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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie 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
Mar 13, 2019	2019_605213_0009	001394-18, 011116-18, 030978-18, 003025-19	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Secord Trails Care Community
263 Wonham Street South INGERSOLL ON N5C 3P6

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

RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 19, 20 and 21, 2019

This inspection was completed related to
Log #001394-18, Critical Incident #2628-000005-18 related to an respiratory outbreak.
Log #011116-18, Critical Incident #22628-000014-18 related to alleged staff to resident verbal abuse.
Log #030978-18, a follow up to Compliance Order #001 issued in inspection #2018_722630_0023 related to skin and wound assessments issued November 22, 2018.
Log #003025-19, Critical Incident #2628-000002-19 related to an respiratory outbreak.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Associate Director of Care, the Director of Resident Programs and Admissions, Registered Nurses, Registered practical Nurses, Personal Support Workers, a Physiotherapy Assistant, a Restorative Care Aide, the Office Manager and residents.

The Inspector also made observations and reviewed health records, internal investigation records, meeting minutes, policies and procedures, communications, and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **2 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. 229. Infection prevention and control program

Findings/Faits saillants :

1. The licensee has failed to ensure, (a) that there was an interdisciplinary team

approach in the co-ordination and implementation of the program; (b) that the interdisciplinary team that co-ordinates and implements the program met at least quarterly; (c) that the local medical officer of health was invited to the meetings; (d) that the program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and (e) that a written record was kept relating to each evaluation under clause (d) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee also failed to ensure that all staff participated in the implementation of the program.

The licensee also failed to ensure that on every shift, (a) symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and (b) the symptoms were recorded and that immediate action is taken as required.

The licensee also failed to ensure that there were in place, (a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and (b) a written plan for responding to infectious disease outbreaks.

The home reported the following Critical Incident System (CIS) reports to the Ministry of Health and Long Term Care (MOHLTC) over the past two years:
- Respiratory outbreak declared February 2, 2019 (Influenza A) (declared over on February 19, 2019)
- Respiratory outbreak declared November 19, 2018
- Respiratory outbreak declared July 20, 2018
- Respiratory outbreak declared January 15, 2018
- Respiratory outbreak declared December 12, 2017
- Respiratory outbreak declared October 21, 2017
- Respiratory outbreak declared May 3, 2017

Record review of the line listing created by the home for the Influenza A outbreak declared February 2, 2019, showed 23 identified residents were isolated with symptoms of the outbreak. Vital signs and progress notes in Point Click Care (PCC) were reviewed

for three residents for the time period they were isolated and showed:
- One resident was isolated for seven days and was positive for Influenza A. Seven shifts during the seven day period did not have a temperature recorded.
- A second resident was isolated from for six days. Two shifts during the six day period did not have a temperature recorded.
- A third resident was isolated for nine days and was positive for Influenza A. Five shifts during the nine day period did not have a temperature recorded.

In an interview with a registered nursing staff member, the Inspector and the nurse reviewed the health records for the three residents and agreed that temperatures and all symptoms were not documented for these residents every shift while they were isolated with symptoms during the Influenza A outbreak.

In an interview with Director of Care (DOC), the Inspector and the DOC reviewed the health records for the three residents and agreed that temperatures and all symptoms were not documented for these residents every shift while they were isolated with symptoms during the Influenza A outbreak.

On another date, the DOC reported that another resident was isolated during the outbreak. A record review of the line listing showed that this resident was not included in the line listing. The DOC said that the resident should have been included on the line listing and was not. A record review of vital signs and progress notes in PCC showed that this resident was isolated for eleven days with symptoms of the outbreak including fever and eighteen shifts during the eleven day period there was no temperature or symptoms recorded.

In an interview with the DOC, when asked about the Infection Prevention and Control (IPAC) lead, team and program, the DOC said that an identified registered nursing staff member was the lead for IPAC in the home. When asked if there was an IPAC team, the DOC said no. When asked if there were IPAC team meetings, the DOC said no, that IPAC was discussed at management meetings, but that the IPAC lead and public health did not attend, and the Medical Officer of Health was not invited. When asked for the IPAC program evaluation, the DOC said that they were not able to find one. When asked if there was an outbreak meeting for the Influenza A outbreak from February 2 to 19, 2019, the DOC said that there was a phone call with public health, but no meeting.

In an interview with the Administrator, when asked about the IPAC lead, team and program, the Administrator said that a identified registered nursing staff member was the

lead for IPAC in the home. When asked if there was an IPAC team, the Administrator said no. When asked if there were IPAC team meetings, the Administrator said no, that IPAC was discussed at management meetings, but that the IPAC lead and public health did not attend and the Medical Officer of Health was not invited. When asked for the IPAC program evaluation, the Administrator said that the last evaluation was completed in 2017 and had not been done in 2018.

The Inspector requested the home's outbreak management policy each day during the inspection. The Administrator and DOC provided the following policies:
- Infection Control – General #XIII-E-10.00
- Reporting of Communicable Diseases and Outbreaks #IX-B010-00
- Statement of Purpose & Goals #IX-A-10.00
- Infection Control Assessment of Risk for the Transmission of Microorganisms – Admission & Ongoing #IX-D-10.70
- Outbreak Management Team #IX-F-10.20

The Statement of Purpose & Goals #IX-A-10.00 policy stated:
The Executive Director/Administrator will:
- Establish an Infection Prevention & Control Committee (IPCC) with representation from the interdisciplinary team, including a member of the Joint Health & Safety Committee.
- Together with the IPCC, annually establish measurable and specific results driven objectives that support the goals and purposes of the program.

The Infection Control Assessment of Risk for the Transmission of Microorganisms – Admission & Ongoing #IX-D-10.70 indicated nothing about monitoring and recording resident symptoms of the presence of infection every shift.

The Reporting of Communicable Diseases and Outbreaks #IX-B010-00 stated:
The Infection Control Practitioner will:
- Maintain daily communication with Public Health Unit representatives, including completion and faxing of line-listing reports, to ensure accurate sharing of disease progression/resolution information (including new cases, resolved cases, and any deaths that can be associated to the disease), testing results, and any other factors contributing to effective management of the disease.

The Executive Director/Administrator or designate will:
- Notify the Public Health Unit liaison officer and the Medical Director for the residence and the MOHLTC and provide the following information:
    - Name(s) and date of birth of residents affected

- Signs and symptoms presented, including dates first observed

The Outbreak Management Team #IX-F-10.20 policy stated:
The Infection Control Practitioner will:
- Act as chair and ensure that the outbreak investigation checklist is completed and minutes of each meeting are recorded, including follow-up to identified actions
- Ensure meetings take place daily until the outbreak is declared over.

The home did not have an infection control team, four residents with symptoms of the outbreak did not have symptoms documented every shift, one resident isolated with symptoms of the outbreak was not included on the line listing communication to public health, the infection control program was not evaluated in 2018 and the infection control/outbreak management policies did not include that residents' symptoms must be monitored and recorded every shift and were not complied with. [s. 229.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff. The licensee has also failed to comply with Compliance Order #001 issued in inspection #2018_722630_0023 related to skin and wound assessments issued November 22, 2018 with a compliance date of January 21, 2019.

The order stated:
The licensee must be compliant with O. Reg. 79/10, s 50 (2)(b)(iv).
Specifically, the licensee shall ensure that:
a) Resident #005, #007 and #075 and all residents exhibiting altered skin integrity are assessed at least weekly by a member of the registered nursing staff. This weekly assessment must include an assessment of each area of altered skin integrity for each resident. There must be a documented record of the weekly assessments in accordance with the home's policies and procedures.
b) A tracking and auditing system is developed and implemented for all residents exhibiting altered skin integrity to ensure all residents exhibiting altered skin integrity are receiving the required assessments and treatments in accordance with the home's policies and procedures. A written record of this tracking and auditing system must be kept in the home.

Upon arrival at the home, the Inspector requested the written tracking and auditing system to ensure that all residents exhibiting altered skin integrity were receiving the required assessments and treatments in accordance with the home's policies and procedures. The following day, the Inspector requested the tracking and auditing tool again. The Director of Care (DOC) and the lead for the skin and wound program were found to be altering a previous version of the auditing tool two hours later and said that there was a glitch in the tool and multiple residents who had passed away in previous years had showed up on the tool.

The lead for the skin and wound program provided a tracking and auditing document that was printed from Point Click Care (PCC) that included the residents in PCC that had skin assessments completed. The nurse said that the document was printed on January 2, 2019 and that was the last time that they had completed an audit. The nurse said that they used to be given every Wednesday to do skin and wound rounds and audits, but they hadn't been given any days for this since January 2, 2019. When asked, the nurse said that the printout only included residents that had assessments completed and that if

an assessment had been missed for a resident with impaired skin integrity, the auditing tool would not show that.

The home's "Skin & Wound Care Management Protocol", policy #VII-G-10.80-SSLI was reviewed and stated:
The Skin Care Coordinator/Resource Nurse will:
- Oversee the Skin & Wound Program and collaborate with all disciplines to achieve the goals of the skin care program and individualized wound are management plan.
- Work collaboratively with an interprofessional team to determine etiology of each wound i.e. surgical, pressure, diabetic arterial, venous, trauma.
- Conduct weekly wound and skin care rounds with Registered Nurse (RN)/RPN in resident home area, assessing pressure injuries stage II or greater and wounds with other etiologies.
- Audit resident records to ensure completion of head to toe assessments, weekly skin and wound assessments, Treatment Administration Record (TAR), care plans, and appropriate referrals.
- Participate in the quality improvement process as related to the management of skin & wound:
    • Monitoring incidence of skin breakdown on a monthly basis using appropriate tracking tools
    • Providing information related to skin breakdown rates to DOC for performance indicator tracking

In an interview, the DOC said that the home's Skin & Wound Care Management Protocol was not complied with.

A record review of skin assessments completed and treatment administration records in PCC was completed for three residents.

The first resident had the following skin assessments done:
- Five weekly skin assessments for one area described similarly over a four week period
- One initial assessment described as a different impairment in a different area struck out on the last day of the inspection indicating "incorrect documentation"
This resident had seven different interventions on an identified month Treatment Administration Record (TAR) with two of them described as per the weekly skin assessments and five of them described as the type of impairment in the initial assessment that had been crossed out; however, in a different location.

The second resident had the following skin assessments done:
- One initial assessment described as a particular impairment in an identified area with no further assessments for this area
- One weekly assessment described similarly in a different area with no further assessments for this area
- One weekly assessment described as a "new" area in a different area
- One weekly assessment described as a different impairment in a different area
This resident had the nine different interventions for six different areas on an identified month TAR. Four treatments during this month were not signed as completed.

The third resident had the following skin assessments done:
- Two weekly assessments and one "other" assessments described as different areas of different impairment, with the second one having been struck out by a registered nursing staff member on the last day of the inspection indicating "wrong chart".
This resident had two different interventions for the same area, ordered on the same date and one area to be monitored for which there was no assessment, on an identified month TAR. One intervention was not signed for as completed on one date during the identified month.

In an interview with a registered nursing staff member, the Inspector and the nurse reviewed the assessments and TARs in PCC and the nurse agreed that the assessments did not match the TAR entries and it looked like assessments were not completed weekly for each wound. They said some of the areas were described as different wounds and different areas and it was unclear if they were the same areas described differently or different areas. The nurse agreed that the TARs were confusing to determine what areas of impaired skin integrity each resident had and what needed to be done for each area. When the Inspector pointed out that the treatments for one resident for two different areas were both signed for a four day period, and asked if that meant that there were two different areas requiring two different treatments, the nurse said they would assume so, but were unsure.

In an interview with the Associate Director of Care (ADOC), the Inspector asked about the two different treatments that they signed for, for one resident for a four day period. The ADOC said that there was only one area and they felt the area was in the location as they described it and they did the assessment after they did the treatment. They said that it should not have been documented as the specific type of impairment that it was documented as. They said that they changed the treatment order after completing it and they had to sign for both in order to change it. They said that there was only one area

and one treatment done. When asked about the assessment that was struck out, they said they were unaware that this had happened. When pointed out that it was struck out indicating wrong chart, they said it was not the wrong chart, it was the right chart, they had done the assessment on the right resident.

In an interview with a registered nursing staff member, the Inspector asked about the two different treatments that they signed for, for a resident for a four day period. The RPN said that there was only one area and they felt the area was not as the ADOC described it in the assessment but as they described it in the last assessment. They said that there was only one area and one treatment done. When asked why they signed for two different treatments on two different areas, they said that this was an error. When asked about the assessment that was struck out, they said that the DOC directed them to strike it out the day before.

In two interviews with the DOC, the Inspector and the DOC reviewed the assessments and TARs in PCC and the DOC agreed that the assessments did not match the TAR entries and it looked like assessments were not completed weekly for each wound. They said some of the areas were described as different wounds and different areas and it was unclear if they were the same areas described differently or different areas. The DOC agreed that the TARs were confusing to determine what areas of impaired skin integrity each resident had and what needed to be done for each area. The DOC said that they struck out an initial assessment documented for a resident on the second day of the inspection, indicated as incorrect documentation, because they knew it was wrong. The DOC said that on the same day, they also directed a nurse to strike out the weekly assessment documented for another resident indicated as wrong chart, because they knew it was wrong. When the Inspector pointed out that the treatments for resident for two different areas were both signed for a four day period, and asked if that meant that there were two different areas requiring two different treatments, the DOC said they were unsure and directed a nurse to complete a skin assessment immediately. When asked about the tracking and auditing tool, the DOC said that they review the residents in PCC that had skin assessments completed on a weekly basis and chose a few to check for assessments and treatments. The DOC said that they do not check all of them every week and agreed that the list only included assessments completed and would not capture residents with impaired skin integrity who didn't have skin assessments completed. The DOC said that there was a corporate tracking and auditing tool but they didn't think this was a useful tool and preferred to use a print out from PCC. The DOC agreed that their current auditing method did not ensure that all assessments and treatments were completed appropriately.

In an interview, the Administrator said that they were unaware that wound tracking and auditing was not being completed since the compliance date or that assessments were being struck out. They were unaware that assessments and TARs were not consistent with residents' impaired skin integrity.

The licensee has failed to ensure that three residents who were exhibiting altered skin integrity were reassessed at least weekly by a member of the registered nursing staff when skin assessments and TARs were inconsistent with the residents' areas of altered skin integrity. The licensee has also failed to comply with Compliance Order #001 issued in inspection #2018_722630_0023 related to skin and wound assessments issued November 22, 2018 with a compliance date of January 21, 2019 when there was no tracking and auditing system and the home's skin and wound care program was not complied with. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 002 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 #3: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were reassessed and the plan of care reviewed and revised when the resident's care needs changed.

The home reported a Critical Incident System report to the Ministry of Health and Long-Term Care on an identified date regarding an alleged incident of staff to resident verbal abuse that occurred on the same date.

In an interview, the resident did not recall the reported incident and said that they have never had a complaint or concern about staff. The resident said that they had a change in situation and had not had a mobility device for an approximate six month period of time and required one to meet all of their needs.

Record review of resident's current plan of care in Point Click Care (PCC) showed that there was no indication that the resident had not had mobility device and that the resident's care needs had changed with their situation change.

In interviews with three Personal Support Workers (PSW), the PSWs said that resident had not had a mobility device for an approximate six month period of time and required one to meet all of their needs.

In an interview with a registered nursing staff member, they shared that the resident had not had a mobility device for an approximate six month period of time and required one to meet all of their needs.The Inspector and the nurse reviewed the current plan of care and the nurse said that it had not been updated when the resident's care needs changed with their situation.

In an interview with Director of Care (DOC), they shared that the resident had not had a mobility device for an approximate six month period of time and required one to meet all of their needs. The Inspector and the DOC reviewed the current plan of care and the DOC agreed that it had not been updated when the resident's care needs changed with their situation. The DOC said that the plan of care should have been updated when their care needs changed.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

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 reassessed and plans of care are reviewed and revised when residents' care needs change, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Findings/Faits saillants :

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

Compliance Order #001 was issued in inspection #2018_722630_0023 related to skin and wound assessments on November 22, 2018, with a compliance date of January 21, 2019. This order is being re-issued in this inspection as evidence of compliance with this order was not found.

Upon arrival at the home, the Inspector requested the written tracking and auditing

system to ensure that all residents exhibiting altered skin integrity were receiving the required assessments and treatments in accordance with the home's policies and procedures. The following day, the skin and wound care lead provided a tracking and auditing document that was printed from Point Click Care (PCC) that included the residents in PCC that had skin assessments completed. The nurse said that the document was printed on January 2, 2019, and that was the last time that they had completed an audit. The nurse said that they used to be given every Wednesday to complete skin and wound rounds and audits, but they haven't been given any day for this since January 2, 2019. When asked, the nurse said that the printout only included residents that had assessments completed and that if an assessment had been missed for a resident with impaired skin integrity, the auditing tool would not show that.

The home's "Skin & Wound Care Management Protocol", policy #VII-G-10.80-SSLI was reviewed and stated:
The Skin Care Coordinator/Resource Nurse will:
- Oversee the Skin & Wound Program and collaborate with all disciplines to achieve the goals of the skin care program and individualized wound are management plan.
- Work collaboratively with an interprofessional team to determine etiology of each wound i.e. surgical, pressure, diabetic arterial, venous, trauma.
- Conduct weekly wound and skin care rounds with RN/RPN in resident home area, assessing pressure injuries Stage 2 or greater and wounds with other etiologies.
- Audit resident records to ensure completion of Head to Toe assessments, weekly skin and wound assessments, TARs, care plans, and appropriate referrals.
- Participate in the quality improvement process as related to the management of skin & wound:
  • Monitoring incidence of skin breakdown on a monthly basis using appropriate tracking tools
  • Providing information related to skin breakdown rates to DOC for performance indicator tracking.

In an interview with the DOC, the DOC said that the home's Skin & Wound Care Management Protocol was not being complied with.

In an interview with the DOC, when asked about the skin and wound lead or Skin are Coordinator/Recourse Nurse, the DOC said that an identified registered nursing staff member was the lead for skin and wound care in the home. They said that they were aware that the nurse had not been given time to conduct audits since January 2, 2019. When asked for the skin and wound care program evaluation, the DOC said that they were not able to find one.

In an interview with the Administrator, when asked for the skin and wound care program evaluation, the Administrator said that the last evaluation was completed in 2017 and had not been done in 2018.

The home's skin and wound care program was not complied with and was not evaluated. [s. 30.]

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.

Findings/Faits saillants :

1. The licensee has failed to ensure that mobility devices, including wheelchairs, walkers and canes, were available at all times to residents who required them on a short-term basis.

The home reported a Critical Incident System report to the Ministry of Health and Long-Term Care on an identified date regarding an alleged incident of staff to resident verbal abuse that occurred on the same date.

In interviews with the resident, the resident said that they had not had a mobility device for an approximate six month period of time and required one to meet all of their needs.

In interviews with three Personal Support Workers (PSW), the PSWs said that resident had not had a mobility device for an approximate six month period of time and required one to meet all of their needs.

In an interview with Director of Care (DOC), they shared that the resident had not had a mobility device for an approximate six month period of time and required one to meet all of their needs.

In a phone interview with DOC and Administrator, the Administrator said that they were aware that the resident did not have a mobility device for an approximate six month period of time.

The licensee has failed to ensure that mobility devices were available at all times to a resident who required one on a short-term basis. [s. 39.]

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 mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis, to be implemented voluntarily.

WN #6: 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 each resident of the home was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The home reported a Critical Incident System report to the Ministry of Health and Long-Term Care on an identified date regarding an alleged incident of staff to resident verbal abuse that occurred on the same date.

Record review of the resident's current plan of care in Point Click Care (PCC) showed their preference was an identified method of bath twice weekly and that they needed assistance with the bath.

In interviews with three Personal Support Workers (PSW), the PSWs said that the resident had a change of situation and had not been receiving baths as per the method of their choice for an approximate six month period of time as a result of this change.

In an interview with the resident, they said that they had not had a bath by the method of their choice for several months due to a change of situation.

In a phone interview with Director of Care (DOC) and the Administrator, the Administrator shared that they were unaware that the resident was not receiving baths as per the method of their choice for an approximate six month time period.

The licensee has failed to ensure that a resident was bathed, at a minimum, twice a week by the method of their choice for a six month period of time. [s. 33. (1)]

Issued on this 18th day of March, 2019

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RHONDA KUKOLY (213)
Inspection No. / No de l'inspection :	2019_605213_0009
Log No. / No de registre :	001394-18, 011116-18, 030978-18, 003025-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 13, 2019
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Secord Trails Care Community 263 Wonham Street South, INGERSOLL, ON, N5C-3P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JoAnn Zomer

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

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., 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

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 : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. Infection prevention and control program

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 229.
Specifically, the licensee shall ensure that:
1. An interdisciplinary Infection Prevention and Control (IPAC) team is created in the home.
2. The IPAC team meets quarterly and a written record of the meetings are kept.
3. The IPAC program is evaluated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and a written record kept related to each evaluation, a summary of the changes made and the date that those changes are implemented.
4. A staff member is designated to co-ordinate the program who has education and experience in infection prevention and control practices, including, infectious diseases; cleaning and disinfection; data collection and trend analysis; reporting protocols; and outbreak management.
5. The Infection Prevention and Control Program and policies are reviewed. The program is revised as necessary. The outbreak management policy must be revised to include that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and the symptoms were recorded and that immediate action is taken as required.
6. Training is provided for all registered staff including:
   a. The revised outbreak management policy and program.
   b. Symptoms indicating the presence of infection in residents are monitored and recorded every shift.
   c. All affected residents in an outbreak must be included on the line listing tracking and reporting to public health.
   d. A written record is kept of the training including staff names, dates and training content, to ensure that all registered staff received the training.

Grounds / Motifs :

1. The licensee has failed to ensure, (a) that there was an interdisciplinary team approach in the co-ordination and implementation of the program; (b) that the interdisciplinary team that co-ordinates and implements the program met at least quarterly; (c) that the local medical officer of health was invited to the meetings; (d) that the program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and (e) that a written record was kept relating to each evaluation under clause (d) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee also failed to ensure that all staff participated in the implementation of the program.

The licensee also failed to ensure that on every shift, (a) symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and (b) the symptoms were recorded and that immediate action is taken as required.

The licensee also failed to ensure that there were in place, (a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and (b) a written plan for responding to infectious disease outbreaks.

The home reported the following Critical Incident System (CIS) reports to the Ministry of Health and Long Term Care (MOHLTC) over the past two years:
- Respiratory outbreak declared February 2, 2019 (Influenza A) (declared over on February 19, 2019)
- Respiratory outbreak declared November 19, 2018
- Respiratory outbreak declared July 20, 2018
- Respiratory outbreak declared January 15, 2018
- Respiratory outbreak declared December 12, 2017
- Respiratory outbreak declared October 21, 2017
- Respiratory outbreak declared May 3, 2017

Record review of the line listing created by the home for the Influenza A outbreak declared February 2, 2019, showed 23 identified residents were isolated with symptoms of the outbreak. Vital signs and progress notes in Point Click Care (PCC) were reviewed for three residents for the time period they were isolated and showed:
- One resident was isolated for seven days and was positive for Influenza A. Seven shifts during the seven day period did not have a temperature recorded.
- A second resident was isolated from for six days. Two shifts during the six day period did not have a temperature recorded.
- A third resident was isolated for nine days and was positive for Influenza A. Five shifts during the nine day period did not have a temperature recorded.

In an interview with a registered nursing staff member, the Inspector and the nurse reviewed the health records for the three residents and agreed that temperatures and all symptoms were not documented for these residents every shift while they were isolated with symptoms during the Influenza A outbreak.

In an interview with Director of Care (DOC), the Inspector and the DOC reviewed the health records for the three residents and agreed that temperatures and all symptoms were not documented for these residents every shift while they were isolated with symptoms during the Influenza A outbreak.

On another date, the DOC reported that another resident was isolated during the outbreak. A record review of the line listing showed that this resident was not included in the line listing. The DOC said that the resident should have been included on the line listing and was not. A record review of vital signs and progress notes in PCC showed that this resident was isolated for eleven days with symptoms of the outbreak including fever and eighteen shifts during the eleven day period there was no temperature or symptoms recorded.

In an interview with the DOC, when asked about the Infection Prevention and Control (IPAC) lead, team and program, the DOC said that an identified registered nursing staff member was the lead for IPAC in the home. When asked if there was an IPAC team, the DOC said no. When asked if there were IPAC team meetings, the DOC said no, that IPAC was discussed at management meetings, but that the IPAC lead and public health did not attend, and the

Medical Officer of Health was not invited. When asked for the IPAC program evaluation, the DOC said that they were not able to find one. When asked if there was an outbreak meeting for the Influenza A outbreak from February 2 to 19, 2019, the DOC said that there was a phone call with public health, but no meeting.

In an interview with the Administrator, when asked about the IPAC lead, team and program, the Administrator said that a identified registered nursing staff member was the lead for IPAC in the home. When asked if there was an IPAC team, the Administrator said no. When asked if there were IPAC team meetings, the Administrator said no, that IPAC was discussed at management meetings, but that the IPAC lead and public health did not attend and the Medical Officer of Health was not invited. When asked for the IPAC program evaluation, the Administrator said that the last evaluation was completed in 2017 and had not been done in 2018.

The Inspector requested the home's outbreak management policy each day during the inspection. The Administrator and DOC provided the following policies:
- Infection Control – General #XIII-E-10.00
- Reporting of Communicable Diseases and Outbreaks #IX-B010-00
- Statement of Purpose & Goals #IX-A-10.00
- Infection Control Assessment of Risk for the Transmission of Microorganisms – Admission & Ongoing #IX-D-10.70
- Outbreak Management Team #IX-F-10.20

The Statement of Purpose & Goals #IX-A-10.00 policy stated:
The Executive Director/Administrator will:
- Establish an Infection Prevention & Control Committee (IPCC) with representation from the interdisciplinary team, including a member of the Joint Health & Safety Committee.
- Together with the IPCC, annually establish measurable and specific results driven objectives that support the goals and purposes of the program.

The Infection Control Assessment of Risk for the Transmission of Microorganisms – Admission & Ongoing #IX-D-10.70 indicated nothing about monitoring and recording resident symptoms of the presence of infection every

shift.

The Reporting of Communicable Diseases and Outbreaks #IX-B010-00 stated:
The Infection Control Practitioner will:
- Maintain daily communication with Public Health Unit representatives, including completion and faxing of line-listing reports, to ensure accurate sharing of disease progression/resolution information (including new cases, resolved cases, and any deaths that can be associated to the disease), testing results, and any other factors contributing to effective management of the disease.

The Executive Director/Administrator or designate will:
- Notify the Public Health Unit liaison officer and the Medical Director for the residence and the MOHLTC and provide the following information:
    - Name(s) and date of birth of residents affected
    - Signs and symptoms presented, including dates first observed

The Outbreak Management Team #IX-F-10.20 policy stated:
The Infection Control Practitioner will:
- Act as chair and ensure that the outbreak investigation checklist is completed and minutes of each meeting are recorded, including follow-up to identified actions
- Ensure meetings take place daily until the outbreak is declared over.

The home did not have an infection control team, four residents with symptoms of the outbreak did not have symptoms documented every shift, one resident isolated with symptoms of the outbreak was not included on the line listing communication to public health, the infection control program was not evaluated in 2018 and the infection control/outbreak management policies did not include that residents' symptoms must be monitored and recorded every shift and were not complied with.

The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 3 as it was related to 4 out of 4 residents reviewed. The home had a level 2 history as they did not have a history of non-compliance in this section of the legislation. (213)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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 : Jun 28, 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_722630_0023, CO #001;

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 O. Reg. 79/10, s. 50

Specifically, the licensee shall ensure that:

1. Resident #002, #003 and #004 and all residents exhibiting altered skin integrity are assessed at least weekly by a member of the registered nursing staff. This weekly assessment must include an assessment of each area of altered skin integrity for each resident. There must be a documented record of the weekly assessments in accordance with the home's policies and procedures.
2. Appropriate treatments to be completed must be clearly documented and communicated to registered staff for each area of altered skin integrity for each resident.
3. A tracking and weekly auditing system is developed and implemented for all residents exhibiting altered skin integrity to ensure all residents exhibiting altered skin integrity are receiving the required assessments and treatments in accordance with the home's policies and procedures to ensure consistency and completion.
4. A written record of this tracking system and weekly audits completed is kept in the home and includes: the resident name, location impaired skin integrity, type of impaired skin integrity, stage (when applicable), origin, date of origin, treatment, treatment completed, initial assessment completed, weekly assessment completed, final assessment completed, other non-pharmacological interventions initiated, date of audit and name of person conducting audit.
5. An interdisciplinary skin and wound care team is created in the home with a staff member is designated to co-ordinate the skin and wound care program who has education and experience in skin and wound care, data collection and trend analysis.
6. The interdisciplinary skin and wound care team meets quarterly and a written record of the meetings are kept.
7. The skin and wound care program is evaluated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and a written record kept related to each evaluation, a summary of the changes made and the date that those changes are implemented.
8. The skin and wound care program and policies are reviewed and the program and policies are revised as necessary.
9. A protocol for initiating and completing assessments and communicating treatments and plans of care for residents with impaired skin integrity is documented.
9. Training is provided for all registered staff including:
    a. The revised skin and wound care policy and program, including the tracking

and auditing system.

b. The home's protocol for initiating and completing assessments and communicating treatments and plans of care for residents with impaired skin integrity.

c. A written record is kept of the training including staff names, dates and training content, to ensure that all registered staff received the training.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident who was exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff. The licensee has also failed to comply with Compliance Order #001 issued in inspection #2018_722630_0023 related to skin and wound assessments issued November 22, 2018 with a compliance date of January 21, 2019.

The order stated:
The licensee must be compliant with O. Reg. 79/10, s 50 (2)(b)(iv).
Specifically, the licensee shall ensure that:
a) Resident #005, #007 and #075 and all residents exhibiting altered skin integrity are assessed at least weekly by a member of the registered nursing staff. This weekly assessment must include an assessment of each area of altered skin integrity for each resident. There must be a documented record of the weekly assessments in accordance with the home's policies and procedures.
b) A tracking and auditing system is developed and implemented for all residents exhibiting altered skin integrity to ensure all residents exhibiting altered skin integrity are receiving the required assessments and treatments in accordance with the home's policies and procedures. A written record of this tracking and auditing system must be kept in the home.

Upon arrival at the home, the Inspector requested the written tracking and auditing system to ensure that all residents exhibiting altered skin integrity were receiving the required assessments and treatments in accordance with the home ’s policies and procedures. The following day, the Inspector requested the tracking and auditing tool again. The Director of Care (DOC) and the lead for the skin and wound program were found to be altering a previous version of the auditing tool two hours later and said that there was a glitch in the tool and multiple residents who had passed away in previous years had showed up on

the tool.

The lead for the skin and wound program provided a tracking and auditing document that was printed from Point Click Care (PCC) that included the residents in PCC that had skin assessments completed. The nurse said that the document was printed on January 2, 2019 and that was the last time that they had completed an audit. The nurse said that they used to be given every Wednesday to do skin and wound rounds and audits, but they hadn't been given any days for this since January 2, 2019. When asked, the nurse said that the printout only included residents that had assessments completed and that if an assessment had been missed for a resident with impaired skin integrity, the auditing tool would not show that.

The home's "Skin & Wound Care Management Protocol", policy #VII-G-10.80-SSLI was reviewed and stated:
The Skin Care Coordinator/Resource Nurse will:
- Oversee the Skin & Wound Program and collaborate with all disciplines to achieve the goals of the skin care program and individualized wound are management plan.
- Work collaboratively with an interprofessional team to determine etiology of each wound i.e. surgical, pressure, diabetic arterial, venous, trauma.
- Conduct weekly wound and skin care rounds with Registered Nurse (RN)/RPN in resident home area, assessing pressure injuries stage II or greater and wounds with other etiologies.
- Audit resident records to ensure completion of head to toe assessments, weekly skin and wound assessments, Treatment Administration Record (TAR), care plans, and appropriate referrals.
- Participate in the quality improvement process as related to the management of skin & wound:
    • Monitoring incidence of skin breakdown on a monthly basis using appropriate tracking tools
    • Providing information related to skin breakdown rates to DOC for performance indicator tracking

In an interview, the DOC said that the home's Skin & Wound Care Management Protocol was not complied with.

A record review of skin assessments completed and treatment administration records in PCC was completed for three residents.

The first resident had the following skin assessments done:
- Five weekly skin assessments for one area described similarly over a four week period
- One initial assessment described as a different impairment in a different area struck out on the last day of the inspection indicating "incorrect documentation"
This resident had seven different interventions on an identified month Treatment Administration Record (TAR) with two of them described as per the weekly skin assessments and five of them described as the type of impairment in the initial assessment that had been crossed out; however, in a different location.

The second resident had the following skin assessments done:
- One initial assessment described as a particular impairment in an identified area with no further assessments for this area
- One weekly assessment described similarly in a different area with no further assessments for this area
- One weekly assessment described as a "new" area in a different area
- One weekly assessment described as a different impairment in a different area
This resident had the nine different interventions for six different areas on an identified month TAR. Four treatments during this month were not signed as completed.

The third resident had the following skin assessments done:
- Two weekly assessments and one "other" assessments described as different areas of different impairment, with the second one having been struck out by a registered nursing staff member on the last day of the inspection indicating "wrong chart".
This resident had two different interventions for the same area, ordered on the same date and one area to be monitored for which there was no assessment, on an identified month TAR. One intervention was not signed for as completed on one date during the identified month.

In an interview with a registered nursing staff member, the Inspector and the nurse reviewed the assessments and TARs in PCC and the nurse agreed that the assessments did not match the TAR entries and it looked like assessments

were not completed weekly for each wound. They said some of the areas were described as different wounds and different areas and it was unclear if they were the same areas described differently or different areas. The nurse agreed that the TARs were confusing to determine what areas of impaired skin integrity each resident had and what needed to be done for each area. When the Inspector pointed out that the treatments for one resident for two different areas were both signed for a four day period, and asked if that meant that there were two different areas requiring two different treatments, the nurse said they would assume so, but were unsure.

In an interview with the Associate Director of Care (ADOC), the Inspector asked about the two different treatments that they signed for, for one resident for a four day period. The ADOC said that there was only one area and they felt the area was in the location as they described it and they did the assessment after they did the treatment. They said that it should not have been documented as the specific type of impairment that it was documented as. They said that they changed the treatment order after completing it and they had to sign for both in order to change it. They said that there was only one area and one treatment done. When asked about the assessment that was struck out, they said they were unaware that this had happened. When pointed out that it was struck out indicating wrong chart, they said it was not the wrong chart, it was the right chart, they had done the assessment on the right resident.

In an interview with a registered nursing staff member, the Inspector asked about the two different treatments that they signed for, for a resident for a four day period. The RPN said that there was only one area and they felt the area was not as the ADOC described it in the assessment but as they described it in the last assessment. They said that there was only one area and one treatment done. When asked why they signed for two different treatments on two different areas, they said that this was an error. When asked about the assessment that was struck out, they said that the DOC directed them to strike it out the day before.

In two interviews with the DOC, the Inspector and the DOC reviewed the assessments and TARs in PCC and the DOC agreed that the assessments did not match the TAR entries and it looked like assessments were not completed weekly for each wound. They said some of the areas were described as different

wounds and different areas and it was unclear if they were the same areas described differently or different areas. The DOC agreed that the TARs were confusing to determine what areas of impaired skin integrity each resident had and what needed to be done for each area. The DOC said that they struck out an initial assessment documented for a resident on the second day of the inspection, indicated as incorrect documentation, because they knew it was wrong. The DOC said that on the same day, they also directed a nurse to strike out the weekly assessment documented for another resident indicated as wrong chart, because they knew it was wrong. When the Inspector pointed out that the treatments for resident for two different areas were both signed for a four day period, and asked if that meant that there were two different areas requiring two different treatments, the DOC said they were unsure and directed a nurse to complete a skin assessment immediately. When asked about the tracking and auditing tool, the DOC said that they review the residents in PCC that had skin assessments completed on a weekly basis and chose a few to check for assessments and treatments. The DOC said that they do not check all of them every week and agreed that the list only included assessments completed and would not capture residents with impaired skin integrity who didn't have skin assessments completed. The DOC said that there was a corporate tracking and auditing tool but they didn't think this was a useful tool and preferred to use a print out from PCC. The DOC agreed that their current auditing method did not ensure that all assessments and treatments were completed appropriately.

In an interview, the Administrator said that they were unaware that wound tracking and auditing was not being completed since the compliance date or that assessments were being struck out. They were unaware that assessments and TARs were not consistent with residents' impaired skin integrity.

The licensee has failed to ensure that three residents who were exhibiting altered skin integrity were reassessed at least weekly by a member of the registered nursing staff when skin assessments and TARs were inconsistent with the residents' areas of altered skin integrity. The licensee has also failed to comply with Compliance Order #001 issued in inspection #2018_722630_0023 related to skin and wound assessments issued November 22, 2018 with a compliance date of January 21, 2019 when there was no tracking and auditing system and the home's skin and wound care program was not complied with.

The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 3 as it was related to 3 out of 3 residents reviewed. The home had a level 4 history as despite the issuance of a non-compliance, non-compliance continues with the original area of non-compliance in this section of the LTCHA that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued March 26, 2018 (2018_605213_0004)
- Compliance Order (CO) issued November 22, 2018 (2018_722630_0023).
(213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 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:

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 13th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

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