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 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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 3, 2018	2018_737640_0021	019250-18	Critical Incident System

Licensee/Titulaire de permis

Stayner Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Stayner Care Centre
244 Main Street East, 7308 Highway #26, P.O. Box 350 STAYNER ON L0M 1S0

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

HEATHER PRESTON (640)

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): August 20, 21, 22 and 23, 2018.

The purpose of this inspection was to inspect a Critical Incident.

Log #019250-18 related to unexpected death following two falls.

During the course of the inspection, the Long-Term Care Homes Inspector toured the home, observed the provision of care, reviewed clinical records, reviewed policy and procedure and observed residents.

During the course of the inspection, the inspector(s) spoke with residents, families, PSWs, Registered Practical Nurses, Registered Nurses, Fall and Restraint/PASD Lead, Staff Educator and the Administrator.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Pain
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **2 VPC(s)**
- **5 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

The licensee failed to ensure that when a Personal Assistive Services Device (PASD)

was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

a) On an identified date in June 2018, resident #001 fell with no injury. On a second date in June 2018, resident #001 fell a second time resulting in altered skin integrity.

During an interview with PSWs #100 and #104, they told the LTCH Inspector that a specific Personal Assistive Services Device (PASD) was implement following the second fall.

The home's policy "Resident Rights, Care and Services – Minimizing of Restraining – Personal Assistive Services Device (PASD)" Version 1 with an effective date of April 23, 2018, directed that prior to the introduction of a PASD with restraining qualities, the following was to occur:

- A multidisciplinary assessment was to be completed.
- An order from a physician or registered nurse in the extended class was to be obtained
- The registrant/Restorative Care Coordinator/designate was to meet with the resident or substitute decision maker (SDM) to obtain consent
- Resident's plan of care was to be updated to include the use of the PASD

The Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record and the use of the PASD was not included in the plan of care. The clinical record did not include the approval of the use of the PASD by a regulated health professional, an order for it's use and there was no consent for the use of the PASD.

During an interview with the home's Fall Lead, they told the LTCH Inspector they had implemented the use of the specific PASD to reduce the likelihood of falls for resident #001 on an identified date in June 2018. They told the LTCH Inspector they had not included the use of the PASD in the resident's plan of care and did not get approval for the implementation of the PASD and they had not obtained consent from the resident/SDM for the use of the PASD.

b) Resident #005 was admitted to the home on an identified date in March 2018, with multiple medical conditions and was not ambulatory and required extensive assistance.

According to the fall lead, on an identified date in April 2018, a specific PASD was

implemented to prevent the resident from falling.

The Long-Term Care Homes (LTCH) Inspector observed the resident on three occasions during the inspection and noted the PASD in varying positions.

During an interview with RPN #102 and PSW #101, they stated the PASD was implemented earlier this year.

During an interview of PSWs #100, #106 and #107, they did not know where to find directions regarding the use of the PASD nor what position it should be in and when.

The Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record and the use of the PASD was not included in the plan of care. The clinical record did not include the approval of the use of the PASD by a regulated health care professional, an order for it's use and there was no consent by the resident or SDM for the use of the PASD.

During an interview with the home's Fall Lead, they told the LTCH Inspector they had implemented the use of the PASD to reduce the likelihood of falls and for comfort for resident #005. They told the LTCH Inspector they had not included the use of the PASD in the resident's plan of care and did not get approval for the implementation of the PASD and they had not obtained consent from the resident/SDM for the use of the PASD.

c) Resident #004 was admitted to the home on an identified date in April 2016. They were using alternate form of mobility and they required extensive assistance of staff.

During an interview with the fall lead, they stated that on an identified date in May 2018, a specific PASD was implemented to prevent falls.

The Long-Term Care Homes (LTCH) Inspector observed the resident on three occasions during the inspection and noted the PASD was in varying positions.

During an interview with RPN #102 and PSW #101 they stated the specific PASD was implemented about three or four months ago. It was implemented as the resident would fall.

During an interview of PSWs #100, #106 and #107, they did not know where to find directions as to how to position the resident and when. They stated it was not included in

the kardex or plan of care.

The Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record and the use of the PASD was not included in the plan of care. The clinical record did not include the approval of the use of the PASD by a regulated health professional, an order for it's use and there was no consent from the resident or SDM for the use of the PASD.

During an interview with the home's Fall Lead, they told the LTCH Inspector they had implemented the use of the specific PASD to reduce the likelihood of falls and for comfort for resident #004. They told the LTCH Inspector they had not included the use of the PASD in the resident's plan of care and did not get approval for the implementation of the PASD and they had not obtained consent from the resident/SDM for the use of the PASD. [s. 33. (3)]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including fall prevention, were developed and implemented in the home and each program must meet the requirements as set out in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30. O. Reg. 79/10, s.48.

1) On an identified date in June 2018, resident #001 fell. On a second date in June 2018, resident #001 fell a second time and sustained altered skin integrity. Both falls were unwitnessed.

a) The home's policy "Resident Rights, Care and Services – Required Programs – Fall Prevention and Management – Program", Version 4 with a revised date of December 29, 2017, directed staff to implement head injury routine (HIR) when head injury was evident and when a fall was unwitnessed.

The home's policy "Resident Rights, Care and Services – Emergency Care – Head Injury Routine, Version 3 with a revised date of July 18, 2016, directed staff to initiate HIR using the head injury form, complete the document at prescribed times, monitor for signs and symptoms of head injury (several listed), assess for clinical signs of acute subdural haematoma and hold medications until the resident was assessed by the physician.

The Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record and found two specific assessment forms related to the above falls.

One assessment form was initiated on an identified date in June 2018 at a specific time. On four occassions the assessments were not conducted. The final assessment included on the form, had no notations made.

The second assessment form was initiated on a second date in June 2018 at a specific time. On 11 required occasions, there was no documentation related to a specific type of assessment. At a certain time on another identified date in June 2018 no assessment was completed.

During an interview with RN #103, they stated it was an expectation that the specific assessment was to be completed for all required timelines.

RN #103 acknowledged that the home did not follow their policy related to the completion

of the specific assessments for resident #001.

b) The home's policy "Resident Rights, Care and Services – Required Programs – Fall Prevention and Management – Program", Version 4 with a revised date of December 29, 2017, directed staff to complete fall follow up progress note for at least three shifts following the incident.

The LTCH Inspector reviewed the clinical record and found one fall follow up progress note on an identified date in July 2018.

During an interview with the Fall Lead they stated it was expected that a fall follow up progress note be completed for three shifts following the fall using the appropriate progress note for that purpose.

The LTCH Inspector and the Fall Lead reviewed the clinical record for resident #001 and found that following the first fall the required fall follow up notes for two shifts had not been completed. Following the second incident, the required fall follow up notes for two shifts were not completed.

The Fall Lead acknowledged that the home failed to follow their policy related to post fall follow up progress notes.

2) On an identified date in July 2018, resident #005 fell which was unwitnessed

a) The Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record and found a specific assessment with an identified date in July 2018.

The assessment form was initiated at a specific time on an identified date in July 2018. On seven occasions, there was no specific assessment completed as required. Each of the above scheduled assessment times had the word "sleeping" written in it. On an identified date in July 2018 at a specific time, the assessment was incomplete. On seven of 14 required occasions, the resident did not have their specific assessments completed.

During an interview with RN #103, they stated it was an expectation that the specific assessment was to be completed for all required timelines whether the resident was asleep or not

RN #103 acknowledged that the home did not follow their policy related to the completion of the specific assessments for resident #005

b) The LTCH Inspector reviewed the clinical record and was unable to locate any follow up fall notes as per the home's policy for resident #005.

During an interview with RN #103, they stated it was expected that a fall follow up progress note be completed for three shifts following the fall using the appropriate progress note for that purpose.

The LTCH Inspector and the RN reviewed the clinical record for resident #005 and found that following the fall on an identified date in July 2018 the required fall follow up notes for three shifts following the fall were not completed.

RN #103 acknowledged that the home failed to follow their policy related to post fall follow up progress notes.

3) On an identified date in April 2018, resident #003 had an unwitnessed fall resulting in a specific injury.

a) The Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record and found a specific assessment form dated for an identified date in April 2018.

During a review of the specific assessment form by the LTCH Inspector, it was noted that assessments were not completed for three required dates and times.

During an interview with RN #103, they stated it was an expectation that the specific assessment was to be completed for all required timelines.

RN #103 acknowledged that the home did not follow their policy related to the completion of the specific assessments for resident #003.

b) The LTCH Inspector reviewed the clinical record and was unable to locate any follow up fall notes as per the home's policy for resident #003.

During an interview with RN #103, they stated it was expected that a fall follow up progress note be completed for three shifts following the fall using the appropriate progress note for that purpose.

The LTCH Inspector and the RN reviewed the clinical record for resident #003 and found that following the fall on an identified date in April 2018 the required fall follow up notes for three shifts following the fall were not completed.

RN #103 acknowledged that the home failed to follow their policy related to post fall follow up progress notes. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

The licensee failed to ensure that the fall prevention program, in addition to the requirements set out in section 30, provided for screening protocols.

During an inspection related to fall prevention for residents #001, #003 and #005, the Long-Term Care Home (LTCH) Inspector reviewed the clinical records to determine the resident's assessed fall risk score. There were no assessment tools within the documentation system of PointClickCare nor in the written clinical records for the three residents being inspected.

The LTCH Inspector interviewed the Fall Lead who was not aware of any tool that the home used to determine risk for falls. They stated that all new admissions were assumed to be high risk for falls but after that there was no tool available to determine the risk of falls for a resident.

During an interview with the Administrator, they told the LTCH Inspector that when they inquired of the registered staff, they said they go on the internet to see how to do a fall risk assessment. They weren't aware of any tool available in the home.

The Administrator acknowledged the home did not have any screening protocols to determine risk for fall of their residents. [s. 48. (2) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

a) On an identified date in June 2018, resident #001 fell. On a second date in June 2018, resident #001 fell a second time resulting in altered skin integrity on two locations.

The Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record and found that no skin/wound assessment had been completed for either of the areas of altered skin integrity that occurred as a result of the second fall.

During an interview with RN #103, they stated it was an expectation that a skin/wound assessment be completed for both areas of altered skin integrity.

The home's policy "Resident Rights, Care and Services – Required Programs – Skin and Wound Care – Program", Version 4 with a revised date of February 28, 2018, directed staff to complete a wound assessment and treatment record for all areas of altered skin integrity followed by an appropriate weekly assessment found in the progress notes of PCC.

During an interview with RN #103, they told the LTCH Inspector it was expected for any altered skin integrity that a wound assessment in the assessment section of PCC be completed. For the both areas of altered skin integrity, a weekly wound note in the progress notes was to be completed.

The clinical record was reviewed with RN #103 who acknowledged that both areas of altered skin integrity for resident #001 that was a result of the fall in June 2018, had not been assessed using a clinically appropriate assessment instrument specifically designed for skin and wounds.

b) On an identified date in August 2018, the Long-Term Care Homes (LTCH) Inspector observed resident #003 and noted several areas of altered skin integrity.

The LTCH Inspector reviewed the resident's clinical record and noted the plan of care included a focus of interference in structural layers of the skin. There were directions to observe, document and follow the treatment record. The most recent Minimum Data Set (MDS) assessment completed, noted the resident had areas of altered skin integrity.

During an interview of RN #109 they told the LTCH Inspector that a wound/treatment assessment was to be completed for the areas of altered skin integrity and a wound note weekly thereafter. There were no wound/treatment initial assessment completed related to the altered skin integrity.

The LTCH Inspector interviewed RN #103 who stated that a wound/treatment assessment was expected to be done related to the altered skin integrity. The clinical record was reviewed with the LTCH Inspector and there were no wound/treatment notes included in the record for the altered skin integrity.

The RN acknowledged the home had not assessed the altered skin integrity using their clinically appropriate assessment instrument specifically designed for the assessment of skin and wound.

c) On an identified date in April 2018, a PSW informed RPN #111 that resident #002 had new areas of altered skin integrity.

On an identified date in May 2018, RPN #112 noted there was another area of altered skin integrity.

On a second date in May 2018, RPN #108 documented there was an third area of altered skin integrity.

During an interview with RPN #108, they stated that for any areas of altered skin integrity, it was expected that a wound and treatment assessment be completed as found in the assessment tab in PCC followed by weekly wound assessments.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record with RPN #108. The RPN reviewed the progress note and confirmed there should have been an assessment as above. The RPN reviewed the assessments both in the assessment tab and in the progress notes and noted there were no required wound/treatment assessments completed.

RPN #108 acknowledged the home failed to assess resident #002's areas of altered skin integrity using the appropriate assessment instrument. [s. 50. (2) (b) (i)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

The licensee failed to ensure that when a resident's pain was not relieved by initial interventions the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

a) On an identified date in June 2018, resident #001 fell. On a second date in June

2018, resident #001 fell a second time resulting in altered skin integrity on two areas.

On an identified date in July 2018 resident #001 complained of pain and was administered an analgesic and had a documented pain score of minimum. Later that same day, the resident was still complaining of pain and had no change in their pain score documented in the clinical record. It was documented that the analgesic given earlier was ineffective. A second dose of analgesic was administered for pain with a moderate pain score.

On an identified date in July 2018 the resident complained of pain with a high pain score. Analgesic was administered. The documentation noted this intervention was ineffective. No further interventions were documented.

The LTCH Inspector reviewed the clinical record and noted there were no clinically appropriate assessments completed for the unrelieved pain on the two dates in July 2018.

During an interview with RPN #105, they explained when resident's pain was unrelieved they would notify the physician.

During an interview with the Administrator, they told the LTCH Inspector it was expected that a pain assessment was completed upon admission and when the pain score was four out of ten or higher. At that point it was expected a pain assessment to be completed weekly.

The Administrator acknowledged that when pain was not relieved by initial interventions, the home was not assessing the resident using a clinically appropriate assessment instrument specifically designed for the assessment of pain.

b) Resident #002 had chronic pain.

According to the Medication Administration Record (MAR), the resident was routinely receiving analgesic daily.

On an identified date in April 2018 the resident complained of pain. The resident's pain score was noted to be moderate at this time. The resident was administered a stronger analgesic as a result of the increasing pain with effect.

On an identified date in April 2018 resident #002 complained of pain. Their pain score was noted to be at the highest level. The resident was administered their stronger analgesic as a result of the increasing pain with effect.

The clinical record was reviewed by the Long-Term Care Homes (LTCH) Inspector and a pain assessment related to the unrelieved pain, had not been conducted at either time.

During an interview with RPN #105, they explained when resident's pain was unrelieved they would notify the physician.

During an interview with the Administrator, they told the LTCH Inspector it was expected that a pain assessment was completed upon admission and when the pain score was four out of ten or higher. At that point it was expected a pain assessment to be completed weekly.

The Administrator acknowledged that when pain was not relieved by initial interventions, the home was not assessing the resident using a clinically appropriate assessment instrument specifically designed for the assessment of pain.

c) Resident #003 had a diagnosis the resulted in pain.

The resident had an analgesic administered daily as a routine and a different analgesic available as needed (prn) for mild pain up to four times daily.

On an identified date in July 2018, resident #003 had a high pain score and the prn analgesic was administered with effect. On a second date in July 2018, the resident had pain at high score and the prn analgesic was administered but ineffective. On an identified date in July 2018 the resident's pain level was moderate to high and the same analgesic was administered with effect. Later that day their pain score was high and the same analgesic was administered and was ineffective. No further treatment was documented.

The LTCH Inspector reviewed resident #003's clinical record and there were no clinically appropriate assessments completed for the unrelieved pain for the two dates in July 2018.

During an interview with RPN #105, they explained when resident's pain was not relieved, the RPN would then notify the physician.

During an interview with the Administrator, they told the LTCH Inspector it was expected that a pain assessment was completed upon admission and when the pain score was four out of ten or higher and when initial interventions were not effective. At that point it was expected a pain assessment to be completed weekly.

The Administrator acknowledged that when pain was not relieved by initial interventions, the home was not assessing the resident using a clinically appropriate assessment instrument specifically designed for the assessment of pain. [s. 52. (2)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following in respect to the resident, 7. Physical functioning, and the type and level of assistance that was required relating to activities of daily living and 8. Continence, including bowel and bladder elimination.

Resident #001 was admitted to the home on an identified date in June 2018 had multiple medical diagnosis.

Shortly after admission the home's physiotherapist assessed resident #001 to require two persons assist for transfers and was non-ambulatory.

On an identified date in June 2018, resident #001 was assessed for continence. They were assessed to require a continent product related to the inability to always get to the toilet when needed.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record and identified the plan of care did not include any direction to staff regarding the transfer status and level of assistance required for the act of transferring and for the act of toileting. The plan of care did not address the level of continence for either bowel or bladder and the method required for toileting resident #001.

During an interview with PSW #100, they told the LTCH Inspector the resident was believed to need two persons for transfers but was not sure where this information was kept. Interview of PSW #104 they told the LTCH Inspector they did not have access to the plan of care and the nurses would tell them what care the resident needed when the resident was admitted.

During an interview with the Administrator, they acknowledged the plan of care did not include assistance required for transfers and any focus related to continence care and toileting. [s. 26. (3) 7.]

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 the licensee must ensure that a plan of care is based on, at a minimum, interdisciplinary assessment of the following in respect to the resident, 7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living and 8. Continence, including bowel and bladder elimination, to be implemented voluntarily.

WN #7: 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).

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

Findings/Faits saillants :

1. The licensee failed to ensure they kept a written record relating to the evaluation of the falls prevention program that included the date of the evaluation, the names of the persons who participated in the evaluation and a summary of the changes made and the date that those changes were implemented.

a) The Long-Term Care Homes (LTCH) Inspector reviewed the home's annual evaluation of the falls prevention program dated July 10, 2018. The written record did not include any changes made to the program and the date those changes were made.

During an interview with the Administrator, they acknowledged there were no changes identified and dates of any changes made to the fall prevention program.

b) The Long-Term Care Homes (LTCH) Inspector reviewed the home's annual evaluation of the skin and wound care program dated June 29, 2018. The written record identified a change to the program but did not include the date those changes were made.

During an interview with the Administrator, they acknowledged the date of the identified change that was made to the skin and wound program was not included in the written record.

c) The Long-Term Care Homes (LTCH) Inspector reviewed the home's annual evaluation of the pain program dated October 3, 2017. The written record identified a change to the pain program but did not include the date those changes were made.

During an interview with the Administrator, they acknowledged the date of the identified change that was made to the pain program was not included in the written record. [s. 30. (1) 4.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

a) On an identified date in June 2018, resident #001 fell. On a second date in June 2018, resident #001 fell a second time resulting in two areas of altered skin integrity.

The plan of care in place at the time included risk for falls and included basic falls prevention strategies.

During review of the clinical record by the Long-Term Care Homes (LTCH) Inspector, there was a progress note stating the resident was placed in their specific PASD.

There were no revisions to the plan of care following both falls however, during interviews with PSWs #100 and #101, they told the LTCH Inspector there was no place to document when they provided the intervention to the resident.

During an interview with the Falls Lead, they told the LTCH Inspector they had

implemented the use of the specific PASD after the second fall to prevent further falls but did not document the implementation of the PASD and the specific interventions related to its' use. As a result, the PSWs were unable to document the interventions of the use of the PASD and the interventions implemented for the resident even though this care was provided.

The Falls Lead acknowledged the home did not document the implementation of the specific PASD and the related, required interventions for resident #001.

b) On an identified date in May 2018, a specific PASD was implemented for resident #004 to prevent falls and improve comfort. A second specific PASD was added shortly thereafter.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record and noted there were no entries in the plan of care/kardex related to the use of the two PASDs and the interventions required while using the PASDs.

During an interview with PSWs #100 and #101, they told the LTCH Inspector there was no place to document when they provided any interventions or when they implemented the two PASDs.

During an interview with the Falls Lead, they told the LTCH Inspector they had implemented the use of the PASDs to prevent falls and improve comfort. They stated they did not document the use of the PASDs and the required interventions for the resident. They had not included the interventions in the PSWs documentation tool.

The Falls Lead acknowledged the home did not document the implementation of the specific PASDS and required interventions for resident #004.

c) On an identified date in April 2018, a specific PASD was implemented for the resident #005 to prevent falls and improve comfort.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record and noted there were no entries in the plan of care/kardex or documentation system related to the use of the PASD and the required interventions for the resident while using the PASD.

During an interview with PSWs #100 and #101, they told the LTCH Inspector there was no place to document the use of the PASD and the implementation of the required

interventions.

During an interview with the Falls Lead, they told the LTCH Inspector they had implemented the use of the PASD to prevent falls and improve comfort. They stated they did not document the implementation of the PASD an the required interventions for the resident. They had not included the interventions and the PASD in the PSWs documentation tool.

The Falls Lead acknowledged the home did not document the use of the PASD and the required interventions for resident #005. [s. 30. (2)]

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 the licensee must ensure they keep a written record relating to the evaluation of the falls prevention program, the skin and wound program and the pain program that includes the date of the evaluation, the names of the persons who participated in the evaluation and a summary of the changes made and the date that those changes were implemented and to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that for purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provided direct care to residents; 2. Skin and Wound Care

As a result of a critical incident inspection related to a fall with subsequent altered skin integrity, the Long-Term Care Homes (LTCH) Inspector reviewed the home's required annual additional training for direct care staff.

For the calendar year 2017, 89 percent of registered staff received additional annual training for skin and wound care.

During an interview with the Staff Educator, they acknowledged that not all registered staff were trained in skin and wound care for the year 2017. [s. 221. (1) 2.]

Issued on this 18th day of October, 2018

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

Ministére 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) :	HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2018_737640_0021
Log No. / No de registre :	019250-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 3, 2018
Licensee / Titulaire de permis :	Stayner Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	Stayner Care Centre 244 Main Street East, 7308 Highway #26,, P.O. Box 350, STAYNER, ON, L0M-1S0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Emily Dillman

To Stayner Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Order / Ordre :

The licensee must be compliant with s. 33 (3) of the LTCHA.

Specifically the licensee must:
a) Include tilt wheelchairs as a Personal Assistance Services Device (PASD) where applicable as such, in the plan of care for residents #001, #004 and #005 and any other resident.
b) Ensure that all legislative requirements regarding the use of PASDs for residents #001, #004 and #005 and any other resident have been followed prior to the implementation of the PASD.

Grounds / Motifs :

1. The licensee failed to ensure that when a Personal Assistive Services Device (PASD) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

a) On an identified date in June 2018, resident #001 fell with no injury. On a second date in June 2018, resident #001 fell a second time resulting in altered skin integrity.

During an interview with PSWs #100 and #104, they told the LTCH Inspector that a specific Personal Assistive Services Device (PASD) was implement following the second fall.

The home's policy "Resident Rights, Care and Services – Minimizing of Restraining – Personal Assistive Services Device (PASD)" Version 1 with an effective date of April 23, 2018, directed that prior to the introduction of a PASD

with restraining qualities, the following was to occur:

- A multidisciplinary assessment was to be completed.
- An order from a physician or registered nurse in the extended class was to be obtained
- The registrant/Restorative Care Coordinator/designate was to meet with the resident or substitute decision maker (SDM) to obtain consent
- Resident's plan of care was to be updated to include the use of the PASD

The Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record and the use of the PASD was not included in the plan of care. The clinical record did not include the approval of the use of the PASD by a regulated health professional, an order for it's use and there was no consent for the use of the PASD.

During an interview with the home's Fall Lead, they told the LTCH Inspector they had implemented the use of the specific PASD to reduce the likelihood of falls for resident #001 on an identified date in June 2018. They told the LTCH Inspector they had not included the use of the PASD in the resident's plan of care and did not get approval for the implementation of the PASD and they had not obtained consent from the resident/SDM for the use of the PASD.

b) Resident #005 was admitted to the home on an identified date in March 2018, with multiple medical conditions and was not ambulatory and required extensive assistance.

According to the fall lead, on an identified date in April 2018, a specific PASD was implemented to prevent the resident from falling.

The Long-Term Care Homes (LTCH) Inspector observed the resident on three occasions during the inspection and noted the PASD in varying positions.

During an interview with RPN #102 and PSW #101, they stated the PASD was implemented earlier this year.

During an interview of PSWs #100, #106 and #107, they did not know where to find directions regarding the use of the PASD nor what position it should be in and when.

The Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record and the use of the PASD was not included in the plan of care. The clinical record did not include the approval of the use of the PASD by a regulated health care professional, an order for it's use and there was no consent by the resident or SDM for the use of the PASD.

During an interview with the home's Fall Lead, they told the LTCH Inspector they had implemented the use of the PASD to reduce the likelihood of falls and for comfort for resident #005. They told the LTCH Inspector they had not included the use of the PASD in the resident's plan of care and did not get approval for the implementation of the PASD and they had not obtained consent from the resident/SDM for the use of the PASD.

c) Resident #004 was admitted to the home on an identified date in April 2016. They were using alternate form of mobility and they required extensive assistance of staff.

During an interview with the fall lead, they stated that on an identified date in May 2018, a specific PASD was implemented to prevent falls.

The Long-Term Care Homes (LTCH) Inspector observed the resident on three occasions during the inspection and noted the PASD was in varying positions.

During an interview with RPN #102 and PSW #101 they stated the specific PASD was implemented about three or four months ago. It was implemented as the resident would fall.

During an interview of PSWs #100, #106 and #107, they did not know where to find directions as to how to position the resident and when. They stated it was not included in the kardex or plan of care.

The Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record and the use of the PASD was not included in the plan of care. The clinical record did not include the approval of the use of the PASD by a regulated health professional, an order for it's use and there was no consent from the resident or SDM for the use of the PASD.

During an interview with the home's Fall Lead, they told the LTCH Inspector they

had implemented the use of the specific PASD to reduce the likelihood of falls and for comfort for resident #004. They told the LTCH Inspector they had not included the use of the PASD in the resident's plan of care and did not get approval for the implementation of the PASD and they had not obtained consent from the resident/SDM for the use of the PASD. [s. 33. (3)]

The severity of this issue was determined to be a level 2, minimal harm or potential for actual harm. The scope of the issue was a level 3, widespread. The home had a level 2 compliance history, previous unrelated non-compliance. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

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

Specifically, the licensee must:
a) Ensure that staff follow the home's policy regarding the implementation of head injury routine for unwitnessed falls and suspected head injury as directed in the policy.
b) Ensure that staff follow the home's fall prevention policy and complete post fall assessments following a fall as directed in the home's policy.

Grounds / Motifs :

1.
Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including fall prevention, were developed and implemented in the home and each program must meet the requirements as set out in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30. O. Reg. 79/10, s.48.

1) On an identified date in June 2018, resident #001 fell. On a second date in June 2018, resident #001 fell a second time and sustained altered skin integrity. Both falls were unwitnessed.

a) The home's policy "Resident Rights, Care and Services – Required Programs – Fall Prevention and Management – Program", Version 4 with a revised date of December 29, 2017, directed staff to implement head injury routine (HIR) when head injury was evident and when a fall was unwitnessed.

The home's policy "Resident Rights, Care and Services – Emergency Care – Head Injury Routine, Version 3 with a revised date of July 18, 2016, directed staff to initiate HIR using the head injury form, complete the document at prescribed times, monitor for signs and symptoms of head injury (several listed), assess for clinical signs of acute subdural haematoma and hold medications until the resident was assessed by the physician.

The Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record and found two specific assessment forms related to the above falls.

One assessment form was initiated on an identified date in June 2018 at a specific time. On four occassions the assessments were not conducted. The final assessment included on the form, had no notations made.

The second assessment form was initiated on a second date in June 2018 at a specific time. On 11 required occasions, there was no documentation related to a specific type of assessment. At a certain time on another identified date in June 2018 no assessment was completed.

During an interview with RN #103, they stated it was an expectation that the specific assessment was to be completed for all required timelines.

RN #103 acknowledged that the home did not follow their policy related to the completion of the specific assessments for resident #001.

b) The home's policy "Resident Rights, Care and Services – Required Programs – Fall Prevention and Management – Program", Version 4 with a revised date of December 29, 2017, directed staff to complete fall follow up progress note for at least three shifts following the incident.

The LTCH Inspector reviewed the clinical record and found one fall follow up progress note on an identified date in July 2018.

During an interview with the Fall Lead they stated it was expected that a fall follow up progress note be completed for three shifts following the fall using the appropriate progress note for that purpose.

The LTCH Inspector and the Fall Lead reviewed the clinical record for resident #001 and found that following the first fall the required fall follow up notes for two shifts had not been completed. Following the second incident, the required fall follow up notes for two shifts were not completed.

The Fall Lead acknowledged that the home failed to follow their policy related to post fall follow up progress notes.

2) On an identified date in July 2018, resident #005 fell which was unwitnessed

a) The Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record and found a specific assessment with an identified date in July 2018.

The assessment form was initiated at a specific time on an identified date in July 2018. On seven occasions, there was no specific assessment completed as required. Each of the above scheduled assessment times had the word "sleeping" written in it. On an identified date in July 2018 at a specific time, the assessment was incomplete. On seven of 14 required occasions, the resident did not have their specific assessments completed.

During an interview with RN #103, they stated it was an expectation that the specific assessment was to be completed for all required timelines whether the resident was asleep or not

RN #103 acknowledged that the home did not follow their policy related to the completion of the specific assessments for resident #005

b) The LTCH Inspector reviewed the clinical record and was unable to locate any follow up fall notes as per the home's policy for resident #005.

During an interview with RN #103, they stated it was expected that a fall follow up progress note be completed for three shifts following the fall using the

appropriate progress note for that purpose.

The LTCH Inspector and the RN reviewed the clinical record for resident #005 and found that following the fall on an identified date in July 2018 the required fall follow up notes for three shifts following the fall were not completed.

RN #103 acknowledged that the home failed to follow their policy related to post fall follow up progress notes.

3) On an identified date in April 2018, resident #003 had an unwitnessed fall resulting in a specific injury.

a) The Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record and found a specific assessment form dated for an identified date in April 2018.

During a review of the specific assessment form by the LTCH Inspector, it was noted that assessments were not completed for three required dates and times.

During an interview with RN #103, they stated it was an expectation that the specific assessment was to be completed for all required timelines.

RN #103 acknowledged that the home did not follow their policy related to the completion of the specific assessments for resident #003.

b) The LTCH Inspector reviewed the clinical record and was unable to locate any follow up fall notes as per the home's policy for resident #003.

During an interview with RN #103, they stated it was expected that a fall follow up progress note be completed for three shifts following the fall using the appropriate progress note for that purpose.

The LTCH Inspector and the RN reviewed the clinical record for resident #003 and found that following the fall on an identified date in April 2018 the required fall follow up notes for three shifts following the fall were not completed.

RN #103 acknowledged that the home failed to follow their policy related to post fall follow up progress notes. [s. 8. (1) (a),s. 8. (1) (b)]

The severity of this issue was determined to be a level 2, minimal harm or potential for actual harm. The scope of the issue was a level 3, widespread as it related to three of three residents reviewed. The home had a level 3 compliance history, previous related non-compliance that included:

- a Voluntary Plan of Correction (VPC) was issued January 9, 2017 during inspection # 2017_595604_0001.

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2018

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

Ministére 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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Order / Ordre :

The licensee must be compliant with s. 48 (2) of O. Reg. 79/10.

Specifically the licensee must:
a) Ensure the home develops and provides a screening protocol for the assessment of fall risk.
b) Assess resident #001 and any other resident for risk of falls and include the fall risk in the resident's plan of care.

Grounds / Motifs :

1. The licensee failed to ensure that the fall prevention program, in addition to the requirements set out in section 30, provided for screening protocols.

During an inspection related to fall prevention for residents #001, #003 and #005, the Long-Term Care Home (LTCH) Inspector reviewed the clinical records to determine the resident's assessed fall risk score. There were no assessment tools within the documentation system of PointClickCare nor in the written clinical records for the three residents being inspected.

The LTCH Inspector interviewed the Fall Lead who was not aware of any tool that the home used to determine risk for falls. They stated that all new admissions were assumed to be high risk for falls but after that there was no tool available to determine the risk of falls for a resident.

During an interview with the Administrator, they told the LTCH Inspector that when they inquired of the registered staff, they said they go on the internet to see how to do a fall risk assessment. They weren't aware of any tool available in the home.

The Administrator acknowledged the home did not have any screening protocols to determine risk for fall of their residents. [s. 48. (2) (a)]

The severity of this issue was determined to be a level 2, minimal harm or potential for actual harm. The scope of the issue was a level 3, widespread. The home had a level 2 compliance history, previous unrelated non-compliance. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2018

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

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

Specifically the licensee must:
a) Ensure that residents #001, #002 and #003 and any other resident receive a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument specifically designed for skin and wound assessment for altered skin integrity to include skin breakdown, pressure ulcers, skin tears or wounds.

Grounds / Motifs :

1. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

a) On an identified date in June 2018, resident #001 fell. On a second date in June 2018, resident #001 fell a second time resulting in altered skin integrity on two locations.

The Long-Term Care Homes (LTCH) Inspector reviewed the resident's clinical record and found that no skin/wound assessment had been completed for either of the areas of altered skin integrity that occurred as a result of the second fall.

During an interview with RN #103, they stated it was an expectation that a skin/wound assessment be completed for both areas of altered skin integrity.

The home's policy "Resident Rights, Care and Services – Required Programs – Skin and Wound Care – Program", Version 4 with a revised date of February 28, 2018, directed staff to complete a wound assessment and treatment record for all areas of altered skin integrity followed by an appropriate weekly assessment found in the progress notes of PCC.

During an interview with RN #103, they told the LTCH Inspector it was expected for any altered skin integrity that a wound assessment in the assessment section of PCC be completed. For the both areas of altered skin integrity, a weekly wound note in the progress notes was to be completed.

The clinical record was reviewed with RN #103 who acknowledged that both

areas of altered skin integrity for resident #001 that was a result of the fall in June 2018, had not been assessed using a clinically appropriate assessment instrument specifically designed for skin and wounds.

b) On an identified date in August 2018, the Long-Term Care Homes (LTCH) Inspector observed resident #003 and noted several areas of altered skin integrity.

The LTCH Inspector reviewed the resident's clinical record and noted the plan of care included a focus of interference in structural layers of the skin. There were directions to observe, document and follow the treatment record. The most recent Minimum Data Set (MDS) assessment completed, noted the resident had areas of altered skin integrity.

During an interview of RN #109 they told the LTCH Inspector that a wound/treatment assessment was to be completed for the areas of altered skin integrity and a wound note weekly thereafter. There were no wound/treatment initial assessment completed related to the altered skin integrity.

The LTCH Inspector interviewed RN #103 who stated that a wound/treatment assessment was expected to be done related to the altered skin integrity. The clinical record was reviewed with the LTCH Inspector and there were no wound/treatment notes included in the record for the altered skin integrity.

The RN acknowledged the home had not assessed the altered skin integrity using their clinically appropriate assessment instrument specifically designed for the assessment of skin and wound.

c) On an identified date in April 2018, a PSW informed RPN #111 that resident #002 had new areas of altered skin integrity.

On an identified date in May 2018, RPN #112 noted there was another area of altered skin integrity.

On a second date in May 2018, RPN #108 documented there was an third area of altered skin integrity.

During an interview with RPN #108, they stated that for any areas of altered skin integrity, it was expected that a wound and treatment assessment be completed

as found in the assessment tab in PCC followed by weekly wound assessments.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record with RPN #108. The RPN reviewed the progress note and confirmed there should have been an assessment as above. The RPN reviewed the assessments both in the assessment tab and in the progress notes and noted there were no required wound/treatment assessments completed.

RPN #108 acknowledged the home failed to assess resident #002's areas of altered skin integrity using the appropriate assessment instrument. [s. 50. (2) (b) (i)]

The severity of this issue was determined to be a level 2, minimal harm or potential for actual harm. The scope of this issue was a level 3, widespread as it related to three of three residents reviewed. The home had a level 4 compliance history, ongoing non-compliance despite previous action taken by the Ministry, that included:

- a Voluntary Plan of Correction (VPC) issued March 21, 2016 during inspection #2016_440210_0004.

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 21, 2018

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must be compliant with s. 52 (2) of O. Reg. 79/10.

Specifically the licensee must:
a) Complete a pain assessment using a clinically appropriate assessment instrument specifically designed for the purpose for residents #001, #002 and #003 and any other resident who has pain not relieved by initial interventions.

Grounds / Motifs :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

a) On an identified date in June 2018, resident #001 fell. On a second date in June 2018, resident #001 fell a second time resulting in altered skin integrity on two areas.

On an identified date in July 2018 resident #001 complained of pain and was administered an analgesic and had a documented pain score of minimum. Later that same day, the resident was still complaining of pain and had no change in their pain score documented in the clinical record. It was documented that the analgesic given earlier was ineffective. A second dose of analgesic was administered for pain with a moderate pain score.

On an identified date in July 2018 the resident complained of pain with a high pain score. Analgesic was administered. The documentation noted this intervention was ineffective. No further interventions were documented.

The LTCH Inspector reviewed the clinical record and noted there were no clinically appropriate assessments completed for the unrelieved pain on the two dates in July 2018.

During an interview with RPN #105, they explained when resident's pain was unrelieved they would notify the physician.

During an interview with the Administrator, they told the LTCH Inspector it was expected that a pain assessment was completed upon admission and when the pain score was four out of ten or higher. At that point it was expected a pain assessment to be completed weekly.

The Administrator acknowledged that when pain was not relieved by initial interventions, the home was not assessing the resident using a clinically appropriate assessment instrument specifically designed for the assessment of pain.

b) Resident #002 had chronic pain.

According to the Medication Administration Record (MAR), the resident was routinely receiving analgesic daily.

On an identified date in April 2018 the resident complained of pain. The resident's pain score was noted to be moderate at this time. The resident was administered a stronger analgesic as a result of the increasing pain with effect.

On an identified date in April 2018 resident #002 complained of pain. Their pain score was noted to be at the highest level. The resident was administered their stronger analgesic as a result of the increasing pain with effect.

The clinical record was reviewed by the Long-Term Care Homes (LTCH) Inspector and a pain assessment related to the unrelieved pain, had not been conducted at either time.

During an interview with RPN #105, they explained when resident's pain was unrelieved they would notify the physician.

During an interview with the Administrator, they told the LTCH Inspector it was

expected that a pain assessment was completed upon admission and when the pain score was four out of ten or higher. At that point it was expected a pain assessment to be completed weekly.

The Administrator acknowledged that when pain was not relieved by initial interventions, the home was not assessing the resident using a clinically appropriate assessment instrument specifically designed for the assessment of pain.

c) Resident #003 had a diagnosis the resulted in pain.

The resident had an analgesic administered daily as a routine and a different analgesic available as needed (prn) for mild pain up to four times daily.

On an identified date in July 2018, resident #003 had a high pain score and the prn analgesic was administered with effect. On a second date in July 2018, the resident had pain at high score and the prn analgesic was administered but ineffective. On an identified date in July 2018 the resident's pain level was moderate to high and the same analgesic was administered with effect. Later that day their pain score was high and the same analgesic was administered and was ineffective. No further treatment was documented.

The LTCH Inspector reviewed resident #003's clinical record and there were no clinically appropriate assessments completed for the unrelieved pain for the two dates in July 2018.

During an interview with RPN #105, they explained when resident's pain was not relieved, the RPN would then notify the physician.

During an interview with the Administrator, they told the LTCH Inspector it was expected that a pain assessment was completed upon admission and when the pain score was four out of ten or higher and when initial interventions were not effective. At that point it was expected a pain assessment to be completed weekly.

The Administrator acknowledged that when pain was not relieved by initial interventions, the home was not assessing the resident using a clinically appropriate assessment instrument specifically designed for the assessment of pain. [s. 52. (2)]

The severity of this issue was determined to be a level 2, minimal harm or potential for actual harm. The scope of the issue was a level 3, widespread as it related to three of three residents reviewed. The home had a level 2 compliance history, previous unrelated non-compliance.
(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 21, 2018

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 3rd day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére 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

Name of Inspector / Nom de l'inspecteur : Heather Preston

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