Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 17, 2019	2019_624196_0020 (A1)	013027-19	Follow up

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

Amended by LAUREN TENHUNEN (196) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

An extension to the compliance due date has been provided to allow the licensee to attain sustainable compliance.

Issued on this 17th day of September, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 17, 2019	2019_624196_0020 (A1)	013027-19	Follow up

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

Amended by LAUREN TENHUNEN (196) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 12-15, 2019

The following intake was inspected upon during this Follow up Inspection:

- one log related to compliance order (CO) #001 that was issued during inspection #2019_633577_0015, pursuant to r. 48. (1) of the Ontario Regulation 79/10.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (Acting DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and a Nurse Practitioner (RN EC).

The Inspector also conducted a walk through of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed several resident health care records, reviewed the home's skin and wound care policy and various skin and wound care documents.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 following interdisciplinary program was developed and implemented in the home: 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.

During inspection #2019_633577_0015, CO #001 was issued to the home, which ordered the licensee to:

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.

The compliance due date of this order was August 2, 2019.

Inspector #196 requested a copy of the audit of all of the residents in the home requiring weekly wound assessments by registered nursing staff. The Acting Director of Care (Acting DOC) provided an undated piece of paper with the handwritten names of residents on it, some of which were illegible and required decyphering. They reported this list was made in mid July 2019 and was based upon residents that had PN-WA (progress notes - wound assessments) in Gold Care. They further added that they and RN #100 talked to staff the previous afternoon, after the Inspector had left for the day, to determine names of other residents that may have had wounds and did not have PN-WA documentation.

The Acting DOC also reported to the Inspector that August 12, 2019, was their first opportunity to meet with RN #100 who was to assist with the audit and they spoke with staff to determine other residents that may have had wounds that had not been documented in Gold Care. They further added that together the Acting DOC and RN #100 would be planning a specific day to do audits.

Together with RN #100, the Inspector reviewed the impaired skin integrity documentation for four residents that were identified on the provided audit, resident #001, #002, #003 and #004, from the date of compliance August 2, 2019, and onward.

Resident #001 was identified as having two areas of impaired skin integrity that required treatment and documentation. RN #100 confirmed to the Inspector that the provision of treatment to both areas, was not documented in the electronic Treatment Administration Record (eTAR) on a specific date and that the PUSH tool had not been initiated for one of the areas of impaired skin integrity. RN #100 further confirmed that they had created a PUSH tool document on August 13, 2019, upon discovery that there had not been initiated for one of the areas of

impaired skin integrity. In addition, RN #100 reported that the PUSH tool scoring was inaccurate with the calculations for the other area of impaired skin integrity.

Resident #003 was identified as having two areas of impaired skin integrity that required treatment. There was an order for treatment of one area but not for the other area of impaired skin integrity. The PUSH tools were not completed for either areas of impaired skin integrity on a weekly basis as required, with the last entry recorded on the day before the review. The provision of treatment for the one area of impaired skin integrity was documented in the eTAR, and the other area of impaired skin integrity had an eTAR entry for registered staff to enter a "PN-WA". RN #100 confirmed to the Inspector that there was no written order for the treatment of the one area of impaired skin integrity and there was no treatment identified in the eTAR as there should have been, as the registered staff had documented on the PUSH tool as using a particular dressing type on the area.

Resident #004 was identified as having an area of impaired skin integrity that required treatment. There was an order for treatment of this area and the provision of treatment was documented as required in the eTAR. RN #100 confirmed to the Inspector that a PUSH tool document was initiated on this day of review, as they could not locate a current record for this area of impaired skin integrity.

Interviews were conducted with several registered staff members to ascertain their knowledge of the home's skin and wound care program and the required documentation as outlined in the compliance order.

During an interview with RN #104, they reported to the Inspector that they would record a progress note for a new area of impaired skin integrity, and a note in the eTAR to monitor the area and when there was an open wound, then would use the PN-WA to document the assessment of the wound. They further added that they would do a PUSH tool once a week when a dressing change was completed and also do a PN-WA to document changes to the wound status, and would not actually write an order on the Medical Doctor (MD) order sheet, just on the eTAR.

During an interview with RN #105, they reported they would complete a PUSH tool for a pressure wound, once the area was open, weekly. They further added that they would write an order on the MD order sheet for non-medicated treatment so it would go to the pharmacy and then be included in the eTAR. In addition, they

reported that they don't, "really do a PN-WA" and the RPNs do them.

During an interview with RPN #106, they reported that when an area of impaired skin integrity was identified, they would assess it, measure it, mark it in the doctor's book and inform the RN. They further added that a PUSH tool would be done for a pressure ulcer on a weekly basis. In addition, they reported that a PN-WA would be done weekly for venous ulcers and not for pressure ulcers. They reported that the provision of wound care would be documented in the eTAR and in Gold Care program under skin integrity focus; both places every time. When asked if they could write dressing orders for an area of impaired skin integrity, they reported that this was being debated, as they had heard that they could, but were waiting to hear back about this further.

An interview was conducted with the Acting DOC, and they reported that registered staff were to: determine whether to do an assessment and use the appropriate assessment instrument depending on the type of wound; complete the PUSH tool weekly on a bath day as this served as the weekly wound assessment tool; utilize the binder for guidelines to follow; take immediate actions; and that the registered staff could write orders for non-medicated wound treatments which would then transcribe the order into the eTAR and communicate it to the pharmacy. They added that training from a supplier was provided to approximately 25 of the 40 registered staff in the home in July 2019, regarding the binder and the guidance documents for skin and wound care.

In a further interview with the Acting DOC, they had provided a document titled, "Orders July 2019" which identified what had been done, and what still required completion, in reference to the sections of the compliance orders.

During an interview with the Administrator, they reported to the Inspector that they should have asked for an extension on the compliance due date, and confirmed that the specific instructions in the compliance order had not been followed. [s. 48. (1) 2.]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that they complied with an order made under the Long-Term Care Homes Act, 2007, c. 8, s. 101. (3).

The licensee was to be compliant with Compliance Order (CO) #001 from Inspection #2019_633577_0015 that was issued to the home on July 2, 2019, which had a compliance due date of August 2, 2019.

The licensee was ordered to ensure that they were compliant with section 48. (1) (2) of the Ontario Regulation 79/10.

Specifically the licensee was ordered to:

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.

In an interview with the Acting DOC, they had provided a document titled, "Orders July 2019" which identified what had been done, and what still required completion, in reference to the sections of the compliance orders.

At the time of the inspection, section "a", had not been completed in entirety; the process to address section "c", "d", and "e" had not been completed; and section "f" and "g" had not been established by the start of the inspection.

During an interview with the Administrator, they reported to the Inspector that they should have asked for an extension to the compliance due date and confirmed that the specific instructions in the compliance order had not been followed. [s. 101. (3)]

Issued on this 17th day of September, 2019 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LAUREN TENHUNEN (196) - (A1)
Inspection No. / No de l'inspection :	2019_624196_0020 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	013027-19 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 17, 2019(A1)
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

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_633577_0015, CO #001;

Pursuant to / Aux termes de :

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

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

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

Order / Ordre :

The licensee must be compliant with s. 48. (1) of the LTCHA.

Specifically the licensee must:

a) Conduct an audit of all the residents in the home that require weekly wound assessments by registered nursing staff.
b) Ensure the audit is recorded legibly, and includes the full name of each resident, the type of wound present, current treatment, and the written order for treatment.
c) Based upon the audit, ensure that there is a current written order for wound treatment as indicated in the homes' skin and wound care policy.
d) Ensure weekly wound assessments are conducted accurately utilizing the appropriate assessment instrument, as indicated in the homes' skin and wound care policy.
e) Ensure the electronic Treatment Administration Records (eTARs) identify the treatment regimes, and accurate documentation of the treatment provided.
f) Establish an auditing tool and routine to ensure that weekly wound assessments are being completed and are accurate; there are written orders for wound treatments; the appropriate wound assessment tools are being utilized; the eTARs include accurate information; and that treatments are documented as required.
g) Develop a plan that will ensure the registered staff are aware of the requirements of the homes' skin and wound care program.
h) Maintain records of all of the above actions.

Please submit the written plan for achieving compliance for inspection 2019_624196_0020 to Lauren Tenhunen, LTC Homes Inspector, MLTC, by email to SudburySAO.moh@ontario.ca by September 17, 2019. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order CO#001 from inspection #2019_633577_0015 issued on July 2, 2019, with a compliance date of August 2, 2019.

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.

The licensee completed step "h" and "i".

The licensee failed to complete steps "a" through and including "g".

The licensee has failed to ensure that the following interdisciplinary program was developed and implemented in the home: 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.

Inspector #196 requested a copy of the audit of all of the residents in the home requiring weekly wound assessments by registered nursing staff. The Acting Director of Care (Acting DOC) provided an undated piece of paper with the handwritten names of residents on it, some of which were illegible and required decyphering. They reported this list was made in mid July 2019 and was based upon residents that had PN-WA (progress notes - wound assessments) in Gold Care. They further added that they and RN #100 talked to staff the previous afternoon, after the Inspector had

left for the day, to determine names of other residents that may have had wounds and did not have PN-WA documentation.

The Acting DOC also reported to the Inspector that August 12, 2019, was their first opportunity to meet with RN #100 who was to assist with the audit and they spoke with staff to determine other residents that may have had wounds that had not been documented in Gold Care. They further added that together the Acting DOC and RN #100 would be planning a specific day to do audits.

Together with RN #100, the Inspector reviewed the impaired skin integrity documentation for four residents that were identified on the provided audit, resident #001, #002, #003 and #004, from the date of compliance August 2, 2019, and onward.

Resident #001 was identified as having two areas of impaired skin integrity that required treatment and documentation. RN #100 confirmed to the Inspector that the provision of treatment to both areas, was not documented in the electronic Treatment Administration Record (eTAR) on a specific date and that the PUSH tool had not been initiated for one of the areas of impaired skin integrity. RN #100 further confirmed that they had created a PUSH tool document on August 13, 2019, upon discovery that there had not been initiated for one of the areas of impaired skin integrity. In addition, RN #100 reported that the PUSH tool scoring was inaccurate with the calculations for the other area of impaired skin integrity.

Resident #003 was identified as having two areas of impaired skin integrity that required treatment. There was an order for treatment of one area but not for the other area of impaired skin integrity. The PUSH tools were not completed for either areas of impaired skin integrity on a weekly basis as required, with the last entry recorded on the day before the review. The provision of treatment for the one area of impaired skin integrity was documented in the eTAR, and the other area of impaired skin integrity had an eTAR entry for registered staff to enter a "PN-WA". RN #100 confirmed to the Inspector that there was no written order for the treatment of the one area of impaired skin integrity and there was no treatment identified in the eTAR as there should have been, as the registered staff had documented on the PUSH tool as using a particular dressing type on the area.

Resident #004 was identified as having an area of impaired skin integrity that

required treatment. There was an order for treatment of this area and the provision of treatment was documented as required in the eTAR. RN #100 confirmed to the Inspector that a PUSH tool document was initiated on this day of review, as they could not locate a current record for this area of impaired skin integrity.

Interviews were conducted with several registered staff members to ascertain their knowledge of the home's skin and wound care program and the required documentation as outlined in the compliance order.

During an interview with RN #104, they reported to the Inspector that they would record a progress note for a new area of impaired skin integrity, and a note in the eTAR to monitor the area and when there was an open wound, then would use the PN-WA to document the assessment of the wound. They further added that they would do a PUSH tool once a week when a dressing change was completed and also do a PN-WA to document changes to the wound status, and would not actually write an order on the Medical Doctor (MD) order sheet, just on the eTAR.

During an interview with RN #105, they reported they would complete a PUSH tool for a pressure wound, once the area was open, weekly. They further added that they would write an order on the MD order sheet for non-medicated treatment so it would go to the pharmacy and then be included in the eTAR. In addition, they reported that they don't, "really do a PN-WA" and the RPNs do them.

During an interview with RPN #106, they reported that when an area of impaired skin integrity was identified, they would assess it, measure it, mark it in the doctor's book and inform the RN. They further added that a PUSH tool would be done for a pressure ulcer on a weekly basis. In addition, they reported that a PN-WA would be done weekly for venous ulcers and not for pressure ulcers. They reported that the provision of wound care would be documented in the eTAR and in Gold Care program under skin integrity focus; both places every time. When asked if they could write dressing orders for an area of impaired skin integrity, they reported that this was being debated, as they had heard that they could, but were waiting to hear back about this further.

An interview was conducted with the Acting DOC, and they reported that registered staff were to: determine whether to do an assessment and use the appropriate assessment instrument depending on the type of wound; complete the PUSH tool

weekly on a bath day as this served as the weekly wound assessment tool; utilize the binder for guidelines to follow; take immediate actions; and that the registered staff could write orders for non-medicated wound treatments which would then transcribe the order into the eTAR and communicate it to the pharmacy. They added that training from a supplier was provided to approximately 25 of the 40 registered staff in the home in July 2019, regarding the binder and the guidance documents for skin and wound care.

In a further interview with the Acting DOC, they had provided a document titled, "Orders July 2019" which identified what had been done, and what still required completion, in reference to the sections of the compliance orders.

During an interview with the Administrator, they reported to the Inspector that they should have asked for an extension on the compliance due date, and confirmed that the specific instructions in the compliance order had not been followed.

The severity of this issue was determined to be a level 3 as there was actual risk of harm to residents. The scope of the issue was a level 3, as it related to three of four residents reviewed. The home had a level 4 compliance history as they had on-going non-compliance with this section of the O. Reg. 79/10, and one or fewer compliance orders that included:
-Compliance Order (CO) issued July 2, 2019 (2019_633577_0015) with a compliance due date of August 2, 2019. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2019(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 17th day of September, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by LAUREN TENHUNEN (196) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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