Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 16, 2019	2018_610633_0022 (A1)	002961-18, 011168-18, 020633-18, 026976-18, 026977-18, 026980-18, 027307-18, 027308-18, 029463-18, 029881-18, 029882-18, 031260-18	Follow up

Licensee/Titulaire de permis

LaPointe-Fisher Nursing Home, Limited
1934 Dufferin Avenue WALLACEBURG ON N8A 4M2

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

LaPointe-Fisher Nursing Home
271 Metcalfe Street GUELPH ON N1E 4Y8

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

Amended by SHERRI COOK (633) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Order #004 request for extension to May 24, 2019.

Issued on this 16th day of April, 2019 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by SHERRI COOK (633) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 20-23, 19-23, 26-30, December 3-7, 10-12, 14, and 17, 2018.

The following intakes were completed during this inspection:

Log #027307-18- Follow-up (FU) to order #001 from inspection 2018_601532_0014 related to plan of care.

Log #027308-18- FU to order #002 from inspection 2018_601532_0014 related to policies.

Log #026976-18- FU to order #001 from inspection 2018_580568_0008 related to 24/7 RN.

Log #026977-18- FU to order #002 from inspection 2018_580568_0008 related to the prevention of abuse policy.

Log #026980-18- FU to order #003 from inspection 2018_580568_0008 related to skin and wound care.

Log #002961-18, #020633-18, #011168-18 and #029882-18 related to falls prevention.

Log #029881-18, #031260-18 and #029463-18 related to abuse.

Inspector Kristal Pitter #735 was present during this inspection.

PLEASE NOTE: Non-compliance related to LTCHA, 2007, s. 6(7), O. Reg. 79/10, s.

30(2) and s. 50 (2)(b)(ii)(iv) was identified in complaint inspection #2018_755728_0013 that was competed concurrently, served January 16, 2019, has been issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), the Assistant Director of Nursing/Wound Care Lead (ADON/WCL), the Resident Care Coordinator (RCC), the Food Services Manager, the Registered Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Certified Enterostomal Therapy Nurse (ET Nurse), Personal Support Workers (PSW), Environmental Services Workers, residents, and family members.

During the course of the inspection the inspector(s) observed resident care, meal and snack service, staff to resident interactions, staffing and medication administration. In addition, the clinical records and plans of care for identified residents and the home's relevant documentation and policies were reviewed.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

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

- **10 WN(s)**
- **2 VPC(s)**
- **8 CO(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

This inspection was completed as a follow up to CO #001 from inspection 2018_601532_0014 related to plan of care.

A) A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) related to a concern regarding the management of a specific health condition of an identified resident.

The family member of the resident stated that the home did not complete a specific intervention.

The plan of care for the resident did not include this intervention. On a specified date the resident had a specific symptom that required treatment.

The ADON said that the care was not completed as ordered by the physician and their plan of care. The resident required treatment as a result.

The licensee has failed to ensure that a specified intervention for an identified resident was provided to the resident as specified in their plan of care.

B) The plan of care for two identified residents stated that they had areas of altered skin integrity. Assessments and monitoring were scheduled at frequencies in addition to the weekly wound assessments. The plan of care did not include all assessments and monitoring on multiple dates.

Two registered staff and the ADON/WCL all stated that the expectation was that residents received the wound care interventions as directed by their plan of care.

The licensee has failed to insure that the care set out in the plan of care related to skin and wound assessments and monitoring were provided to two residents as specified in their plans of care.

Additional Required Actions:

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulation.

This inspection was completed as a follow up to CO #001 from inspection 2018_580568_0008 related to 24/7 RN.

The registered staff schedules showed that there was no RN present and working in the home for four shifts during a specified time period.

The homes staffing plan stated that there was to be at least one RN on duty and present in the home at all times.

The Administrator said that there was no RN present and working in the home for the identified shifts.

The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

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 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 the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

This inspection was completed as a follow up to CO #002 from inspection 2018_580568_0008 related to following the home's prevention of abuse policy.

The home's abuse policy outlined a process that staff were required to follow related to any incidents of alleged or witnessed abuse which included reporting and investigations. A registered staff member, the DON and Administrator all confirmed this process.

The plan of care documented that an identified resident told a registered staff member that another staff member was verbally abusive towards them.

A registered staff member said that there was no other documentation or communication related to this incident until the resident brought the same allegation forward to another staff member of the home.

The DON and Administrator both said that they were unaware of this incident and that an investigation was not completed at that time. The DON and Administrator also said that the registered staff did not follow the home's abuse policy related to reporting and investigations.

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

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 :

The licensee has failed to ensure that 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 was complied with.

This inspection was completed as a follow up to CO #001 from inspection 2018_601532_0014 related to following the home's falls prevention policies.

A) The home's Falls Prevention and Management policy stated that a post fall huddle would be held and documented on a post fall huddle form. This policy did not document that a post fall assessment would be completed.

The plan of care for three residents did not document that the required post fall assessments were completed. There was no documentation of a completed post fall huddle.

Two registered staff, the ADON and the DOC were inconsistent related to the home's process for post fall assessments and huddles. The DON agreed that the home's policy does not capture the changes made and the current practices at the home related to post fall assessment, huddles and documentation.

B) The home's Falls Prevention and Management policy stated that post fall a registered staff would initiate a head injury routine (HIR) assessment. The home's HIR policy stated the process and documentation required by the registered staff.

The plan of care for three residents did not document the required HIR assessments and monitoring during a specific time frame.

The ADON and DON stated that the expectation was that HIR assessments were to be completed by the registered staff per the home's HIR policy. The DON agreed that the home's policy did not capture the changes made and the current practices at the home related to HIR.

The licensee has failed to ensure that the home's Fall Prevention and Management policy, and the HIR policy and protocol were complied with for three residents. The home's policies did not reflect the current practices at the home.

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

The licensee has failed to ensure that skin and wound care training was provided to all staff who provided direct care to residents.

This inspection was completed as a follow up to CO #003 from inspection 2018_601532_0014 related to skin and wound care.

The home's staff education related to skin and wound was provided by the ADON in response to CO #003. Surge leaning online was completed by all registered staff, however, the material contained minimal information on wound assessment and treatment.

The staff sign-off on the remaining education did not document that all registered staff had completed the skin and wound assessment and treatment education. In

addition, all registered staff had not completed and signed off on the home's skin and wound care policy. None of the home's training included a specific content related to wound care.

Three registered staff said that RNs completed the wound treatments at the home however RPNs would also do wound treatments. The plan of care for three identified residents documented that RPN's had completed wound treatments. The home's training was not attended by all RPNs.

Four registered staff said that the training they had received by the home related to skin and wound care, was basic and did not include complex treatments. They all said that more staff training was required.

The home's skin and wound policy stated that the DOC, ADOC or designate would facilitate education for new employees, on-going and annual education for current employees and the ET/Wound Care Specialist would provide staff education.

The ADON/WCL stated that they did not have formal training related to skin and wound care. The ET Nurse said that they had not been asked nor had they provided any training to the home related to skin and wound care.

The ADON/WCL agreed that all registered staff had not completed the education related to skin and wound care. The ADON/WCL also said the home's current wound care training needed to be revised.

The licensee has failed to ensure that skin and wound care training was provided to all staff who provided direct care to residents. The current training at the home was insufficient.

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that any actions taken with respect to a resident under the skin and wound program, that included assessments, reassessments, and interventions, were documented.

The plan of care for an identified resident stated that they were dependent on staff for their mobility and they required a specific intervention related to their altered skin integrity. There was no documentation related to the provision of this intervention.

A registered staff member reviewed the plan of care and stated that there was no documentation related to the provision of this intervention.

The licensee has failed to ensure that any actions taken with respect to a resident under the skin and wound program was documented.

2. O. Reg. 79/10, s. 232 stated that the licensee shall ensure that the records of the residents of the home were kept at the home.

The ET Nurse said that they were the contracted services at the home for wound care and their documentation was completed by the registered staff at the home or the ADON/WCL. They also said that they maintained a notebook that was not kept at the home. The ET Nurse referred to their notebook and stated that they had assessed the wounds of two residents on specific dates.

Record review of the plan of care for four residents did not include any documentation by the ET Nurse. The plan of care for three residents and the the

home's related documentation did not include all assessments by the ET Nurse when the ET Nurse said they were present at the home on specific dates.

The Home's policy stated that the ET Nurse/Wound Specialist would complete assessments on their own forms. The policy did not include a process to ensure that the wound care records of the residents that were completed by the wound care specialist were completed by them and maintained at the home. The ADON agreed that they completed the documentation for the ET Nurse.

The licensee has failed to ensure that any actions taken with respect to residents by the contracted ET Nurse, that were made under the skin and wound care program, were documented and maintained at the home.

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

The licensee has failed to ensure that an interdisciplinary skin and wound care program, that promoted skin integrity, prevented the development of wounds and pressure ulcers, and provided effective skin and wound care interventions, was implemented.

This inspection was completed as a follow up to CO #003 from inspection 2018_601532_0014 related to skin and wound care.

Two complaints received by the Ministry of Health and Long-Term Care (MOHLTC) outlined concerns related to the treatment of wounds at the home.

A) Registered staff and the home's relevant documentation indicated that the skin and wound program was not inclusive and interdisciplinary.

B) The current best practices for wound care treatment as identified by the ET Nurse and ADON/WCL were not implemented by the home.

The home's skin and wound care policy stated that it was based on current best practice guidelines however, they were not implemented related to a clean and aseptic technique during wound care and wound debridement. Staff education did not include when and how to clean and aseptic technique.

The home relied upon the contracted ET Nurse as there was no one qualified at the home to complete wound debridement. The ET Nurse said they only assessed the wounds of residents identified by the ADON/WCL. The plan of care for the identified residents and the home's relevant wound care documentation stated that the ET Nurse had not assessed their wounds until they were advanced. There was no timely opportunity to consider and/or complete wound debridement treatment by the ET Nurse.

2. Weekly wound assessments were not completed for three identified residents. Two identified residents had not received the treatment required to promote healing and control infection. Re-issue of order #003 from inspection 2018_580568_0008 related to O. Reg. 50. (2)(b)(ii)(iv) is contained in this report.

3. The plan of care was not followed for two identified residents related to their skin and wound care. Order #001 related to LTCHA 2007, s. 6.(7) is contained in this report.

4. Wound care documentation by the contracted ET Nurse was not completed by the ET Nurse and was not all present in the identified residents plan of care. There was no process at the home to ensure that the clinical records by the contracted ET/RN related to wound care were maintained at the home. Order #006 related to O. Reg. 30. (2) is contained in this report.

5. Staff education related to wound care was insufficient and incomplete. Registered staff stated that more education was required. RPNs completed wound care treatments, however, were not included in all of the intended training. A wound care specialist was not involved in the development and implementation of the skin and wound staff training at the home. Order #005 related to O. Reg. 221.(1)(2) is contained in this report.

The licensee has failed to ensure that an interdisciplinary skin and wound care program was implemented at the home that prevented the development of wounds and pressure ulcers and provided effective skin and wound care interventions for multiple identified residents.

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #8: 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 :

The licensee has failed to ensure that a resident that exhibited altered skin integrity received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

This inspection was completed as a follow up to CO #003 from inspection 2018_601532_0014 related to skin and wound care.

The plan of care for an identified resident stated that they had areas of altered

skin integrity. Treatment was ordered.

The plan of care for the resident, the home's related documentation and the ET Nurse all stated that the resident's dressings had not all been applied with the ordered treatment.

The area progressed and an x-ray was ordered. The medical certificate of death stated altered skin integrity was a contributing condition.

The ADON/WCL stated that the expectation was that residents received the wound care treatment as ordered and as directed by the plan of care.

The licensee has failed to ensure that an identified resident, who exhibited altered skin integrity received the immediate treatment and interventions to promote healing and prevent infection when required.

2. Order #003 related to O. reg 79/10, s. 50. (2)(b)(ii) from inspection 2018_580568_0008 had a compliance due date of October 19, 2018. The following is further evidence to support this order:

The plan of care for an identified resident stated that they had areas of altered skin integrity. Treatment was ordered.

The contracted ET Nurse did not assess the resident until a later date. They recommended that the treatment be discontinued. The resident had received the treatment for a number of days prior to the assessment by the ET Nurse. The ET Nurse did not re-assess the area of altered skin integrity again until a later date. The area of altered skin integrity worsened and the resident developed specific symptoms. A specific treatment was ordered.

The ET Nurse said that the area of altered skin integrity was already established when they first assessed the resident.

The home's skin and wound care policy included a process for referral and monitoring by the ET Nurse.

The ADON said that the home relied on the contracted ET Nurse as there was no wound care specialist at the home. The ADON also said they used to have the ET Nurse attend the home preventively, however, this was no longer occurring.

The licensee has failed to ensure that an identified resident, with altered skin integrity, received the immediate treatment and interventions to promote healing and prevent infection when required.

3. The licensee has failed to ensure that a resident that exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

A) The plan of care for two identified resident documented that they had areas of altered skin integrity. Weekly wound assessments were ordered.

A weekly wound assessment was completed on a specific date for both residents and not again until 11 days later.

Two RNs and the ADON/WCL stated that weekly wound assessments were to be completed and documented in the plan of care for all residents with altered skin integrity.

The licensee has failed to ensure that two residents who exhibited altered skin integrity were reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

4. Order #003 related to O. reg 79/10, s. 50. (2)(b)(iv) from inspection 2018_580568_0008 had a compliance due date of October 19, 2018. The following is further evidence to support this order:

The licensee has failed to ensure that an identified resident who exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

The plan of care for the resident stated that the resident had areas of altered skin integrity. The plan of care also documented signs of infection. A weekly assessment was completed on a specific date, and not again until 10 days later.

Two RNs and the ADON/WCL stated that weekly wound assessments were to be completed and documented in the plan of care for all residents with altered skin integrity.

The licensee has failed to ensure that an identified resident who exhibited altered skin integrity with signs of infection was reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm to a resident was immediately reported to the Director with the suspicion and the information upon it was based.

The home's complaints binder contained a document which stated that a resident alleged an incident of abuse. An investigation by the home had the same date.

The Administrator and DON both said that this incident was not reported to the Director as required.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident was immediately reported to the Director with the suspicion and the information upon it was based.

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 a person who had reasonable grounds to suspect that improper care of a resident and abuse of a resident by anyone that resulted in harm or risk of harm to a resident is immediately reported to the Director with the suspicion and the information upon it was based, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licensee that the licensee shall comply with every order made under this Act.

On August 8, 2018, the following compliance order (CO #002) from inspection number 2018_580568_0008 was made under s. 20 (1), LTCHA, 2007:

Specifically the licensee must:
a) Ensure that all staff receive education related to the home's policy to promote zero tolerance of abuse and neglect of residents and that this education specifically addresses the duty to report and the process that each staff member is to follow with respect to reporting. A record of the education, the dates offered and who attended must be kept.
b) Ensure that the management staff of the home follow their process for investigation of the alleged incidents of abuse/neglect, and that records are kept of the investigation and these records are stored in a secure area.
c) Ensure that the Administrator or designate is aware of and oversees the investigation process and has access to the investigation records.

The compliance due date was October 19, 2018.

The licensee completed part b) and part c) of order #002. The licensee did not complete part a) ensure that all staff received education related to the home's policy to promote zero tolerance of abuse and neglect of residents.

The home's related documentation identified two staff members that did not complete training on the home's policy to promote zero tolerance of abuse and neglect.

The Administrator confirmed that two staff members had not completed education on the home's specific policy to promote zero tolerance of abuse and neglect including reporting requirements.

The licensee failed to ensure that all staff received education related to the home's policy to promote zero tolerance of abuse and neglect of residents.

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 licensee complies with every order made under this Act, to be implemented voluntarily.

Issued on this 16th day of April, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SHERRI COOK (633) - (A1)
Inspection No. / No de l'inspection :	2018_610633_0022 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002961-18, 011168-18, 020633-18, 026976-18, 026977-18, 026980-18, 027307-18, 027308-18, 029463-18, 029881-18, 029882-18, 031260-18 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 16, 2019(A1)
Licensee / Titulaire de permis :	LaPointe-Fisher Nursing Home, Limited 1934 Dufferin Avenue, WALLACEBURG, ON, N8A-4M2
LTC Home / Foyer de SLD :	LaPointe-Fisher Nursing Home 271 Metcalfe Street, GUELPH, ON, N1E-4Y8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dahlia Burt-Gerrans

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To LaPointe-Fisher Nursing Home, Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_601532_0014, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with LTCHA 2007, s. 6(7).

Specifically, the licensee must ensure:
a) that a specific ordered intervention is completed for an identified resident, and all other residents, who have scheduled orders for this intervention.
b) that treatment, including scheduled assessments and monitoring related to altered skin integrity are completed for two identified residents, and all other residents, as directed by their electronic treatment record (eTAR) and plan of care.

Grounds / Motifs :

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

This inspection was completed as a follow up to CO #001 from inspection 2018_601532_0014 related to plan of care.

A) A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) related to a concern regarding the management of a specific health condition of an identified resident.

The family member of the resident stated that the home did not complete a specific intervention.

The plan of care for the resident did not include this intervention. On a specified date the resident had a specific symptom that required treatment.

The ADON said that the care was not completed as ordered by the physician and their plan of care. The resident required treatment as a result.

The licensee has failed to ensure that a specified intervention for an identified resident was provided to the resident as specified in their plan of care.

B) The plan of care for two identified residents stated that they had areas of altered skin integrity. Assessments and monitoring were scheduled at frequencies in addition to the weekly wound assessments. The plan of care did not include all assessments and monitoring on multiple dates.

Two registered staff and the ADON/WCL all stated that the expectation was that residents received the wound care interventions as directed by their plan of care.

The licensee has failed to insure that the care set out in the plan of care related to skin and wound assessments and monitoring were provided to two residents as specified in their plans of care.

The scope of this issue was a level 2, pattern. The severity of the issue was determined to be a level 3, actual harm. The home has a level 5 history of non-compliance with this section of the regulation:
-voluntary plan of correction (VPC) from inspection 2017_604519_0004 issued March 10, 2017;
-CO #001 from inspection 2017_604519_0006 issued May 17, 2017, and compliance due date August 3, 2017;
-VPC from inspection 2018-5723606_0007 issued June 26, 2018;
-VPC from inspection 2018-580568_0008 issued August 18, 2018;
-CO #001 from inspection 2018_601532_0014 issued September 6, 2018 and compliance due date October 19, 2018. (633) (728)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2019

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2018_580568_0008, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, s. 8 (3).

Specifically the licensee must:
a) ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception for this requirement.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulation.

This inspection was completed as a follow up to CO #001 from inspection 2018_580568_0008 related to 24/7 RN.

The registered staff schedules showed that there was no RN present and working in the home for four shifts during a specified time period.

The homes staffing plan stated that there was to be at least one RN on duty and present in the home at all times.

The Administrator said that there was no RN present and working in the home for the identified shifts.

The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

The scope of this issue was a level 3, widespread. The severity of the issue was determined to be a level 2, potential for actual harm. The home has a level 5 history of non-compliance that included:
-CO #001 from inspection 2018_580568_0008 issued August 8, 2018 and compliance due date October 19, 2018.

(728)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2019

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2018_580568_0008, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, s. 20.(1).

Specifically the licensee must:
a) ensure that all staff follow the home's abuse policy related to reporting.
b) ensure that all staff follow the home's abuse policy related to investigations.

Grounds / Motifs :

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

This inspection was completed as a follow up to CO #002 from inspection 2018_580568_0008 related to following the home's prevention of abuse policy.

The home's abuse policy outlined a process that staff were required to follow related to any incidents of alleged or witnessed abuse which included reporting and investigations. A registered staff member, the DON and Administrator all confirmed this process.

The plan of care documented that an identified resident told a registered staff member that another staff member was verbally abusive towards them.

A registered staff member said that there was no other documentation or communication related to this incident until the resident brought the same allegation forward to another staff member of the home.

The DON and Administrator both said that they were unaware of this incident and that an investigation was not completed at that time. The DON and Administrator also said that the registered staff did not follow the home's abuse policy related to reporting and investigations.

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

The scope of this issue was a level 1, isolated. The severity of the issue was determined to be a level 2, potential for actual harm. The home has a level 5 history of non-compliance that included:
-VPC from inspection 2017_604519_0006 issued May 17, 2017;
-CO #002 from inspection 2018_580568_0008 issued August 8, 2018 and compliance date of October 19, 2018.
(728)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2019

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2018_601532_0014, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8. (1) of Ontario Regulation 79/10.

Specifically the licensee must:
a) ensure that the policy related to fall prevention specifically post fall assessment and monitoring and head injury routine (HIR), when indicated are completed for three identified residents, and any other resident in the home who has fallen.
b) review and revise the home's falls prevention and HIR policy to reflect the current practices at the home related to post fall huddles, post fall assessments and HIR. The date of the review, who attended, changes made and date the changes were implemented must be documented.
c) educate all registered staff on the revised policies. All staff must sign off on the completed education and maintain documentation of staff completion in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that 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 was complied with.

This inspection was completed as a follow up to CO #001 from inspection 2018_601532_0014 related to following the home's falls prevention policies.

A) The home's Falls Prevention and Management policy stated that a post fall huddle would be held and documented on a post fall huddle form. This policy did not document that a post fall assessment would be completed.

The plan of care for three residents did not document that the required post fall assessments were completed. There was no documentation of a completed post fall huddle.

Two registered staff, the ADON and the DOC were inconsistent related to the home's process for post fall assessments and huddles. The DON agreed that the home's policy does not capture the changes made and the current practices at the home related to post fall assessment, huddles and documentation.

B) The home's Falls Prevention and Management policy stated that post fall a registered staff would initiate a head injury routine (HIR) assessment. The home's HIR policy stated the process and documentation required by the registered staff.

The plan of care for three residents did not document the required HIR assessments and monitoring during a specific time frame.

The ADON and DON stated that the expectation was that HIR assessments were to be completed by the registered staff per the home's HIR policy. The DON agreed that the home's policy did not capture the changes made and the current practices at the home related to HIR.

The licensee has failed to ensure that the home's Fall Prevention and Management policy, and the HIR policy and protocol were complied with for three residents. The home's policies did not reflect the current practices at the home.

The scope of this issue was a level 3, widespread. The severity of the issue was determined to be a level 2, potential for actual harm. The home has a level 5 history

of non-compliance that included:
-VPC from inspection 2016_723606_0004 issued April 13, 2017;
-CO #002 from inspection 2017_448155_0006 issued May 17, 2017, and compliance date of August 17, 2017;
-VPC from inspection 2018_723606_0007 issued June 26, 2018;
-CO #002 from inspection 2018_601532_0014 issued September 6, 2018 and compliance date of October 19, 2018. (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 24, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 221.(1)(2).

Specifically, the licensee must ensure:
a) that all registered staff and the wound care lead receive education related to skin and wound. This training must include at a minimum clean and aseptic technique, assessment and treatment.
b) that the skin and wound training is developed according to best practices and in consultation with a wound care specialist.
c) that a written record is kept of the education that includes the content and date of staff completion.

Grounds / Motifs :

1. The licensee has failed to ensure that skin and wound care training was provided to all staff who provided direct care to residents.

This inspection was completed as a follow up to CO #003 from inspection 2018_601532_0014 related to skin and wound care.

The home's staff education related to skin and wound was provided by the ADON in response to CO #003. Surge learning online was completed by all registered staff, however, the material contained minimal information on wound assessment and treatment.

The staff sign-off on the remaining education did not document that all registered staff had completed the skin and wound assessment and treatment education. In addition, all registered staff had not completed and signed off on the home's skin and wound care policy. None of the home's training included a specific content related to wound care.

Three registered staff said that RNs completed the wound treatments at the home however RPNs would also do wound treatments. The plan of care for three identified residents documented that RPN's had completed wound treatments. The home's training was not attended by all RPNs.

Four registered staff said that the training they had received by the home related to skin and wound care, was basic and did not include complex treatments. They all said that more staff training was required.

The home's skin and wound policy stated that the DOC, ADOC or designate would facilitate education for new employees, on-going and annual education for current employees and the ET/Wound Care Specialist would provide staff education.

The ADON/WCL stated that they did not have formal training related to skin and wound care. The ET Nurse said that they had not been asked nor had they provided any training to the home related to skin and wound care.

The ADON/WCL agreed that all registered staff had not completed the education related to skin and wound care. The ADON/WCL also said the home's current wound care training needed to be revised.

The licensee has failed to ensure that skin and wound care training was provided to

all staff who provided direct care to residents. The current training at the home was insufficient.

The scope of this issue was a level 3, widespread. The severity of the issue was determined to be a level 2, potential for actual harm. The home has a level 5 history of non-compliance that included:
-CO #002 from inspection 2018_580568_0008 issued August 8, 2018, and compliance date of October 19, 2018.

(633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 19, 2019

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 30 (2).

Specifically, the licensee must:
a) develop and implement a process to ensure that the records of the contracted ET Nurse/Wound Care Specialist are completed by them and maintained in the clinical records of all residents at the home.
b) review and revise the home's skin and wound care policy to include this process. The date of the review, who attended, the changes made and the date the change was implemented must be documented.

Grounds / Motifs :

1. The licensee has failed to ensure that any actions taken with respect to a resident under the skin and wound program, that included assessments, reassessments, and interventions, were documented.

O. Reg. 79/10, s. 232 stated that the licensee shall ensure that the records of the residents of the home were kept at the home.

The ET Nurse said that they were the contracted services at the home for wound care and their documentation was completed by the registered staff at the home or the ADON/WCL. They also said that they maintained a notebook that was not kept at the home. The ET Nurse referred to their notebook and stated that they had assessed the wounds of two residents on specific dates.

Record review of the plan of care for four residents did not include any documentation by the ET Nurse. The plan of care for three residents and the the home's related documentation did not include all assessments by the ET Nurse when the ET Nurse said they were present at the home on specific dates.

The Home's policy stated that the ET Nurse/Wound Specialist would complete assessments on their own forms. The policy did not include a process to ensure that the wound care records of the residents that were completed by the wound care specialist were completed by them and maintained at the home. The ADON agreed that they completed the documentation for the ET Nurse.

The licensee has failed to ensure that any actions taken with respect to residents by the contracted ET Nurse, that were made under the skin and wound care program, were documented and maintained at the home.

The scope of this issue was a level 3, widespread. The severity of the issue was determined to be a level 2, potential for actual harm. The home has a level 3 history of non-compliance. (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 19, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 48 (1).

The licensee shall prepare, submit and implement a plan to ensure that an interdisciplinary skin and wound care program, that promotes skin integrity, prevents the development of wounds and pressure ulcers, and provides effective skin and wound care interventions, is implemented.

The plan must include, but is not limited, to the following:
1. developing and implementing an interdisciplinary wound care team according to best practices and in consultation with a Wound Care Specialist.
2. the frequency of interdisciplinary wound care team meetings and who will attend.
3. a process to track meetings, recommended changes and evaluation of the skin and wound care program.
4. timelines to review and revise the home's skin and wound policy to include:
-universal precautions and aseptic technique including how and when indicated;
-the implementation of a process for early and preventative wound assessment by the ET Nurse/Wound Care Specialist.
- when and how registered staff will be educated on policy changes.
5. education for the wound care lead and all registered staff as outlined in order #005 of this report. The plan should include timelines and who will provide the training.
6. an interim plan for who will be responsible for, and how, residents with wounds will be assessed, monitored and treated according to best practices until such time as the wound care lead and registered staff have been educated.
7. to ensure that weekly skin and wound assessments are completed and documented in the plan of care.
8. to ensure that treatment and monitoring of wounds is completed, documented and aligned with best practices.

Please submit the written plan.

Grounds / Motifs :

1. The licensee has failed to ensure that an interdisciplinary skin and wound care

program, that promoted skin integrity, prevented the development of wounds and pressure ulcers, and provided effective skin and wound care interventions, was implemented.

This inspection was completed as a follow up to CO #003 from inspection 2018_601532_0014 related to skin and wound care.

Two complaints received by the Ministry of Health and Long-Term Care (MOHLTC) outlined concerns related to the treatment of wounds at the home.

A) Registered staff and the home's relevant documentation indicated that the skin and wound program was not inclusive and interdisciplinary.

B) The current best practices for wound care treatment as identified by the ET Nurse and ADON/WCL were not implemented by the home.

The home's skin and wound care policy stated that it was based on current best practice guidelines however, they were not implemented related to a clean and aseptic technique during wound care and wound debridement. Staff education did not include when and how to clean and aseptic technique.

The home relied upon the contracted ET Nurse as there was no one qualified at the home to complete wound debridement. The ET Nurse said they only assessed the wounds of residents identified by the ADON/WCL. The plan of care for the identified residents and the home's relevant wound care documentation stated that the ET Nurse had not assessed their wounds until they were advanced. There was no timely opportunity to consider and/or complete wound debridement treatment by the ET Nurse.

2. Weekly wound assessments were not completed for three identified residents. Two identified residents had not received the treatment required to promote healing and control infection. Re-issue of order #003 from inspection 2018_580568_0008 related to O. Reg. 50. (2)(b)(ii)(iv) is contained in this report.

3. The plan of care was not followed for two identified residents related to their skin and wound care. Order #001 related to LTCHA 2007, s. 6.(7) is contained in this report.

4. Wound care documentation by the contracted ET Nurse was not completed by the ET Nurse and was not all present in the identified residents plan of care. There was no process at the home to ensure that the clinical records by the contracted ET/RN related to wound care were maintained at the home. Order #006 related to O. Reg. 30. (2) is contained in this report.

5. Staff education related to wound care was insufficient and incomplete. Registered staff stated that more education was required. RPNs completed wound care treatments, however, were not included in all of the intended training. A wound care specialist was not involved in the development and implementation of the skin and wound staff training at the home. Order #005 related to O. Reg. 221.(1)(2) is contained in this report.

The licensee has failed to ensure that an interdisciplinary skin and wound care program was implemented at the home that prevented the development of wounds and pressure ulcers and provided effective skin and wound care interventions for multiple identified residents.

The scope of this issue was a level 3, widespread. The severity of the issue was determined to be a level 3, actual harm. The home has a level 5 history of related non-compliance that included:
-VPC from inspection 2017_604519_0004 issued March 10, 2017;
-VPC from inspection 2018_723606_0007 issued June 26, 2018;
-CO #003 from inspection 2018_580568_0008 issued August 8, 2018 and compliance date of October 19, 2018;
-written notification (WN) from inspection 2018_580568_0009 issued October 2, 2018. (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 19, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 008

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

Linked to Existing Order / Lien vers ordre existant: 2018_580568_0008, CO #003;

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 s. 50 (2)(b)(ii)(iv) of O. Reg. 79/10.

Specifically the licensee must:
a) ensure that residents exhibiting altered skin integrity receive immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection.
b) ensure that two identified residents, and all residents, are reassessed at least weekly by a member of the registered nursing staff.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident that exhibited altered skin integrity received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

This inspection was completed as a follow up to CO #003 from inspection 2018_601532_0014 related to skin and wound care.

The plan of care for an identified resident stated that they had areas of altered skin integrity. Treatment was ordered.

The plan of care for the resident, the home's related documentation and the ET Nurse all stated that the resident's dressings had not all been applied with the ordered treatment.

The area progressed and an x-ray was ordered. The medical certificate of death stated altered skin integrity was a contributing condition.

The ADON/WCL stated that the expectation was that residents received the wound care treatment as ordered and as directed by the plan of care.

The licensee has failed to ensure that an identified resident, who exhibited altered skin integrity received the immediate treatment and interventions to promote healing and prevent infection when required.

2. The licensee has failed to ensure that a resident that exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

The plan of care for two identified resident documented that they had areas of altered skin integrity. Weekly wound assessments were ordered.

A weekly wound assessment was completed on a specific date for both residents and not again until 11 days later.

Two RNs and the ADON/WCL stated that weekly wound assessments were to be completed and documented in the plan of care for all residents with altered skin integrity.

The licensee has failed to ensure that two residents who exhibited altered skin integrity were reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

The scope of this issue was a level 3, widespread. The severity of the issue was determined to be a level 3, actual harm. The home has a level 5 history of related non-compliance that included:
-VPC from inspection 2017_604519_0004 issued March 10, 2017;
-VPC from inspection 2018_723606_0007 issued June 26, 2018;
-CO #003 from inspection 2018_580568_0008 issued August 8, 2018 and compliance date of October 19, 2018;
-written notification (WN) from inspection 2018_580568_0009 issued October 2, 2018.

(633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 19, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 16th day of April, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by SHERRI COOK (633) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Service Area Office / Bureau régional de services : Central West Service Area Office