Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: June 20, 2023	
Inspection Number: 2023-1230-0002	
Inspection Type: Critical Incident System	
Licensee: Stayner Care Centre Inc.	
Long Term Care Home and City: Stayner Care Centre, Stayner	
Lead Inspector Sharon Perry (155)	**Inspector Digital Signature**
Additional Inspector(s) Tanya Murray (000735)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 24 -26, and 29-30, 2023 and offsite on May 31, 2023.

The following intake(s) were inspected:

- Intake: #00086887 regarding an unexpected death of a resident.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

The licensee failed to ensure that every resident has the right to have their personal health information within meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

Rationale and Summary

During the inspection staff shared that they used their personal cell phones to text a physician when they needed to advise the physician of concerns regarding residents. A Registered Nurse (RN) said that they have taken pictures of wounds with their personal cell phones and sent them to a physician.

When staff shared personal health information through text messaging on their personal cell phones, resident's personal health information was not kept confidential in accordance with the Personal Health Information Protection Act, 2004.

Sources: Interviews with RNs and a physician. [000735]

COMPLIANCE ORDER CO #001 Skin and Wound Care

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee failed to comply with s. 55 (2)(b)(ii) of O.Reg. 246/22.

The licensee shall:

a) Develop and implement a process to ensure that communication with the physician regarding residents with altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds is documented in the resident's records to ensure residents receive immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection. At a minimum, the documentation should include the date, time, the concern being communicated, the physician's response, follow-up done to ensure physician's response was actioned and the name of the staff.

b) Develop an audit to ensure that communication with the physician is documented in the resident's records. The audit, at a minimum, will include the date, time, resident's name, issue communicated to physician, how it was communicated, the physician's response and date of response. If deficiencies are identified the audit shall include the corrective actions taken regarding the deficiencies. The audits shall be accurate, completed weekly and kept available in the home until this order is complied.

Grounds

The licensee failed to ensure that a resident with a pressure injury received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Rational and Summary

A resident was identified to have a pressure injury. On the same day, it was recommended that the resident be administered a medication daily to promote better intake for wound healing. The medication was never administered.

Seven days after the pressure injury was identified, a wound care consult was done. It was recommended that the home ask the physician to provide a specific treatment. The physician was not notified of the recommendations until two days later and ordered a treatment. The treatment was not started until four days after the wound consult was completed.

On day eleven, the resident's pressure injury was assessed and there was evidence of infection and increased pain. The physician was not notified and no pain medications were given.

On day fifteen, the resident's pressure injury was assessed and the resident's pain was worse. No pain medications were administered. The wound care specialist reassessed the pressure injury and noted it had deteriorated. They recommended that the physician be contacted. The physician was not contacted until the following day.

On day twenty-one, a call was made to the physician regarding a decline in the resident's status and increased pain. The physician responded the next day and ordered additional pain medication. This was not administered until the following day.

On day twenty-four, the resident passed away.

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The resident not having immediate treatment and interventions to relieve pain, promote healing and address the infection resulting from a worsening wound contributed to the resident's suffering and death.

Sources: resident's clinical records, drug records, physician's communication book, Infection Prevention and Control Daily Surveillance Audit/Log-Residents, resident's Medical Certificate of Death-Form 16; interviews with Director of Care and Physician. [000735]

This order must be complied with by July 24, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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