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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Amended Public Copy/Copie modifiée 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
Jan 14, 2022	2021_824736_0022 (A1)	015463-21	Complaint

Licensee/Titulaire de permis

Orillia Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street Midland ON L4R 2E1

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

Leacock Care Centre
25 Museum Drive Orillia ON L3V 7T9

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

Amended by AMANDA BELANGER (736) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested an extension to the compliance due dates for CO #001, #002, and #003. The request for the compliance due dates to be extended to February 14, 2022, has been approved.

Issued on this 14th day of January, 2022 (A1)

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

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

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

Amended by AMANDA BELANGER (736) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 1-5, and November 8-10, 2021.

During the course of the inspection, the following intakes were inspected:

-one intake, a complaint submitted to the Director related to staffing levels, and care concerns. An additional intake of a Critical Incident was also inspected during this inspection as it related to the same concern identified in complaint log.

Follow Up Inspection #2021_824736_0020 and Critical Incident System Inspection #2021_824736_0021 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Director of Care (DOC), Co-Director of Care (Co-DOC), Staff Educator(s), Regional Manager, Administrative Assistant, Nurse Manager(s), Registered Nurse(s) (RNs), Registered Practical Nurse(s) (RPNs), Personal Support Worker(s) (PSWs), Dietary Aide(s), residents and family members.

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

PLEASE NOTE: Non-compliance related to s. 6 (1) c, and s. 19 of the Long-Term Care Homes Act 2007, identified in Critical Incident Inspection #2021_824736_0021, were issued in this report.

The following Inspection Protocols were used during this inspection:

Dining Observation
Medication
Personal Support Services
Safe and Secure Home
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **8 WN(s)**
- **2 VPC(s)**
- **3 CO(s)**
- **1 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. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents written records were kept up to date at all times.

A) During the course of the inspection, the Inspectors noted two entries that had been entered into the resident's chart as "late entries". These late entries were entered into the resident's chart eight and 14 days after the assessments had been completed. On one of the occasions, the staff member who created the late entry was noted to not be on the schedule for the date that the assessment was completed.

B) Also during the inspection, the Inspectors noted three additional entries into another resident's chart as "late entries". These late entries were entered in the resident's chart between 10 and 19 days after the assessments were completed. The Inspector also noted that other entries had been started in the resident's chart, however, not completed until 13 days, to six weeks later.

The Director of Care (DOC) indicated that the assessments could be altered until it was locked, and that an additional entry would be generated into the resident's chart, once the assessment was completed. The DOC indicated that the resident's records were not kept current when assessments were not locked after being completed, and when entries were late into the resident's records.

C) A resident's medical record had assessments opened, that were not closed for between three and 22 days. The assessments were to generate entries into the resident's chart.

There was risk of harm to the resident by the resident records not being kept up to date.

Sources: Resident charts; staff schedules; interviews with Co-Director of Care (Co-DOC), DOC, Acting Administrator and other staff. [s. 231. (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Findings/Faits saillants :

The licensee has failed to ensure that residents were protected from neglect.

Section 2 (1) of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

A) A resident had impaired skin integrity that required daily treatments to be applied.

During a two week period, there were days when the treatment had not been applied to the resident's impaired skin integrity, and also days when there was no documentation to support that the treatment had been applied. One RPN indicated that they were unsure of how to apply the treatment for the resident.

For a period of time, there were no treatments provided, nor was the impaired skin integrity observed by staff. When the impaired skin integrity was next observed by staff, there were concerns identified.

B) An order was identified in the resident's chart after a concern in the impaired skin integrity was identified, that directed staff to immediately provide treatment to

the resident.

The Co-DOC indicated that the treatment was not done the day prior and they inputted this order so it would get done.

The failure to complete the resident's required treatments may have contributed to resident harm including deterioration of the impaired skin integrity.

Sources: The resident's progress notes and assessments; CIS Report; licensee policy titled "Resident Rights, Care and Services - Abuse - Zero Tolerance Policy for Resident Abuse and Neglect" last revised June 2020; the home's internal investigation notes; the RN's employee file; interviews with RNs, the Acting Administrator, and other staff.

2) During the shift, the RPN discovered that the PSW had not provided the required care to three residents, despite the staff member documenting that resident care had been completed. The incident was not reported to management until three days later.

The residents' care plans provided direction to staff related to the care that was to be provided during the shift. One of the residents was noted to be found in a condition that indicated care had not been provided.

The home's investigation revealed that the RPN discovered that care was not provided by the PSW to the three residents
.
During a review of the home’s investigation notes, the Inspector identified a prior allegation of staff to resident abuse by the PSW, that occurred before this incident had been reported to the management of the home.

There was harm to the residents by the home not protecting residents from neglect by staff members.

Sources: The home’s zero tolerance of abuse and neglect policy; last updated June 2020; the home’s internal investigation notes and written staff statements; CIS report; residents care plans, flow sheets and progress notes; and interviews with the Co-DOC, Acting Administrator, and other staff. [s. 19.]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: 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 three residents received immediate treatment and interventions to promote healing and prevent infection, as required.

A) A resident had altered skin integrity. An order provided direction to staff related to treatment and assessment of the altered skin integrity.

i. Progress notes indicated that there were occasions where staff did not record the assessment of the resident's altered skin integrity as they should have.

ii. There was also an occasion where there was no documentation related to the treatment of the impaired skin integrity.

The Co-DOC indicated that if it was not documented, the treatment was not done.

The treatment not being provided as directed may have contributed to the resident's impaired skin integrity worsening.

Sources: Licensee policy titled "Resident Rights, Care and Services - Required Programs – Skin and Wound Care - Program" last revised October, 2018; resident's records; CIS report; the homes investigation notes; and interviews with the Co-DOC and other staff members.

B) A resident's chart indicated that the resident was to have a specific treatment applied to their impaired skin integrity.

i) A progress note indicated that the treatment was not applied and, additional progress notes indicated that the treatment was not replaced until the next day.

ii) The resident's chart provided direction to registered staff to change the resident's treatment specific days of the week.

A review of the resident's documentation indicated that on two occasions, the treatment was not changed as per the eMAR direction.

iii) The resident was assessed for their impaired skin integrity, and a treatment was ordered for the healing of the impaired skin integrity.

For two days, the documentation indicated that the treatment was not provided, as staff were unsure of how to apply the treatment, despite training; and due to the resident not being in the correct position.

There was risk of harm to the resident by wound care not being provided as ordered.

Sources: The resident's progress notes and eMAR; interviews with the Co-DOC, and other staff.

C) A resident's chart indicated that the resident was to have treatment provided on specified days of the week.

On two occasions, it was identified that the resident was sleeping, and treatment was not provided.

There was actual risk of harm to the resident by the care not being provided as ordered.

Sources: The resident's progress notes and eMAR documentation; interview with the Co-DOC, and other staff. [s. 50. (2) (b) (ii)]

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

Two residents had areas of altered skin integrity that were not assessed at least weekly.

There was risk of harm to the residents, when wounds were not assessed every seven days by a member of the registered staff.

Sources: The residents' progress notes and Skin and Wound Assessments; licensee policy titled "Resident Rights, Care and Services - Required Programs - Skin and Wound Care – Program" last revised October 2018; interview with the RPN, Staff Educator, Co-DOC, and other staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' plans of care provided clear direction to staff and others who provided direct care to the resident.

A) The resident's treatments were changed from one treatment to another.

At the time of the inspection, the resident's care plan indicated both treatments were to be implemented.

The plan of care not providing clear direction to staff was relevant as new or temporary staff on the home area may have referenced the resident's care plan and interpreted that the resident was to have both treatments applied at the same time.

Sources: The resident's chart; interview with the Staff Educator, and other staff.

B) The resident was observed and noted to have a specific intervention in place to manage their responsive behaviours.

A review of the resident's plan of care did not indicate that the resident was to have the intervention.

The plan of care not providing clear direction to staff was relevant as new or temporary staff on the home area may have referenced the resident's care plan and not been aware of the need for the resident to have the intervention as part of the home's actions to prevent altercations related to their responsive behaviours.

Source: The resident's chart; Inspector observations; interviews with the Staff Educator, and other staff. [s. 6. (1) (c)]

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 plan of care provides clear direction to staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that four residents were bathed twice a week by the method of their choice.

A) A resident's care plan indicated the resident's preferred method of bathing.

i) Documentation in the resident's medical record indicated that the resident's preferred method of bathing was not provided as scheduled

The PSW confirmed that a bed bath was provided due to time restraints as they were short staffed.

B) Three residents were scheduled to be bathed by their preferred method on a specified date.

The PSW expressed concerns to the Inspector, regarding staffing levels on the date identified. They indicated that there were only two PSWs on the day shift to complete their duties and provide care to all residents on the home area. They were only able complete one of the five scheduled baths.

The three residents were not offered the preferred method of their choice.

C) A resident's clinical record indicated that a bed bath was provided to a resident due to a time restraint.

The PSW confirmed that they were “short staffed” and therefore, a bed bath was provided to the resident. There was no indication that the missed tub bath/shower was made up on another day.

There was minimal risk of harm to the residents by the residents not being provided bathing twice weekly, by their preferred method.

Sources: The residents' charts; bath binders; policy titled "Resident Rights, Care and Services - Nursing and Personal Support Services - Bathing" last revised August 2021; interviews a resident, PSWs, the Staff Educator and other relevant staff. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are bathed twice weekly by a method of their choice, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of an investigation into an allegation of neglect of a resident was reported to the Director.

A CIS Report was submitted to the Director in relation to an allegation of neglect. The CIS report was amended two days later, but did not include the results of the investigation.

Sources: Licensee policy titled "Resident Rights, Care and Services - Abuse - Zero Tolerance Policy for Resident Abuse and Neglect", last revised June 30, 2020; CIS Report; and interviews with the Acting Administrator and other relevant staff. [s. 23. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that substituted menu items were communicated to residents.

The menu posted outside of a dining room indicated that minestrone soup would be served for lunch.

The Inspector observed that a staff member was serving cream of potato soup to the residents.

The Dietary Aide indicated that there was no minestrone soup available, and that the change in the menu was not communicated to the residents.

There was minimal risk of harm to the residents by the menu change not being communicated to the residents.

Sources: Interviews with the Dietary Aide and other relevant staff members; Licensee policy titled "Resident Rights, Care and Services - Nutrition Care and Hydration Programs - Meal Service" last revised July 2020; the Inspector's dining observations; and "Week 3 Lunch" menu. [s. 72. (2) (f)]

WN #8: 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. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff members only assisted one or two residents at the same time who needed total assistance with eating or drinking.

During the inspection, the Inspector observed a staff member assisting three different residents who required total assistance with eating or drinking, at two separate tables. Residents at both tables needed to wait between bites of food for staff to attend to their table to provide the required assistance.

There was risk to all three residents, as they each required individualized assistance that was not being provided by the staff, which had the potential to negatively impact their food and fluid consumption during the meal service.

Sources: Inspector observations; licensee policy "Resident Rights, Care and Service- Nutrition Care and Hydration Programs-Meal Service", revised July 2020; interview with Acting Administrator. [s. 73. (2) (a)]

2. The licensee has failed to ensure that a resident, who required total assistance with eating and drinking, was not served a meal until someone was available to provide assistance.

During the inspection, a resident was served soup during the lunch meal service. Seven minutes later, a PSW sat with the resident to provide assistance.

The resident's care plan indicated their nutritional risk, and directed staff the level of support required for meal service.

The PSW indicated that the soup should not have been put in front of the resident until staff were readily available to assist the resident.

There was risk to the resident by the soup being placed in front of the resident, when no staff were available to assist, as the resident required total assistance with eating and drinking. The soup may not have been given to the resident at the appropriate, and palatable temperature, which then had the potential to negatively impact the resident's food consumption during the meal service.

Sources: The Inspector's observations; interviews with the PSW and other relevant staff; policy titled: "Resident Rights, Care and Services - Nutrition Care and Hydration Programs - Meal Service" last revised July 2020; and the resident's care plan. [s. 73. (2) (b)]

Issued on this 14th day of January, 2022 (A1)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMANDA BELANGER (736) - (A1)
Inspection No. / No de l'inspection :	2021_824736_0022 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	015463-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 14, 2022(A1)
Licensee / Titulaire de permis :	Orillia Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, Midland, ON, L4R-2E1
LTC Home / Foyer de SLD :	Leacock Care Centre 25 Museum Drive, Orillia, ON, L3V-7T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carrie Acton

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 Orillia Long Term Care Centre Inc., 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. 231. Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Order / Ordre :

The licensee must comply with s. 231(1) of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee shall ensure that residents' written records are kept up to date related to assessments and progress notes.

Grounds / Motifs :

1. The licensee has failed to ensure that residents written records were kept up to date at all times.

A) During the course of the inspection, the Inspectors noted two entries that had been entered into the resident's chart as "late entries". These late entries were entered into the resident's chart eight and 14 days after the assessments had been completed. On one of the occasions, the staff member who created the late entry was noted to not be on the schedule for the date that the assessment was completed.

B) Also during the inspection, the Inspectors noted three additional entries into another resident's chart as "late entries". These late entries were entered in the resident's chart between 10 and 19 days after the assessments were completed. The Inspector also noted that other entries had been started in the resident's chart,

however, not completed until 13 days, to six weeks later.

The Director of Care (DOC) indicated that the assessments could be altered until it was locked, and that an additional entry would be generated into the resident's chart, once the assessment was completed. The DOC indicated that the resident's records were not kept current when assessments were not locked after being completed, and when entries were late into the resident's records.

C) A resident's medical record had assessments opened, that were not closed for between three and 22 days. The assessments were to generate entries into the resident's chart.

There was risk of harm to the resident by the resident records not being kept up to date.

Sources: Resident charts; staff schedules; interviews with Co-Director of Care (Co-DOC), DOC, Acting Administrator and other staff.

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

Severity: There was minimal risk of harm to the residents by the residents' written records not being kept up to date.

Scope: This non-compliance was widespread, as three out of three resident records that were reviewed, were not kept up to date.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O.Reg 79/10 s. 231 and one VPC and one Written Notice (WN) were issued to the home. (736)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 14, 2022(A1)

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: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

The licensee must comply with s. 19 of the LTCHA.

Specifically, the licensee must ensure that residents are protected from neglect.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from neglect.

Section 2 (1) of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

A) A resident had impaired skin integrity that required daily treatments to be applied.

During a two week period, there were days when the treatment had not been applied to the resident's impaired skin integrity, and also days when there was no documentation to support that the treatment had been applied. One RPN indicated that they were unsure of how to apply the treatment for the resident.

For a period of time, there were no treatments provided, nor was the impaired skin integrity observed by staff. When the impaired skin integrity was next observed by staff, there were concerns identified.

B) An order was identified in the resident's chart after a concern in the impaired skin integrity was identified, that directed staff to immediately provide treatment to the resident.

The Co-DOC indicated that the treatment was not done the day prior and they inputted this order so it would get done.

The failure to complete the resident's required treatments may have contributed to resident harm including deterioration of the impaired skin integrity.

Sources: The resident's progress notes and assessments; CIS Report; licensee policy titled "Resident Rights, Care and Services - Abuse - Zero Tolerance Policy for Resident Abuse and Neglect" last revised June 2020; the home's internal investigation notes; the RN's employee file; interviews with RNs, the Acting Administrator, and other staff.

2) During the shift, the RPN discovered that the PSW had not provided the required care to three residents, despite the staff member documenting that resident care had been completed. The incident was not reported to management until three days later.

The residents' care plans provided direction to staff related to the care that was to be provided during the shift. One of the residents was noted to be found in a condition that indicated care had not been provided.

The home's investigation revealed that the RPN discovered that care was not provided by the PSW to the three residents
.
During a review of the home's investigation notes, the Inspector identified a prior allegation of staff to resident abuse by the PSW, that occurred before this incident had been reported to the management of the home.

There was harm to the residents by the home not protecting residents from neglect by staff members.

Sources: The home's zero tolerance of abuse and neglect policy; last updated June 2020; the home's internal investigation notes and written staff statements; CIS report; residents care plans, flow sheets and progress notes; and interviews with the Co-DOC, Acting Administrator, and other staff.

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

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

Severity: There was actual harm to the residents.

Scope: There was a pattern noted, as there were two incidents of neglect of residents that resulted in actual harm.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s.19, and one Compliance Order (CO) was issued to the home. (736)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 14, 2022(A1)

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: 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must comply with s. 50(2) of the O.Reg 79/10.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that residents receive immediate treatment and interventions related to impaired skin integrity; as well as to ensure that residents impaired skin integrity is assessed at least weekly by a member of the registered staff.

The plan must include but is not limited to:
-how the home will ensure that impaired skin integrity is assessed weekly, and who is responsible to monitor that it is completed;
-how the home will ensure that treatments are provided to residents related to impaired skin integrity;
-the person responsible for implementing an action plan if impaired skin integrity treatments and assessments are not completed weekly; and
-actions to address sustainability once the home has been successful in ensuring that impaired skin integrity treatment is completed and the impaired skin integrity is assessed at least weekly.

Please submit the written plan for achieving compliance for inspection #2021_824736_0022 to Amanda Belanger, LTC Homes Inspector, MLTC, by December 30, 2021.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that three residents received immediate treatment and interventions to promote healing and prevent infection, as required.

A) A resident had altered skin integrity. An order provided direction to staff related to treatment and assessment of the altered skin integrity.

i. Progress notes indicated that there were occasions where staff did not record the assessment of the resident's altered skin integrity as they should have.

ii. There was also an occasion where there was no documentation related to the treatment of the impaired skin integrity.

The Co-DOC indicated that if it was not documented, the treatment was not done.

The treatment not being provided as directed may have contributed to the resident's impaired skin integrity worsening.

Sources: Licensee policy titled "Resident Rights, Care and Services - Required Programs – Skin and Wound Care - Program" last revised October, 2018; resident's records; CIS report; the homes investigation notes; and interviews with the Co-DOC and other staff members.

B) A resident's chart indicated that the resident was to have a specific treatment applied to their impaired skin integrity.

i) A progress note indicated that the treatment was not applied and, additional progress notes indicated that the treatment was not replaced until the next day.

ii) The resident's chart provided direction to registered staff to change the resident's treatment specific days of the week.

A review of the resident's documentation indicated that on two occasions, the treatment was not changed as per the eMAR direction.

iii) The resident was assessed for their impaired skin integrity, and a treatment was ordered for the healing of the impaired skin integrity.

For two days, the documentation indicated that the treatment was not provided, as staff were unsure of how to apply the treatment, despite training; and due to the resident not being in the correct position.

There was risk of harm to the resident by wound care not being provided as ordered.

Sources: The resident's progress notes and eMAR; interviews with the Co-DOC, and other staff.

C) A resident's chart indicated that the resident was to have treatment provided on specified days of the week.

On two occasions, it was identified that the resident was sleeping, and treatment was not provided.

There was actual risk of harm to the resident by the care not being provided as ordered.

Sources: The resident's progress notes and eMAR documentation; interview with the Co-DOC, and other staff. (736)

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

Two residents had areas of altered skin integrity that were not assessed at least weekly.

There was risk of harm to the residents, when wounds were not assessed every seven days by a member of the registered staff.

Sources: The residents' progress notes and Skin and Wound Assessments; licensee policy titled "Resident Rights, Care and Services - Required Programs - Skin and Wound Care – Program" last revised October 2018; interview with the RPN, Staff Educator, Co-DOC, and other staff.

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

Severity: There was actual risk of harm to the residents by the treatments not being provided as ordered, and wounds not being assessed weekly by a member of the registered staff.

Scope: This non compliance was noted to be widespread, as it involved three out of three residents reviewed for wound care.

Compliance History: In the last 36 months, the licensee was found to be non-compliance with O.Reg. s. 50(2), and a CO was issued to the home. (736)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 14, 2022(A1)

Order(s) of the Inspector

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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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 14th day of January, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by AMANDA BELANGER (736) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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