Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 2, 2019	2019_633577_0015	006147-19, 007076-19	Complaint

Licensee/Titulaire de permis

Board of Management of the District of Kenora
1220 Valley Drive KENORA ON P9N 2W7

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

Pinecrest (Kenora)
1220 Valley Drive KENORA ON P9N 2W7

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

DEBBIE WARPULA (577)

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): June 17-21, 2019.

The following intakes were inspected upon during this Complaint inspection:
- Two intakes related to multiple care concerns of a resident.

An Other inspection #2019_633577_0014 and a Critical Incident System (CIS) inspection #2019_633577_0013 were conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Nurse Practitioner (NP), Registered Dietician (RD), Physiotherapist (PT), Rehabilitation Assistants, Resident Assessment Instrument (RAI) Coordinator, a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a resident 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, reviewed relevant health care records, as well as reviewed licensee policies, procedures and a program.

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

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

4 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented in the home.

Two complaints were received by the Director on two identified dates. The complaint alleged multiple care concerns, which included skin and wound care regarding resident #008.

A record review of resident #008's progress notes indicated that on an identified date, resident #008 had developed an area of altered skin integrity on a specific area of their body; and over a specified time period, the resident's altered skin integrity had a specific characteristic. A review of the electronic medication administration record (eMAR), identified the initiation of a wound care treatment to an identified area of their body, at a specific frequency on an identified date.

A review of resident #008's care plan, in effect over a specified time period, did not include a focus or intervention related to altered skin integrity.

A review of the home's program, "Skin and Wound Care Program - NUR 035", revised May 2017, indicated that upon the discovery of altered skin integrity, staff were to have initiated a baseline assessment using the appropriate assessment instrument (e.g Pressure Ulcer PUSH Tool NUR 035A); stage the altered skin integrity using the staging

guidelines; ensure the plan of care was established outlining interventions and treatments; resident was to be reassessed weekly if indicated and the care plan was revised accordingly; contact the physician once the Enterstomal Therapist (ET) or Wound Care Specialist has provided recommendations; obtain a physician order for treatment recommendations; after a dressing change, complete the PUSH tool or PN-WA weekly, which included the size (circumference and depth) of wound, discharge from the wound, appearance, progression, pain, nutrition, equipment used; and evaluate and document resident outcomes (using PURS score). The ET or Wound Care Specialist were to have completed and documented an assessment based on nursing or physician referral; recommend treatment options; monitor and document the effectiveness of treatment, and provide staff education.

Inspector #577 reviewed the physician orders, in effect over a specified time period, and found there were no physician orders concerning resident #008's altered skin integrity or treatments. On an identified date, RN #115 had initiated a phone order from the physician which directed staff to apply a dressing treatment to a specific location on the resident's body and change as needed.

During a record review of resident #008's health care records, Inspector #577 could not locate the baseline assessment, a particular assessment record, a progress note-wound assessment (PN-WA), or staging of the altered skin integrity.

In a review of the eMAR, initiated by registered staff on an identified date, it indicated that staff were to apply a dressing treatment to a specific location on the resident's body daily and change as needed (prn).

During a review of the eMAR over an identified three month period, the Inspector identified daily treatments were not documented, as follows:

-documented 2/16 days or 12 per cent, for an identified month;
-documented 9/31 or 29 per cent, for an identified month; and
-documented 6/19 or 31 per cent, for an identified month.

During a review of resident #008's progress notes, Inspector #577 found progress notes on three identified dates, which indicated that a dressing treatment had been applied to a specific area of resident #008's body.

During an interview with RPN #113 they reported that staff were required to document on

the eMAR with every dressing treatment, a progress note-wound assessment (PN-WA) and on a particular assessment record once weekly. RPN #113 confirmed that there was no documentation for resident #008.

During an interview with RN #115 they reported that resident #008 had an area of altered skin integrity of a specified characteristic to a specific area of their body. They confirmed that there were no physician orders for altered skin integrity and treatment; there was no documentation for a PN-WA or a particular assessment record, or any form of a wound assessment completed for resident #008. They further reported that registered staff could order a non medicated dressing treatment to an area of altered skin integrity, add the treatment to the eMAR, and registered staff had been changing the dressing treatment to resident #008's area of altered skin integrity.

During an interview with RPN #119 they reported that staff were required to document a progress note once a week, document on a particular assessment record which included a specific score, once a week, and document on the eMAR with every dressing treatment change.

During an interview with NP #121 they reported that they were the Wound Care Champion for the home. They described resident #008's altered skin integrity. They further reported that since January 2019, they had directed the registered staff to have initiated non-medicated dressing treatments for wound care and staff were not required to obtain an order; staff were to have communicated to the physician or NP and to the pharmacy.

During an interview with Acting DOC they reported that staff were required to document a PN-WA or on the particular assessment record once weekly with altered skin integrity, contact the NP for orders, document on the eMAR with dressing treatment changes, and contact the NP for treatment orders. They further reported that NP #121 was the home's Wound Care Champion and had directed staff to have initiated non-medicated dressing's without an order and staff were to have documented the treatment in the physician progress notes on the physician order sheet. Together, the Acting DOC and the Inspector reviewed resident #008's health care records, and the Acting DOC confirmed that there were no physician or NP orders for a dressing treatment, the eMAR was not being documented daily, and there wasn't a PN-WA or a particular assessment record documented for resident #008. They further confirmed that the home's Wound program was not being implemented in the Home.

During an interview with the Administrator, they confirmed that staff were not implementing the home’s Wound Care program, the NP’s direction to registered staff was not congruent with the home’s policy and they were in the process of updating the policy. [s. 48. (1) 2.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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 the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the care set out in the plan had not been effective.

Two complaints were received by the Director on two identified dates. The complaint alleged multiple care concerns regarding resident #008.

a) Inspector #577 reviewed resident #008’s most current care plan which identified the following interventions specifically related to mobility, falls and toileting:

-transfers with assistance using a specific assistive device;
-staff were to ensure the environment was safe for ambulation;
-staff were to inspect resident’s footwear for safe ambulation, nonslip, good fit;
-staff were to assist the resident to locate the toilet; and
-staff were to observe the resident’s patterns of transferring in/out of bed and chairs,

walking, turning, and using the bathroom, to prevent falls.

During observations through out inspection, Inspector #577 observed resident in bed sleeping, up in a specific mobility aid being portered by staff and being toileted with a specific lift.

During an interview with PSW #122, they reported that staff used a specific lift to toilet and transfer resident #008 in and out of bed. They further reported that the resident had not ambulated for a specific duration, due to a decline.

During an interview with RPN #119 they reported that the registered nurses (RNs) were responsible for updating care plans; they further reported that the care plan was not updated, as the resident did not use a specific assistive device for transfers and they did not ambulate.

During an interview with PSW #123 and PSW #124, together with Inspector #577, the care plan was reviewed. They both reported that staff used a specific lift to transfer the resident; the resident was unable to ambulate; and the care plan did not reflect the resident's current care needs.

b) A record review of resident #008’s progress notes identified that on an identified date, resident #008 had developed an area of altered skin integrity on a specific area of their body; and over a specified time period, the resident's altered skin integrity had a specific characteristic. A review of resident #008’s current care plan did not include any focus or intervention related to altered skin integrity and the care plan was revised to reflect the altered skin integrity on a specified date. A review of the electronic medication administration record (eMAR), identified the initiation of dressing treatment once daily on a specified date.

During an interview with RN #115 they reported that resident #008 had altered skin integrity with a specified characteristic, on a specific area of their body. Together with Inspector #577, RN #115 reviewed the most current care plan, and they confirmed that the care plan did not contain any information about altered skin integrity.

A review of the home's policy, "Care plans - NURS 110", revised October 2014, indicated that staff were required to have reviewed care plans at least quarterly and when there were significant changes to the resident's needs. During the care plan review, unsuccessful interventions should have been deleted or modified to suit their current

needs.

A review of the home's, "Skin and Wound Care Program - NUR 035", revised May 2017, indicated that upon the discovery of a pressure ulcer, staff were to ensure the plan of care was established outlining interventions and treatments and the care plan was revised accordingly.

During an interview with Acting DOC, together with Inspector #577, resident #008's care plan interventions related to falls, toileting, skin integrity and mobility were reviewed. They confirmed that the interventions were not revised to reflect resident #008's current needs and that registered nurses (RNs) were responsible to update care plans. They further confirmed that the focus for altered skin integrity was added to the care plan on a specified date, and should have been in the care plan when resident #008 first developed altered skin integrity.

During an interview with the Administrator, together with Inspector #577, resident #008's care plan was reviewed. They confirmed that staff were required to have been updating care plans when residents' 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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 30. General requirements
Specifically, the licensee failed to comply with the following:

s.30 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation.

The licensee has failed to ensure that the Skin and Wound Care program was evaluated and updated at least annually in accordance with evidence-based practice and if there were none, in accordance with prevailing practices.

Two complaints were received by the Director on two specified dates. The complaint alleged multiple care concerns, which included skin and wound care regarding resident #008.

A record review of resident #008’s progress notes and electronic medication administration record (eMAR), identified that the resident had altered skin integrity on a specific area of their body.

During a review of the home's, "Skin and Wound Care Program - NUR 035", Inspector #577 found that the program was last revised in May 2017.

During an interview with the Administrator, they acknowledged that the program was last revised in May 2017, and they were in the process of updating the program. [s. 30. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Skin and Wound Care program is evaluated and updated at least annually in accordance with evidence-based practice and if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Director of Nursing and Personal Care worked regularly in that position on site at the home for at least 35 hours per week.

Upon entering the home, Inspector spoke with RN #102, and inquired whether the Director of Care was available. RN #102 reported that the DOC was no longer employed in the home, and the Acting DOC #103 was on vacation for the week.

During the entrance conference, the Administrator reported to Inspector #577 that the DOC was no longer employed in the home as of a specified date; the Assistant DOC #103 had been transferred into the role of Acting DOC on a specified date, and they were on vacation from June 17-24, 2019. Inspector #577 inquired whether anyone had been covering the Acting DOC role in their absence, and they reported that they had not thought of it, but would immediately put RN #102 into the Acting DOC role for the week, as they were most senior. [s. 213. (1) 5.]

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 home's Director of Nursing and Personal Care works regularly in that position on site at the home for at least 35 hours per week, to be implemented voluntarily.

Issued on this 3rd day of July, 2019

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

Original report signed by the inspector.

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) : DEBBIE WARPULA (577)

Inspection No. / No de l'inspection : 2019_633577_0015

Log No. / No de registre : 006147-19, 007076-19

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jul 2, 2019

Licensee / Titulaire de permis : Board of Management of the District of Kenora
1220 Valley Drive, KENORA, ON, P9N-2W7

LTC Home / Foyer de SLD : Pinecrest (Kenora)
1220 Valley Drive, KENORA, ON, P9N-2W7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Kevin Queen

To Board of Management of the District of Kenora, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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

Order / Ordre :

The licensee must be in compliance with s. 48. (1) (2) of O. Reg. 79/10.
Specifically the licensee must:

a) Conduct an audit of all of the residents in the home requiring weekly wound assessments by registered nursing staff.

b) Obtain a physician or NP order for wound treatments.

c) Complete a baseline wound assessment of the residents' wounds, utilizing the “Pressure Ulcer PUSH tool” for pressure ulcers and the Goldcare wound note template PN-WA for non-typical surgical/venous/arterial wounds, as required.

d) Complete the “PUSH tool” or PN-WA (weekly) with accurate documentation with every dressing change. Review the guidelines for documentation.

e) Document the treatment regime on the Electronic Medication Administration Record (eMAR) with every dressing change.

f) Establish an auditing routine to ensure that weekly wound assessments are being completed.

g) Establish an auditing routine to ensure that the “PUSH tool” and the eMAR are being completed.

h) Maintain records of the actions taken with respect to the above items.

i) Refer to the Best Practice Guidelines for the Management of Pressure Injuries, if developing medical directives related to the treatment of pressure wounds.

Grounds / Motifs :

1. The licensee has failed to ensure that the skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented in the home.

Two complaints were received by the Director on two identified dates. The complaint alleged multiple care concerns, which included skin and wound care

regarding resident #008.

A record review of resident #008's progress notes indicated that on an identified date, resident #008 had developed an area of altered skin integrity on a specific area of their body; and over a specified time period, the resident's altered skin integrity had a specific characteristic. A review of the electronic medication administration record (eMAR), identified the initiation of a wound care treatment to an identified area of their body, at a specific frequency on an identified date.

A review of resident #008's care plan, in effect over a specified time period, did not include a focus or intervention related to altered skin integrity.

A review of the home's program, "Skin and Wound Care Program - NUR 035", revised May 2017, indicated that upon the discovery of altered skin integrity, staff were to have initiated a baseline assessment using the appropriate assessment instrument (e.g Pressure Ulcer PUSH Tool NUR 035A); stage the altered skin integrity using the staging guidelines; ensure the plan of care was established outlining interventions and treatments; resident was to be reassessed weekly if indicated and the care plan was revised accordingly; contact the physician once the Enterstomal Therapist (ET) or Wound Care Specialist has provided recommendations; obtain a physician order for treatment recommendations; after a dressing change, complete the PUSH tool or PN-WA weekly, which included the size (circumference and depth) of wound, discharge from the wound, appearance, progression, pain, nutrition, equipment used; and evaluate and document resident outcomes (using PURS score). The ET or Wound Care Specialist were to have completed and documented an assessment based on nursing or physician referral; recommend treatment options; monitor and document the effectiveness of treatment, and provide staff education.

Inspector #577 reviewed the physician orders, in effect over a specified time period, and found there were no physician orders concerning resident #008's altered skin integrity or treatments. On an identified date, RN #115 had initiated a phone order from the physician which directed staff to apply a dressing treatment to a specific location on the resident's body and change as needed.

During a record review of resident #008's health care records, Inspector #577

could not locate the baseline assessment, a particular assessment record, a progress note-wound assessment (PN-WA), or staging of the altered skin integrity.

In a review of the eMAR, initiated by registered staff on an identified date, it indicated that staff were to apply a dressing treatment to a specific location on the resident's body daily and change as needed (prn).

During a review of the eMAR over an identified three month period, the Inspector identified daily treatments were not documented, as follows:

-documented 2/16 days or 12 per cent, for an identified month;
-documented 9/31 or 29 per cent, for an identified month; and
-documented 6/19 or 31 per cent, for an identified month.

During a review of resident #008's progress notes, Inspector #577 found progress notes on three identified dates, which indicated that a dressing treatment had been applied to a specific area of resident #008's body.

During an interview with RPN #113 they reported that staff were required to document on the eMAR with every dressing treatment, a progress note-wound assessment (PN-WA) and on a particular assessment record once weekly. RPN #113 confirmed that there was no documentation for resident #008.

During an interview with RN #115 they reported that resident #008 had an area of altered skin integrity of a specified characteristic to a specific area of their body. They confirmed that there were no physician orders for altered skin integrity and treatment; there was no documentation for a PN-WA or a particular assessment record, or any form of a wound assessment completed for resident #008. They further reported that registered staff could order a non medicated dressing treatment to an area of altered skin integrity, add the treatment to the eMAR, and registered staff had been changing the dressing treatment to resident #008's area of altered skin integrity.

During an interview with RPN #119 they reported that staff were required to document a progress note once a week, document on a particular assessment record which included a specific score, once a week, and document on the

eMAR with every dressing treatment change.

During an interview with NP #121 they reported that they were the Wound Care Champion for the home. They described resident #008's altered skin integrity. They further reported that since January 2019, they had directed the registered staff to have initiated non-medicated dressing treatments for wound care and staff were not required to obtain an order; staff were to have communicated to the physician or NP and to the pharmacy.

During an interview with Acting DOC they reported that staff were required to document a PN-WA or on the particular assessment record once weekly with altered skin integrity, contact the NP for orders, document on the eMAR with dressing treatment changes, and contact the NP for treatment orders. They further reported that NP #121 was the home's Wound Care Champion and had directed staff to have initiated non-medicated dressing's without an order and staff were to have documented the treatment in the physician progress notes on the physician order sheet. Together, the Acting DOC and the Inspector reviewed resident #008's health care records, and the Acting DOC confirmed that there were no physician or NP orders for a dressing treatment, the eMAR was not being documented daily, and there wasn't a PN-WA or a particular assessment record documented for resident #008. They further confirmed that the home's Wound program was not being implemented in the Home.

During an interview with the Administrator, they confirmed that staff were not implementing the home's Wound Care program, the NP's direction to registered staff was not congruent with the home's policy and they were in the process of updating the policy. [s. 48. (1) 2.]

The decision to issue this Compliance Order (CO) was based on the scope which was isolated, the severity which was actual harm. In addition, the home's compliance history identified a history of previous on-going unrelated non-compliance. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 02, 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 2nd day of July, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Debbie Warpula

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