplinary team.

The Assistant Director of Care (ADOC) confirmed a monthly tracking tool had not been implemented in the home.

Sources: the home's policy, "Skin and Wound Program: Prevention of Skin Breakdown - RC-23-01-01" updated August 2019, interview with the ADOC. [s. 8. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

The home's Daily Temperature Log from June and July 2021 did not include record of temperature measurements in two resident bedrooms in different parts of the home. The home confirmed measurement and documentation of resident bedrooms was not part of the home's daily temperature monitoring.

Sources: Daily Temperature Log June and July 2021, interview with maintenance staff and the Environmental Supervisor (ES). [s. 21. (2) 1.]

2. The licensee has failed to ensure that the temperature required to be measured under subsection (2) was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

At the time of the inspection, the home's designated cooling areas (DCAs) for residents included the dining room, family room and corridors on both Issac and Davis wings. The DCAs also served as common areas in the home.

The home had a practice to measure and document temperatures daily in the areas noted above in the morning and afternoon; however, they did not measure and record temperatures of any area every evening or night. This was confirmed in the Daily Temperature Log record from June and July 2021.

In June 2021, there were 10 days when temperatures were only recorded once a day in the Daily Temperature Log for some of the DCA/common areas. On June 15, 2021, no temperatures were recorded for any area.

Temperatures were not routinely measured in any resident rooms; therefore there was no record of monitoring of resident rooms.

Sources: Daily Temperature Log June and July 2021, interview with maintenance staff and the ES. [s. 21. (3)]

WN #8: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that they informed the Director of an incident no later than three business days after the occurrence of the incident that caused an injury to a resident for which the resident was taken to a hospital, but the licensee was unable to determine within one business day whether the injury had resulted in a significant change in the resident's health condition.

An incident occurred that caused injury to a resident. The resident was transferred to hospital and experienced a significant change in condition as a result of the incident. The Administrator confirmed a Critical Incident Report (CIR) was not submitted to the Director within three business days, as required.

Sources: a resident’s clinical record, CIR 2724-000006-21, interview with the Administrator.

Issued on this 10th day of August, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LEAH CURLE (585)
Inspection No. / No de l’inspection :	2021_866585_0008
Log No. / No de registre :	003057-21, 006078-21, 006544-21, 009200-21, 010033-21, 010917-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 9, 2021
Licensee / Titulaire de permis :	Six Nations of the Grand River 1745 Chiefswood Road, P.O. Box 5000, Ohsweken, ON, N0A-1M0
LTC Home / Foyer de SLD :	Iroquois Lodge Nursing Home 1755 Chiefswood Road, P.O. Box 309, Ohsweken, ON, N0A-1M0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Andrew Joseph

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Six Nations of the Grand River, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must comply with s. 49. (2) of Ontario Regulation (O. Reg.) 79/10.

Specifically, the licensee must:
1. Provide education to all registered nursing staff on the home's post-fall assessment instrument to ensure all required components of the assessment are completed as required.
2. Document and maintain record of the education, including the date(s) of the education, content of the education, names of the staff who participated and the staff member(s) who provided the education.
3. Ensure a post-fall assessment is conducted using a clinically appropriate assessment instrument specifically designed for falls if a resident experiences a fall.

Grounds / Motifs :

1. The licensee has failed to ensure that when three residents had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

The home's post-fall assessment instrument, "FALLS MANAGEMENT - Post Fall Assessment - V4" was expected to be initiated after any fall. The instrument noted if head injury routine (HIR) initiated, record vital signs on the "FALLS MANAGEMENT - Clinical Monitoring Record".

The Director of Care (DOC) reported staff were expected to complete a Post Fall Assessment after each fall and HIR was to be completed at all scheduled times

using the Clinical Monitoring Record or a Neurological Flow Sheet for unwitnessed falls.

A) A resident had an unwitnessed fall and sustained injury. HIR was initiated but was not completed at all required times.
B) A resident had an unwitnessed fall and sustained injury. A Post Fall Assessment was not completed.
C) A resident had an unwitnessed fall. A Post Fall Assessment was partially completed. HIR was not completed at all required times.

The DOC confirmed post-fall assessments and/or HIR were not fully completed for the three residents.

Failure to complete all parts of the post-fall assessment increased potential risk to the residents as it was used to monitor their condition and evaluate the effectiveness of their plan of care.

Sources: Clinical records of three residents, interview the DOC.

An order was made by taking the following factors into account:

Severity: There was potential risk of harm to the residents.

Scope: Out of the three residents reviewed, all had incomplete post-fall assessments, demonstrating widespread non-compliance.

Compliance History: In the last 36 months, the licensee was non-compliant with s. 49. (2) of O. Reg. 79/10 with one Compliance Order (CO) issued January 11, 2019, 2019_689586_0001 complied on March 21, 2019, 2019_756583_0008. (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 08, 2021

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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 comply with s. 50. (2) (b) (i) and (iv) of O. Reg. 79/10.

Specifically, the licensee must:
1. Provide education to all registered nursing staff on how and when to complete a skin assessment, using the home's clinically appropriate assessment instrument specifically designed for skin and wound assessment; and that areas of altered skin integrity are reassessed weekly by registered nursing staff, if clinically indicated.
2. Document and maintain record of the education, including the date(s) of the education, content of the education, names of the staff who participated and the staff member(s) who provided the education.
3. Ensure residents 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 wound assessment when they exhibit altered skin integrity.
4. Ensure residents are reassessed at least weekly by a member of the registered nursing staff when they exhibit altered skin integrity, if clinically indicated.

Grounds / Motifs :

1. The licensee has failed to ensure that when two residents exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Section 50. (3) of Ontario Regulation 79/10, states: in this section, "altered skin integrity" means potential or actual disruption of epidermal or dermal tissue.

Two residents were noted to have new areas of altered skin integrity. Skin assessments were not completed by a member of the registered nursing staff using the home's clinically appropriate assessment instrument when the alterations were first identified. This was confirmed by the DOC and registered nursing staff.

Sources: two residents clinical records, interviews with registered nursing staff and the DOC. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that when two residents had altered skin integrity, they were reassessed at least weekly by a member of the registered nursing staff, when it was clinically indicated.

The home's Skin and Wound Program: Wound Care Management policy required registered nursing staff to reassess altered skin integrity at minimum every seven days.

Registered nursing staff failed to re-assess two residents weekly when they had altered skin integrity. Both residents did not receive assessments on four occasions, when it was clinically indicated.

Sources: Skin and Wound Program Wound Care Management policy (#RC-23-01-32, dated August 2019), interviews with registered nursing staff and the DOC, two resident clinical records. [s. 50. (2) (b) (iv)]

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to one of the residents. There was potential risk of harm to two of the residents.

Scope: Out of three residents reviewed two did not receive skin assessments when indicated by a member of the registered nursing staff, demonstrating a pattern of non-compliance.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s. 50. (2) (b) of O. Reg. 79/10 with a Voluntary Plan of Correction (VPC) issued in the last 36 months, the licensee was found to be non-compliant with s. 50. (2) (b) of O. Reg. 79/10 with a Voluntary Plan of Correction (VPC) issued February 21, 2020, and a VPC issued August 12, 2019. (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 08, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 9th day of August, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Leah Curle

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