Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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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
Jan 23, 2019	2018_583117_0007 (A1)	021324-18	Resident Quality Inspection

Licensee/Titulaire de permis

Mohawk Council of Akwesasne
P.O. Box 579 CORNWALL ON K6H 5T3

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

Tsiionkwanonhsote
70 Kawehnoke Apartments Road Akwesasne ON K6H 5R7

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

Amended by LYNE DUCHESNE (117) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

On January 21, 2019, the home's management team made a written requested for a 28 day extension to the January 31, 2019 compliance due date for CO #003 related to Staffing Plans and CO #004 related to Skin and Wounds issued on October 30, 2018 under inspection #2018_583117_0007. The extension was granted and the new compliance due date for CO #003 and CO #004 is now February 28, 2019.

Issued on this 23rd day of January, 2019 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Amended by LYNE DUCHESNE (117) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 20, 21, 22, 24, 27, 28, 29, 30, 31, September 4,5,6,7,9,10 and 11, 2018

It is noted that the following inspections were conducted concurrently with the

Resident Quality Inspection and included in this inspection report:

- Log # 025797-16: Follow up inspection related to compliance order CO #003 related to O.Reg. s. 212 (4) - Administrator issued under inspection # 2016_284545_0022 issued August 19, 2016, with a compliance due date of June 30, 2018

- Log #007956-18: Follow up inspection related to compliance order CO #001 related to O.Reg. S. 53(4) (c) - Responsive Behaviours issued under inspection # 2018_619550_0003 issued March 23, 2018, with a compliance due date of April 27, 2018

- Log# 008134-18: Follow up inspection related to compliance order CO #002 related to LTCHA s. 19 - Duty to Protect issued under inspection # #2018_619550_0004 issued April 20, 2018, with a compliance due date of July 6, 2018

- Log # 008133-18: Follow up inspection related to compliance order CO #001 related to O.Reg. S. 213 (1) - Director of Care issued under inspection # 2018_619550_0004 issued April 20, 2018, with a compliance due date of July 13, 2018.

- Log # 008466-18: CIS # 2800-000011-18 related to resident transfer to hospital resulting in a change in condition

- Log #004640-18, CIS # 2800-000005-18, Log #006500-18, CIS # 2800-000006-18 and log #020961, CIS # 2800-000013-18 related to alleged incidents of staff to resident verbal/emotional abuse

- Log #24474-18, CIS # 2800-000014-18 related to an alleged incident of staff to resident neglect

- Log # 007320-18, CIS # 2800-000007-18 related to an alleged incident of resident to resident physical abuse

- Log # 013715-18, CIS # 2800-000012-18 related to a resident transfer to hospital resulting in a change in condition

- Log # 024676-18, CIS # 2800-000015-18 related to an unexpected death

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, RAI Coordinator, the Food Service Dietary Manager, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), the Restorative Care Behavioural Support Ontario PSW, the Education & Recreation Manager, several Dietary Aides, several housekeeping staff members, several maintenance staff members, the Financial Clerk, the Administrative Assistant, the Resident Council Co-Chair as well as several family members.

In addition, during the course of the inspection, the inspectors reviewed several resident health care records, observed the provision of resident care and services, observed the provision of several lunch and evening meal services, observed resident rooms, tub/shower rooms as well as resident common areas, observed the provision medication administration, reviewed the medication management system, reviewed the registered nursing and non-registered nursing staffing schedules, registered nursing staff daily shift duties procedures, reviewed the home's policy "Resident Services:4.6 Transfer and Mobility-SHARP Program" revised 03/08, "Infection Control: 6. Environmental Controls", revised 03/17, "Infection Control:3.3 Standard Precautions", revised 03/17, "Fire Safety and Evacuation Manual", revised October 2017, Medical Pharmacies policy "Section 9-1 Medication Incident Reporting", revised 01/18, "Resident Services:4.13 Palliative Care",revised 03/08, "Resident Services: 4.16 Wound and Skin Care Program, 4.16.10 Assessing Impaired Skin", revised 03/08, "Resident Services: 4.1 Resident Rights and Safety, 4.2 Abuse", revised March 2018, the newly hired nursing staff Orientation and ongoing staff Education Plan as it relates to Resident Rights and the Zero Tolerance for Abuse, internal incident reports, medication incident reports, as well as Resident Council Meeting Minutes from January 1 2018 to August 2018.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **21 WN(s)**
- **17 VPC(s)**
- **4 CO(s)**
- **3 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 212. (4)	CO #003	2016_284545_0022	117
O.Reg 79/10 s. 213. (1)	CO #001	2018_619550_0004	117
O.Reg 79/10 s. 53. (4)	CO #001	2018_619550_0003	117

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #023 was protected from abuse by anyone and free from neglect by the Licensee or staff in the home. (Logs # 020961-18 and 006500-18)

In accordance with O.Reg.79/10 s.2 (1) defined physical abuse as:
a) the use of physical force by anyone other than a resident that causes physical injury or pain.

In accordance with O.Reg.79/10 s.2(1) defined verbal abuse as:
a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

On April 20, 2018 the Licensee was issued a compliance order (CO) #002 regarding duty to protect s.19(1) whereby the Licensee was to protect residents from abuse by anyone and shall ensure that residents are not neglected by the Licensee or staff with a compliance date of July 13, 2018. Inspector #547 completed a follow-up to this compliance order which specified the following:

1. Specific actions were to be taken by the Licensee to ensure that every alleged, suspected or witnessed incidents of abuse of a resident by anyone was immediately reported to the Director.

Resident #023 had two of the three incidents identified in WN # 8, LTCHA s. 24, of this report, that were not immediately reported to the Director as required.

2. The revised policy required by this order was required to be communicated to staff and their level of knowledge to be assessed to ensure compliance with s.24 of the LTCHA by developing a monitoring process to ensure staff training was completed.

As identified in WN # 12, LTCHA s. 76, of this report, two nursing staff member as well as four other nursing staff members new to the home or returning to work from an extended leave of absence, were not communicated this revised policy, or the requirements for mandatory reporting as required.

The DOC indicated that education and communication of the revised policy and procedure for Zero tolerance of Abuse and Neglect was not communicated to three nursing staff in the home being a Personal Support worker, an RPN and an RN. The DOC was supposed to follow-up with these nursing staff members regarding this mandatory training however has not done this to date. The DOC indicated these staff members have been working with residents in the home since the mandatory training took place, but has not taken the time to follow-up with these three staff members.

This area of the compliance order also required that staff report every alleged, suspected or witnessed incidents of abuse or a resident as required. As identified in WN # 11, LTCHA s. 20, of this report, two incidents of staff to resident neglect of residents care needs that the Licensee and staff were aware of, was not reported as required.

Further to this compliance order:
- Resident #023 had incidents of staff to resident neglect of personal care needs that was not investigated as identified in WN # 13, LTCHA s. 23,
- These incidents of neglect were not reported to the appropriate police force as identified in WN # 15, O.REG. s. 98,
- The licensee or staff in the home did not follow the Licensee's policy and procedure for Zero Tolerance of Abuse as identified in WN # 11, LTCHA s. 20, and
- The licensee did not follow-up to investigations with the resident's SDM as identified in WN #14, O.REG. s. 97.
- The licensee failed to ensure that the home's policy to promote Zero Tolerance to Abuse and Neglect of residents is posted in the home. WN # 13 LTCHA s. 79 (3) (c)

As such, resident #023 was not protected from verbal and physical abuse by PSW #141 or free from neglect by the Licensee or staff on three separate occasions in the home between two specified dates in 2018 as identified in this report

It is noted that a compliance order CO #002 for LTCHA s. 19 Duty to Protect was issued under inspection # 2018_619550_0004 on April 20, 2018 with a compliance due date of July 6, 2018. It is noted that based on the above information, this order is being re-issued. [s. 19. (1)]

Additional Required Actions:

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

DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure where bed rails are used, the residents are assessed and bed systems are evaluated in accordance with evidence-based

practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

During the stage one observations, the inspectors noted of the twenty residents observed, that nineteen residents utilized quarter or three-quarter bed rails at all times when in bed. Residents #002, #007 and #012 health care records were reviewed and observations were made. The bed rails for these three residents were observed to be used daily when the residents are in bed and the care plans indicated the need for bed rails for mobility of these resident's while in bed.

In August 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones one -seven), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones one -- four), and prescribes test tools (cone and cylinder tool with spring scale) and methods to measure and assess gaps in some of the potential entrapment zones (Zones one - four).

The HC guidance document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the HC guidance document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003) (FDA 2003 clinical guidance document). This document provides necessary guidance in establishing a clinical assessment where bed rails are used and directs that the automatic use of bed rails is to be avoided as this may pose unwarranted hazards to resident safety.

The inspector was directed to speak with maintenance staff #108 in regards to bed rails as RPN #100 indicated that nursing staff are not required to assess residents for entrapment zones related to bed systems. RPN #100 indicated the residents are all assessed for their personal need for rails, and added to the plan of care accordingly. The inspector requested the documented assessment of the resident bed system including any steps to prevent bed entrapment. Maintenance staff #108 was unaware of any assessment completed related to the use of bed rails and stated the home does not complete these assessments.

The DOC and the Administrator were both interviewed and indicated to inspector #547 they were unaware these assessments were required for residents that utilize bed rails. They further indicated there has been no bed system evaluation completed to include prevention of resident entrapment. The DOC confirmed the majority of the residents in the home utilize bed rails as they are attached to the bed frames.

As such, the Licensee has failed to ensure that where bed rails are used, that the resident's bed system is evaluated in accordance with evidence- based practices and, if there are none, in accordance with prevailing practices, to minimize risk to residents including steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment with bed rails as required by this section. [s. 15. (1) (a)]

2. The licensee has failed to ensure where bed rails are used, the residents are assessed and bed systems are evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Resident #007's plan of care indicated the resident requires the use of two full bed rails when in bed to prevent falling out of bed as restraint.

Resident #007 indicated to inspector #547 on August 29, 2018 they use the bed rails when turning from side to side during the provision of personal care by nursing staff.

PSW #120 indicated the resident is not known to climb out of bed and does not move in bed unless nursing staff ask the resident to grab the bed rails. PSW #120 indicated the resident's bed rails have always been attached to the resident's bed and they have always been placed in the up position when the resident went to

bed since admission. PSW #120 further indicated resident #007 does not have the force to get of bed anymore independently and possibly no longer requires the bed rails.

As such, resident #007's was not assessed and their bed system was not evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)]

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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan: (a) provide for a staffing mix that is consistent with residents' assessed care and safety needs, (d) include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage) (e) get evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's staffing plan was reviewed with the DOC. The home's staffing plan indicated that the following number of staff are to work during a 24 hours period of time:
- RNs work 12 hour shifts, from 0700 hours to 1900 hours, and then 1900 hours to 0700hours
- Day Shift – 0700 hours to 1500 hours : 2 RPNS and 5 PSWs
- Evening Shift – 1500 hours to 23 hours : 2 RPNS and 5 PSWs
- Night Shift – 2300 hours to 0700 hours : 3 PSWs

On August 31, 2018, it was noted by inspectors #117 and #547 that the home was working short staffed (less staff that what is identified in their staffing plan) during the day shift. Both inspectors had been conducting interviews with residents and staff when it was noted that the home had 1 RN, 1 RPN and 3 PSWs working the day shift. There was no staff present to cover for 1 RPN and 2 PSWs positions that day shift.

RN #102, who was the RN in charge, was aware that the day shift was short 3 staff members. The RN #102 said to the inspectors that they had not attempted to contact any staff on the home's staffing list to replace some or all of the open shifts, as they assumed the role and functions of the missing RPN to provide resident care instead of trying to try to find replacement staff. The RN #102 said that they had not advised either the DOC or the home's Administrator when they arrived at the home of the staffing issues. RN #102 said that the RN in charge do not report on a daily basis any staffing issues e.g. missing staff, to the home's DOC or Administrator. It is noted that the home's DOC and Administrator were made aware by the inspectors that the home was short staffed by 1 RPN and 2 PSWs shortly after becoming aware of the situation. Both the DOC and Administrator said that they were not aware of the home being short staffed that day and that they do not inquire with the RN in charge as to the status of the daily nursing staffing plan. It is noted that the DOC did contact various staff members on their staffing list and was able to get a PSW to arrive within one hour to come and work one of the unfilled PSW shifts.

On August 31, 2018, the home's day shift staffing mix (O.Reg. s. 31 (3) a)) was not consistent with the assessed care and safety needs of several residents. RPN #115, PSW# 136, #104, and # 123 said to the inspectors that the following residents care was not given as per their plans of care.

- Residents #001, #024, #025 and #026 all require a 2 person mechanical lift transfer to get up from bed to their mobility devices. They all reside on a resident care unit where there are usually 2 PSWs to provide care and services. On August 31, 2018, the home only had 1 PSW working on this unit as the home was short staffed. The above residents were transferred into their mobility devices with the use of a mechanical lift by PSW #104. No other staff came to assist PSW #104 with these transfers. It is noted that the residents did not sustain any injuries during the transfers.

- Residents #015, #016, # 018, #027, #010 and #028 are all cognitively impaired

and cannot or have difficulties expressing their personal care wishes. The residents plans of care identify that the residents morning care are to given by the day shift. On August 31, 2018, the above residents were washed, dressed and returned to bed by the night shift, prior to the start of the day shift. As per RPN #115 this was done to assist the day shift with the provision of resident care as the home was short staffed that day.

On September 6 and 7, 2018, the RNs in charge #102 and#121, were aware that the home was going to be short 3 evening PSW positions for the weekend shifts of September 8 and 9, 2018. The one of the two other staff members scheduled to work that weekend was identified as requiring modified work provisions and was not able to assist with the lift and transfers of residents. The RNs did communicate the staffing issue to the DOC on both days. The actual staffing complement for the evening shifts of September 8 and 9, 2018 was as follows:

September 8, 2018
- 1 RN from 1900 hours to 0700 hours
- 2 RPN from 1900 hours to 2300 hours
- 4 / 5 PSWs present – One evening PSW shift was not replaced. It is noted that 1 PSW did a double shift, 2 worked from 0700 hours until 2000 hours and the 4th PSW was on modified work duties.
- Only 2/4 PSWs were present from 2000 hours until 2300 hours.

September 9, 2018
- 1 RN from 1900 hours to 0700 hours
- 1 RPN from 1900 hours to 2300 hours – one RPN position not replaced
- 5 PSWs present – it is noted that 2 were doing double shifts, 2 worked until 2000 hours and the 5th PSW was on modified work duties.
- Only 3/5 PSWs were present from 2000 hours until 2300 hours.

On September 8 and 9, 2018, the home's evening shift staffing mix (O.Reg. s. 31 (3) a)) was not consistent with the assessed care and safety needs of several residents. PSWs #106, #138, #123 and #129 said to the inspector that the following residents care were not given care as per their plans of care.

- Residents #036, #016, #023, #037, #038, #013, #039, #015, #002, #008, #028, #024, #030, #025 all require a 2 person mechanical lift transfer from their beds to their mobility devices. The above residents were transferred to their beds with the use of a mechanical lift operated by one either PSWs # 106, #138 or #123 as they

were working short staff and staff # 139 is unable to assist with transfers. It is noted that the residents did not sustain any injuries during the transfers.

The staffing plan was reviewed with the home's DOC. As per the DOC, the DOC plans the monthly nursing staffing schedule. Once the monthly schedule is completed, it is the RN in charge who is then responsible to ensure that any new staff leave or unfilled shift is staffed.

RN #102 and #121, who are regularly the RN in charge, said that they have to adjust on a daily basis their nursing responsibilities to the residents and the need to ensure that the home has a full nursing staffing complement on each shift. The RNs expressed concern that they do not have time to do their nursing responsibilities when they have to oversee staffing replacement needs. On September 7th, RN #102 expressed this concern to the inspector when resident #040 required post fall assessments and but the RN also needed to contact some PSWs to see if they could fill one or more evening shifts for September 8 and 9 2018 (see above re September 8 -9 staffing). The DOC, RNs #102 and #121 said that they do not communicate with each other on a daily basis to discuss or review the home's daily nursing staffing plan.

As per the DOC, the home has a fixed number of nursing staff both full time and part time. The home does not have any staff that have a "casual" designation on their staffing list, nor do they use an external staffing agency should they be short staffed.

When asked when was the home's nursing staffing plan and associated roles and responsibilities were last reassessed, the DOC said that to their knowledge the staffing plan has not been reassessed for several years. The DOC also said that the division of roles and responsibilities of the DOC and the RN in regards to the development, overseeing and management of the nursing staffing schedule has also not been reviewed or revised for several years.

As such, the home's staffing plan has not been evaluated and updated at least annually.

Further to this compliance order:

- a finding of non-compliance is being issued under WN # 12 LTCHA s. 76 (2) (3 &4) as it relates to staff did not receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities

Further to this compliance order:

- a finding of non-compliance is being issued under WN # 12 LTCHA s. 76 (2) (3 &4) as it relates to staff did not receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities. [s. 31. (3)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 003

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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,
(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;
O. Reg. 79/10, s. 50 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff (ii) upon any return of the resident from hospital.

Resident #028 sustained a skin integrity injury to an identified body part that required a medical intervention on a specified day in 2018. The resident's plan of care was reviewed and revised post injury to include a skin and wound care treatment and dressing 9 days later by the home's RAI Coordinator. Further review of the resident's health care record shows that the resident's wound was assessed by the attending physician two days after the injury. No other information was found in the resident's health care record indicating the resident's wound was assessed using a clinically appropriate instrument upon return from the hospital on a specified day in 2018. Progress notes document that the

resident's wound was noted to have a change in condition on a specified day. The attending physician was notified that same day and a medication and new dressing treatment were ordered and implemented. The first wound assessment to be documented using the home's weekly wound assessment was done 12 days and then 23 days after the injury occurred.

The home's DOC said that nursing staff are to assess resident wounds immediately upon start of the wound, in the case of resident #028 when the resident returned from hospital and then weekly thereafter. The DOC said that home's nursing staff are to use to weekly wound assessment in Point Click Care (PCC). The home's DOC said that resident #028's wound was not assessed upon return from hospital on a specified day in 2018 nor weekly thereafter. [s. 50. (2) (a) (ii)]

2.The licensee has failed to 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).

As it relates to r. 50. (2) (b) (i), the licensee has failed to ensure that 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.

1) Resident #028 sustained a skin integrity injury to an identified body part that required a medical intervention on a specified day in 2018. The resident's plan of care was reviewed and revised post injury to include a skin and wound care treatment and dressing 9 days later by the home's RAI Coordinator. Further review of the resident's health care record shows that the resident's wound was assessed by the attending physician two days after the injury. No other information was found in the resident's health care record indicating the resident's wound was assessed using a clinically appropriate instrument upon return from

the hospital on a specified day in 2018. Progress notes document that the resident's wound was noted to have a change of condition on a specified day. The attending physician was notified that same day and a medication and new dressing treatment were ordered and implemented. The first wound assessment to be documented using the home's weekly wound assessment was done 12 days and then 23 days after the injury occurred.

The home's DOC said that nursing staff are to assess resident wounds immediately upon start of the wound, in the care of resident #028 when the resident returned from hospital and then weekly thereafter. The DOC said that home's nursing staff are to use to weekly wound assessment in Point Click Care (PCC). The home's DOC said that resident # 28's wound was not assessed upon return from hospital on a specified day in 2018 nor weekly thereafter. r. 50. (2) (b) (i) (547)

2) Resident #004's health care records were reviewed by inspector #547 on August 29, 2018 regarding skin and wound care related to a pressure ulcer. Resident #004's Treatment Administration Record (TAR) documented the physician's order to have a wound treatment to cleanse the wound with normal saline, then apply a specific treatment product and to cover with another type of dressing daily, for two identified months in 2018. Documented weekly wound assessments were reviewed in the home's electronic documentation system with the Director of Care (DOC) whereby for the two identified months wound assessments using the Licensee's clinically appropriate assessment instrument were completed on two days in one month and then on two days in the second month. These weekly skin assessments identified deterioration to the resident's wound between two identified dates over a six week period.

The DOC indicated to inspector #547 on September 4, 2018 if the assessment was not documented in the electronic documentation system, that the assessment was not completed. The DOC indicated the weekly wound assessments are supposed to be documented every Wednesday. The home's expectation was to have weekly wound assessments for follow up with treatment plan with the weekly visits with the home's physician.

As such, resident #004 who exhibited altered skin integrity of a wound did not receive weekly assessments using the clinically appropriate assessment instrument for three identified weeks in 2018. A Skin assessment instrument was completed on a specified day in the second month, however was not completed

again until 13 days later which was the last assessment documented in the home, to date during the review period. r. 50. (2) (b) (i) (547)

As it relates to r. 50. (2) (b) (ii), the licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required r. 50. (2) (b) (ii)

1) Resident #035 was admitted to the home in on a specified day in 2018 with a pressure ulcer to an identified region. Over the next two months, new pressure ulcers developed, one to an identified region noted on a specified day and one to another identified region that was noted 14 days later.

The resident's plan of care was reviewed and revised on the day the last pressure ulcer was identified to include changes to the skin and wound care treatment. The previous wound treatment dressing q2 days was discontinued. A new treatment order for cleansing the wound with NSS with the application of a specialised dressing q2 days was prescribed by the attending physician. A review of the resident's electronic Treatment Administration Record (eTAR) indicated that the new treatment and dressing order was changed on four (4) identified dates that were not at q2 day intervals. No other documentation was found in the resident's health care record to indicate that the wound care treatment and dressing was done as per the medical order.

On a specified date, resident #035's wound, which was assessed as having progressed and was presenting with drainage, was reassessed by the attending physician. A new skin and wound care treatment with a specialized dressing to be done daily was ordered. A review of the resident's eTAR showed that the new treatment and dressing was not done during the next four days. No other documentation was found in the resident's health care record to indicate that the wound care treatment and dressing was done as per the medical order.

RN #102 and the DOC said that on both the two identified days that new wound treatments were ordered, the home did have the necessary treatment and dressing supplies in the home to initiate the new skin and wound care orders. They also said that the first wound treatment and dressing order, ordered on a specified day, was identified in the eTAR that same day. However as per RPN staff #113 and #115, the eTAR identified the treatment as "being on order" and nursing staff could not document when dressing changes were done in the eTAR.

The only way to document would be to document in the progress notes. RN #102 and the DOC said that they could not recall and have no information as to if the new wound treatment and dressing order was done other than on the documented on four identified days. In regards to the second wound treatment and specialized dressing, the order was clearly documented in the eTAR as being "active". RN #102 and the DOC said that they could not recall and have no information as to if the new wound treatment and dressing order was done on the four days post change of the wound treatment order.

As such, resident #035 did not receive immediate treatment and interventions to their wounds, as per two specified medical orders. r. 50. (2) (b) (ii) (547)

2) Resident #004's health care records were reviewed regarding a wound for two identified months in 2018. The Treatment Administration record (TAR) documented the physician's orders for the wound to cleanse the wound with normal saline, then to apply a specific treatment dressing and to cover with another type of dressing daily that was due at 2000 hours daily. The TAR indicated that the resident's dressing was not completed and unsigned on 13 of 31 days for specified month and on six of the 29 days reviewed in another month.

RN #102 indicated the wound assessments are to be completed weekly by the Registered Practical Nurses working with resident #004 during the evening shifts. RN #102 indicated that the TAR is required to be signed once the wound treatment is completed as ordered. RN #102 further indicated if the TAR is unsigned, that the dressing was not completed as ordered.

Inspector #547 observed on August 27, 2018 with RN #102 and RPN #126 to not have the appropriate medical product for resident #004's wound care treatment as ordered. RPN #126 indicated that the medical treatment product required was a specific product, however the home did not have this product in stock and were replacing this product with a another product that the RPN's are altering to dress the resident's wound. RPN #126 indicated concern for resident #004's wound as it was deteriorating.

On August 31, 2018 the Director of Care (DOC) indicated not being aware that the registered nursing staff were not utilizing the appropriate medical product for resident #004's wound treatment and likely ordered the wrong product. The DOC confirmed that the last time the resident would have received the appropriate treatment product would have been on a specified date in 2018. DOC indicated

that they did not provide any direction to staff what to use in the interim. The DOC indicated the registered nursing staff adapted the treatment product without informing the DOC or the physician. The resident's physician was informed by RN #102, on a specified date, who then ordered to hold the resident's specific wound treatment and would reassess the resident's wound the following day.

As such, the resident's treatment and interventions ordered for a wound was not completed daily or with the appropriate medical product as prescribed. r. 50. (2) (b) (ii) (117)

As it relates to r. 50. (2) (b) (iv), the licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #035 was admitted to the home on a specified date in 2018 with a stage 2 pressure ulcer to an identified region. Over the next two months, new pressure ulcers developed, one to an identified region noted on a specified day and one to another identified region that was noted 14 days later. Nineteen (19) days later, one of the wounds was noted to have a deteriorating change in condition.

The resident's plan of care was reviewed and revised on the day the last pressure ulcer was identified, to include changes to the skin and wound care treatment and dressing and again 19 days later to include a medication treatment and a specialized dressing for the wound. Further review of the resident's health care record shows that the resident's wound was assessed by the attending physician on a specified day after the development of the last pressure ulcer as well as 19 and 26 days later when one of the wounds presented with foul odours and drainage.

As part of the home's skin and wound care program, residents exhibiting altered skin integrity, including pressure ulcers and wounds are to be assessed and reassessed by a member of the home's registered nursing staff using a clinically appropriate assessment tool on a weekly basis, if clinically indicated. A review of the resident's health care record found that the resident's wound was assessed at the time of admission. The resident was not assessed for the next 10 days until a specified day in 2018. The wound was then assessed four (4) days and then 16 days after the specified day of assessment. The next documented wound assessment by registered nursing staff was done on a specified day, one month

after the last weekly skin assessment was done and also when the pressure ulcers were noted to have foul odours and drainage.

The home's DOC said that the home's nursing staff are to use weekly wound assessment in PCC. The home's DOC said that resident # 035's pressure ulcers should have been assessed weekly as the resident was admitted with a pressure ulcer and was identified as being at risk for increased skin integrity alterations. The DOC said that the development and progression of the new pressure ulcers should have been reassessed weekly to ensure the appropriate treatments and monitoring of the resident's wounds. r. 50. (2) (b) (iv) (117)

Further to this compliance order

- findings of non-compliance under WN # 5 LTCHA s. 6 (10) b) are issued in regards the licensee failed to ensure that when the residents are reassessed and the plan of care reviewed and revised, at least every six months and at any other time, when the residents care needs change or care set out in the plan is no longer necessary as it relates to three residents that have skin and wound care issues.

- findings of non-compliance under WN #19 O.REG. s. 229 (4) are issued in regards that the licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program. [s. 50. (2) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 004

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff (ii) upon any return of the resident from hospital, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to

staff and others who provide direct care to the resident related to continence.

On a specified day in 2018, resident #002's plan of care regarding continence care indicated the resident required to be toileted before and after meals as well as at bedtime or any other time requested. Record review of the last fourteen days for bladder continence indicated the resident is incontinent on all shifts during this period. The resident's current care plan documented that toileting times were established based on resident trigger of meals. The resident wears a continence brief at all times as well. The resident utilizes a urinal when in bed.

On August 28, 2018 PSW #116 and #118 indicated to inspector #547 that the resident was incontinent, and was only toileted after supper meal when the resident requests it for bowels. Inspector #547 asked the PSW's to show the writer the resident's plan of care related to bladder continence, and it was noted that PSW's are provided the resident's kardex only in the electronic document sharing system in the home. The resident's kardex did not contain information regarding the resident's toileting program required for bladder continence.

On August 30, 2018 the Director of Care (DOC) indicated that the home will have to review the resident care plans to ensure that resident #002's kardex contained the resident's care requirements regarding toileting as the kardex did not contain the staff direction for the toileting program for bladder continence.

As such, PSW's being the direct care staff in the home regarding toileting of residents, were not provided the information in resident #002's care plan that set out the clear directions to direct care staff regarding the resident's toileting program. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #018's plan of care related to toileting for urinary continence needs set out clear directions to direct care staff who provide care to the resident.

Resident #018 was admitted to the home on a specified day in 2018 with several medical diagnoses including a recent injury, as well as several medical co-morbidities and surgical history. Resident #018 was admitted with a medical device in place that was discontinued the day after admission and required to be monitored for voiding pattern.

On a specified day in 2018, the resident's Substitute Decision Maker (SDM)

indicated to inspector #547 that a six-week care conference was held in the home regarding resident #018 care needs and services. The SDM identified a concern that the resident complained daily during SDM visits for the need to go to the bathroom to void and the interdisciplinary team said they were going to try to arrange more bathroom checks for the resident as a result. The SDM indicated this has not changed, or improved since that meeting and wondered if the resident was ever toileted unless the SDM requested this.

The resident's plan of care identified two nursing staff total assistance for the entire process to take to bathroom, transfer on and off toilet, ensure safety, provide hygiene, apply product, adjust clothing, and wash hands. It was noted in the plans of care that Personal Support Workers (direct care staff for residents in the home) had access to the resident kardex and point of care flow sheets. The resident's plan of care further indicated urinary continence interventions that were added six (6) weeks post admission. This intervention documented that resident #018 required bladder retraining to potentially restore function due to the resident's inability to control urination and to re-establish bladder function. Nursing staff were to encourage increased fluid intake between 0600 and 2000 hours, encourage toileting every two hours and monitor effectiveness. It was noted during this observation of documented plan of care, that direct care staff had access to the toileting intervention information in their point of care system, however they did not have the bladder retraining interventions that were updated six (6) weeks post admission after the resident care conference.

Resident #018's care flow sheets for continence identified incontinent for a period of fourteen days from mid to the end of a specified month in 2018.

On August 30, 2018, PSW #125 indicated to inspector #547 that the resident is known to ask frequently to go to the bathroom to void and the resident is mainly incontinent. The resident was not toileted as they only change the resident's brief when soiled. PSW #125 said they were not aware of a retraining program for resident #018 or that the resident was on any toileting routine. The resident is toileted usually before bed at night for bowel routine, but that is all.

As such, the resident's plan of care did not set out clear directions to direct care staff that resident #018 required a toileting plan for bladder retraining. [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff and others involved in the different

aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Resident #007 was admitted to the home on a specified day in 2017 with several medical diagnoses including a neurological disease. The resident requires assistance for all activities of daily living and cueing and assistance for repositioning. Resident #007 received a new manual wheelchair in a specified month, in 2018, for the resident's needs, however has been observed by nursing staff in the home to be leaning to one side and forward in the wheelchair.

Over the course of this inspection, it has been observed daily that resident #007 leans forward and to one side when seated in the manual wheelchair and complaining of pain to various body areas.

On August 29, 2018 inspector #547 reviewed the resident's progress notes that documented on a specific day in 2018, the Physiotherapist in the home assessed the resident's seating in this manual wheelchair and documented the resident was observed leaning towards one side. The Physiotherapist recommended to provide a small pillow or a folded towel between the side of the resident's trunk and wheelchair armrest to reduce discomfort.

On August 30, 2018, PSW #123 and PSW #124 indicated to inspector #547 that they had no idea about this intervention for seating for this resident, and that it was never added to the resident's plan of care.

Inspector #547 interviewed the physiotherapist who could not remember which nursing staff member they had spoken too about this added intervention as it was not documented. The physiotherapist was not aware that this intervention recommendation was not added to the resident's plan of care. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the care set out in the plan of care for resident #032, was provided to the resident as specified in the plan.

Resident #032 was observed by Inspector #547 on September 6, 2018 at 1145 hours seated in the front lounge of the home, eating a lunch meal at a table alone. Resident #032 has been observed by the inspection team over the course of this inspection to be seated at the front lounge for lunch meals on specified days. Inspector #547 was located inside a room next to this lounge at 1145 hours doing

photocopying, when resident #032 was heard coughing. Inspector #547 left the room to observe the resident and see if nursing staff were assisting the resident. No nursing staff were observed in this lounge area at 1148 hours. Resident #032 continued to cough and continued to eat the lunch meal. The resident's cough then settled and inspector #547 returned into the room where the photocopier was and noted RPN #101 arrived in the next room which was the pharmacy to return the medication cart at approximately 1155 hours.

Inspector #547 interviewed RPN #101 regarding resident #032 and the reason the resident is required to eat alone at the table in the front lounge. RPN #101 indicated the resident received the lunch meal earlier than other residents in the home as the resident has to leave for an external medical appointment. Resident #032 regularly goes to external medical appointments. RPN #101 indicated that the resident is known to cough, and likely should have more supervision. RPN #101 indicated the resident appeared fine, and continued to eat the lunch meal at that time. RPN #101 indicated the PSW's do not supervise the resident, as the dietary staff provide the resident's meal. There is no staff constantly monitoring, but the plan is that the RPN in the South wing, is around. RPN #101 was not sure what the resident's care plan indicated for meal supervision, but indicated that the resident was likely a risk for choking.

Inspector #547 reviewed the resident's plan of care related to nutrition and eating needs that identified the resident required to be monitored closely for intake at each meal and snack. Offer substitutes, supplements or alternative choices if eating poorly. Report any decrease in intake to registered staff. Resident requires meal to be set up to open, cut, and spread food and requires intermittent assistance throughout the meal. Eating may be done before scheduled dining room service due to resident's external medical appointments. Resident may eat meals earlier or later than regular scheduled dining room hours related to the external medical appointments. Provide supervision with minimal set up or assistance i.e. cut food for resident. Resident #032's plan of care further indicated the resident has vision impairments, and required staff assistance for orientation of the resident's plate presentation for eating.

On September 7, 2018, RPN #100 indicated resident #032 is seated in the front lounge for lunches in order to receive a meal before their external medical appointments. RPN #100 indicated the resident needs supervision at the lunch meal as the resident is known to eat too fast and causes the resident to cough. RPN #100 has had to ask the resident to eat slower, to prevent choking. RPN

#100 did not recall any instance when the resident would have choked, but is known to cough during meals. The supervision provided to the resident during the lunch meal, and seated in the front lounge, as staff are often in this area. RPN #101 indicated no PSW or RPN is directly assigned to supervise the resident, however they are around. In this situation, there must have been nobody around to remind the resident to slow down.

As such, resident #032 was not provided the supervision and monitoring at the lunch meal as identified in the resident's plan of care. [s. 6. (7)]

5. The licensee has failed to ensure that when the resident is reassessed and the plan of care reviewed and revised, at least every six months and at any other time, when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #028 sustained a skin integrity injury to an identified area that required a medical intervention on a specified day in 2018. The resident's plan of care was reviewed and revised post injury to include a skin and wound care treatment and dressing. No other changes were made to the resident's plan of care. On two (2) specified days in 2018 it was noted that the resident still had a dressing to the identified area and that the resident was receiving full tub baths twice weekly.

PSW #136 and #104 said to the inspector #117 that they did provide full tub baths to the resident. They both said that they apply a plastic barrier to the dressing to prevent the wound and dressing from getting wet. They report doing this since the time of the resident's injury. PSW #136 said that the application of a barrier was initiated by PSW staff and is not identified in the resident's plan of care. Both PSWs said that the resident's bathing needs were not reassessed when the resident sustained their skin integrity injury. A review of resident #028's health care record and plan of care indicated that the resident receives a full tub bath twice weekly. There is no information regarding the use and application of a plastic barrier to the resident's dressing during the provision of baths.

Inspector spoke with RPN # 115 and RN # 102 regarding the revision of resident #028 bathing needs post injury requiring a dressing. Both RPN #115 and RN #102 said that they have never reassessed the resident's bathing needs and wound dressing when there was a change in the residents' skin integrity. [s. 6. (10) (b)]

6. Resident #004 developed a pressure ulcer to an identified region in a specified month in 2017. On a specified day in 2018, the resident still had a pressure ulcer requiring a specialized dressing. The resident's current plan of care for personal hygiene, identified that the resident requires total assistance with their personal care needs and was to have a full tub bath twice weekly.

The resident's current plan of care was reviewed and revised to include a skin and wound care treatment and dressing as well as for a medication intervention in a specified month in 2018. No other changes regarding any other of the resident's care needs were made to the resident's plan of care. On September 10 and 11, 2018 it was noted that the resident still had specialized dressings and that the resident was receiving full tub baths twice weekly.

PSW #136, #116 and #104 said to the inspector #117 that they and other staff members have been providing full tub baths to resident #004 for the past year, even when the resident's wound has been deteriorating. They said that they do not apply any protective barriers to the dressing to prevent the wound and dressing from getting wet when a tub bath is given. The PSWs said that they have never received any special directions regarding how to provide a bath when the resident has a dressing. A review of resident #004's health care record and plan of care indicates the resident #004's bathing needs were not reassessed when there were noted changes to the resident's skin integrity in 2017 nor when there was a development and ongoing presence of a wound requiring a specialized dressing.

Inspector spoke with RPN # 115 and RN # 102 regarding the revision of resident #004's bathing needs and wound treatment. Both RPN #115 and RN #102 said that they have never reassessed the resident's bathing needs when there was a change in the residents' skin integrity. Both said that in previous years, they had received guidelines from their former physician that permitted residents with wounds to have full tub baths. Both said since then, they have never thought of reassessing a resident's bathing needs when there is a change in the status of the residents' skin integrity, this including wounds with specialized dressings and a change in condition.

During an interview on September 11, 2018, the home's DOC said to the inspector that they were not aware that staff were providing full tub baths to residents #004, #035 and #028 when all three have wounds and dressings. The DOC said that they were aware that in the past, the home's previous attending

physician had given direction for a resident, who had a wound and dressing to have full tub baths at that time. The DOC said that they were not aware that staff continued to provide full tub baths to residents with wounds and dressings. The DOC said that residents' plans of care regarding bathing needs should have been reviewed and revised when the residents developed wounds. [s. 6. (10) (b)]

7.Resident #035 was admitted to the home on a specified day in 2018 with a pressure ulcer to an identified region and had a medical condition requiring contact precautions. The resident's plan of care for personal hygiene, identified that the resident required total assistance with their personal care needs and was to have a full tub bath twice weekly.

Over the next two months, new pressure ulcers developed, one to an identified region noted on a specified day and one to another identified region that was noted 14 days later. Nineteen (19) days later, one of the wounds was noted to have a deteriorating change in condition.

The resident's plan of care was reviewed and revised to include a skin and wound care treatment and dressing as well as for a medication treatment of the wound on a specified day in 2018. No other changes were made to the resident's plan of care. On September 10 and 11, 2018 it was noted that the resident still had specialized dressings to the identified regions and that the resident was receiving full tub baths twice weekly.

PSW #136 and #104 said to the inspector #117 that they have been providing full tub baths to the resident, even when the resident's wound was presenting with a change in condition, since the time of the resident's admission. They both said that they do not apply any protective barriers to the dressings to prevent the wound and dressing from getting wet when a tub bath is given. Both PSWs said that they have not received any special directions regarding how to provide a bath when the resident has a dressing. A review of resident #035's health care record and plan of care indicated the resident #035's bathing needs were not reassessed when there were noted changes to the resident's wounds and dressing.

Inspector spoke with RPN # 115 and RN # 102 regarding the revision of resident #035's bathing needs and wound treatment. Both RPN #115 and RN #102 said that they have never reassessed the resident's bathing needs when there was a change in the residents' skin integrity. Both said that in previous years, they had received guidelines from their former physician that permitted residents with

wounds to have full tub baths. Both said since then, they have never thought of reassessing a resident's bathing needs when there is a change in the status of the residents' skin integrity, this including wounds with specialized dressings and other medical conditions. [s. 6. (10) (b)]

8. The licensee has failed to ensure that resident #023 is being reassessed and the plan of care is being revised because care set out in the plan regarding continence care has not been effective, have different approaches been considered in the revision of the plan of care.

This is related to log #024474-18:

The Licensee submitted a critical incident report regarding an incident of alleged, suspected incident of staff neglect of resident #023 that occurred on a specified day in 2018. The incident report indicated that the resident's declining health required the resident to be placed into a continence program in order to properly assess the resident's continence in order to update the resident's plan of care.

Resident #023 was admitted to the home on a specified day in 2017 with several medical diagnoses. Resident #023's plan of care related to continence management prior to this incident indicated the resident utilized a specified toileting equipment for toileting needs.

PSW # 105 indicated the resident is known to stay for long periods of time on the specified toileting equipment recalled placing the resident on the toileting equipment on a specified day in 2018 at an identified time, and returned to request to remove the toileting equipment at least three times before the end of their shift. Each time, the resident indicated not being ready to have the specified toileting equipment removed. PSW # 105 reported this to the next shift PSW team however the resident remained on the toileting equipment until a specified time, almost three (3) hours later.

Inspector #547 spoke to RN # 102, who also indicated the resident is known to have behaviours related to refusing to be removed from the specified toileting equipment that has not been re-evaluated to date. The resident's plan of care was reviewed with RN # 102, and no behaviours were identified in the resident's plan of care related to toileting.

As such, resident #023's continence needs were not re-evaluated to manage

behaviours related to a specified toileting equipment use. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 1) the plan of care set out clear directions to staff and others who provide direct care to the resident; 2) that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other; 3) the care set out in the plan of care for resident, was provided to the resident as specified in the plan; 4) that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when (b) the resident's care needs change or care set out in the plan is no longer necessary; and 5) when the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, that different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The Licensee provided inspector #547 with a copy of the policy and procedure #4.2 Zero Tolerance of Abuse and Neglect, last revised March 2018 to be in use in the home by nursing staff at this time.

The policy indicated on page 1, that the Zero Tolerance of Abuse and Neglect policy must be communicated and displayed in the home in a manner that is both highly visible and legible for all residents, staff and visitors.

The policy indicated on page 2, that the Zero Tolerance of Abuse and Neglect policy is reviewed with staff during orientation and training and annually thereafter.

The policy further indicated on page 2 and 3, that:
1. Staff will ensure that it takes appropriate action in response to any suspected, alleged or witnessed incident of resident abuse or neglect.
2. The home will notify the resident's Substitute Decision Maker (SDM) immediately upon the home becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a resident.
3. Staff must immediately report every alleged, suspected or witnessed incidents of abuse or neglect of a resident by anyone.
4. Staff must investigate immediately all reports by staff of abuse or neglect.
8. Staff must notify the police as guided by reference to the criminal code offences outlined in the procedure.

Mandatory reporting requirements for s.24 (1) of the LTCHA regarding improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.

The Licensee's policy was not complied as follows:

On August 20, 2018 during the initial tour of the home for the Resident Quality Inspection (RQI) in the home, it was observed that the home had posted only a cover page of the Licensee's policy and procedure for Zero Tolerance of Abuse and Neglect. On September 10, 2018 the Director of Care (DOC) indicated the policy and procedure was not posted in the home, but a cover sheet which identified how to locate a copy if requested was on the bulletin board in the home. The DOC indicated that an entire policy and procedure will need to be posted on

this bulletin board as required.

Inspector #547 reviewed the home's education to staff regarding the policy and procedure of Zero Tolerance of Abuse and Neglect with the DOC who indicated that all nursing staff had not received this education at this time, as the new nursing staff hired in the home since May 1, 2018 had not received this mandatory training to date, as they were short staff and required to have them oriented on the resident care units to work in the home. The Education lead in the home indicated to inspector #547 that two Personal Support Workers (PSW's), an RPN that returned from a leave of absence and an RN were not educated on the home's policy and procedures regarding Zero Tolerance of Abuse and Neglect as required.

On a specified day in 2018, an incident of witnessed alleged neglect of resident #023 by PSW #141 was identified by PSW #129 as well as by the resident's Substitute Decision Maker (SDM) that was not investigated, reported to the Director, reported to the appropriate police force, as required by this policy.

Three (3) days later, an incident of alleged verbal and physical abuse of resident #023 by PSW #141 occurred that was not reported to the appropriate police force to date or any follow up with the resident's SDM regarding this investigation, as required by this policy.

Sixteen (16) days after the second incident, an incident of witnessed alleged neglect of resident #023's care needs was identified to RN #121 that was not immediately investigated until four (4) days after the incident occurred, not reported to the Director immediately until four (4) days after the incident occurred, was not reported to the appropriate police force, and any follow up with the resident's SDM regarding this investigation, as required by this policy.

As such, the Licensee's written policy that promotes Zero Tolerance of Abuse and Neglect of residents was not complied with for the three incidents that occurred with resident #023 in a specified month in 2018. [s. 20. (1)]

2. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

On a specified day in 2018 PSW #129 provided a written incident report form to the Director of Care (DOC) regarding an incident of alleged verbal abuse of

resident #012 by PSW #141.

The DOC indicated to inspector #547 to have likely received this incident report form from under the DOC's office door, and forgot to follow-up with it and filed it away with other documents related to PSW #141.

The DOC indicated having not investigated this incident as required.

The DOC indicated having not reported this to the Director as required.

As such, the written policy and procedure used in the home at the time of this incident was not complied by the DOC. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of staff to resident abuse or neglect that the Licensee knows of or that is reported, is immediately investigated. (log # 024474-18)

On a specified day in 2018, resident #023's Substitute Decision Maker (SDM) asked inspector #547 if they would be completing an inspection regarding an incident of staff abuse towards resident #023. The SDM indicated an alleged incident of verbal and physical abuse by PSW #141 towards resident #023 occurred during morning care a few weeks earlier. The SDM indicated that PSW #141 was neglectful to provide personal care of transfer and toileting as well before this incident on another specified day in 2018. The resident's SDM further indicated another incident of staff neglect occurred with resident #023 on a third specified day in 2018 whereby the resident was left on a specified toileting equipment for almost three hours. The SDM spoke to RN #121 after this incident, since then the resident is no longer using the specified toileting equipment.

On August 29, 2018 inspector #547 interviewed RN #121 who was the charge RN on the day of the reported third alleged incident of neglect in the home. RN #121

indicated resident #023's SDM reported the concern of the resident's use of a specified toileting equipment and to remove this from the resident's care plan. RN #121 indicated the PSW staff working at that time reported the resident was left on a specified toileting equipment from the previous shift that was discovered at an identified time, approximately three (3) hours later. RN #121 indicated this incident was not reported to the DOC as it was not thought to be abuse. RN #121 indicated to inspector #547 that this was neglectful towards resident #023's personal care needs and changed the plan of care, however did not see this related to abuse.

On August 30, 2018 inspector #547 interviewed the Director of Care (DOC) regarding these alleged incidents of staff to resident abuse and neglect. The DOC indicated that they do not recall the incident of neglect that occurred between resident #023 and PSW #141 that occurred on a specified day in 2018, however was in the middle of an investigation of the alleged incident of verbal and physical abuse of resident #023 by PSW #141 that had occurred three days after the alleged incident of neglect. This incident was immediately investigated and PSW #141 was placed on administrative leave immediately when this incident was reported to them. The DOC was not aware of any incident regarding staff neglect towards resident #023 that was alleged to have occurred 16 days after the incident they were currently investigating and would have to get information from staff regarding this incident.

Inspector #547 was provided the investigation package for the incident of staff to resident abuse from a specified day in 2018 that included an incident report form from PSW #129 who indicated the incident regarding PSW #141 allegedly neglecting to provide resident #029 care that had occurred three (3) days prior. PSW #129 indicated that at a specified time, on the day of the alleged incident, that PSW #141 was seated at the South wing nursing station, when resident #023's SDM requested to have the resident transferred back to bed as the resident required toileting. PSW #141 indicated that the resident will have to wait until the next shift staff complete their report to do this task, as it was too late in their shift to do this.

Inspector #547 asked the DOC if this incident of staff to resident neglect from a specified day was investigated, and the DOC indicated that they did not recall this incident report form, and that they likely placed it in the investigation package and forgot about it.

Inspector #547 interviewed PSW #129 regarding this incident report form, who indicated that this was completed on the day the alleged incident occurred and placed under the DOC's door as required, and has not heard anything about it since.

As such, the incidents that occurred on two (2) specified days in 2018, of resident #023's neglect for personal care needs were not immediately investigated as required by this section. [s. 23. (1) (a)]

2. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by PSW #141, that the licensee knows of, or that is reported is immediately investigated.

On September 6, 2018, the DOC provided an investigation package related to an incident involving PSW #141. Included in this investigation package was an incident report form dated a specified day in 2018 from PSW #129 reporting an incident of alleged verbal abuse towards resident #012 by PSW #141 that had occurred the day of the report. PSW #129 reported that resident #012 requested to go outside for a cigarette after the lunch meal, however PSW #129 indicated that the resident required personal care before going outside as the resident had soiled themselves. PSW #141 made derogatory comments about resident #012's personal hygiene and behaviours.

PSW #129 indicated to inspector #547 to having completed this incident report form on the day the incident occurred, as resident #012 was upset about what PSW #141 had to the resident. As indicated above, PSW #129 proceeded to bring resident #012 to the bathroom to provide personal care assistance, and resident #012 indicated that what PSW #141 had said made the resident feel bad, and embarrassed. PSW #129 indicated that the resident requires assistance, and that PSW #141 should not have spoken in such a manner to the resident. PSW #129 indicated no follow-up to this incident report was ever discussed by the DOC.

The DOC indicated that the incident report provided by PSW #129 on the day of the alleged incident regarding resident #012 was not investigated as it must have been filed in the wrong folder. [s. 23. (1) (a)]

3. The licensee has failed to ensure that appropriate action is taken in response to every such incident. (Log #004640-18)

On a specified day in 2018, the Licensee reported a Critical Incident Report (CIR) regarding an alleged witnessed incident of staff to resident #033 abuse that had occurred two days prior. The CIR indicated that on a specified day after a meal service, resident #033 returned to a dining room to visit with another resident who was finishing their meal service when resident #033 was scolded by dietary aide #132 to leave the dining room and not to bother the other resident. PSW #140 observed resident #033 indicate to dietary aide #132 that they wanted to go talk to the other resident and dietary aide #132 indicated to leave the resident alone. Resident #033 began to cry instantly and left the dining room.

On September 10, 2018 the Food Services Supervisor (FSS) indicated having been informed about this incident on the day that the incident occurred and went to interview resident #033 with the charge RN and the PSW who reported this incident shortly after its occurrence. Resident #033 described the incident to the FSS. The FSS indicated having begun an investigation to this incident and provided reassurance to the resident, however did not remove dietary aide #132 from resident care until the next day, after dietary aide #132 would have provided care to residents in a dining room including resident #033 for two meals. The FSS then provided a written letter to dietary aide #132 six (6) days later describing that the dietary aide was placed on administrative leave as of a specified date, four days after the incident occurred with resident #033. The FSS did not report the incident to the resident's Substitute Decision Maker in order to support resident #033 needs related to this abuse. The FSS did not have any documented education or further discussion with dietary aide #132 related to this incident, or actions taken in response to this incident.

As such, the Licensee did not ensure that appropriate actions were taken in response to staff to resident emotional abuse of resident #033 that occurred as required by this section.

It is noted this incident was not added to the current order for duty to protect as this incident occurred on a specified date in 2018 which was prior to previous order Compliance Order (CO) #002 from report 2018_619550_0004. [s. 23. (1) (b)]

4. The licensee has failed to ensure that the results of the abuse investigation were reported to the Director. (Log #004640-18)

On a specified date in 2018, the Licensee reported a Critical Incident of an

alleged witnessed incident of staff to resident verbal abuse that occurred on two (2) days prior. This incident was immediately investigated by the home's Food Services Supervisor the same day it was reported. The Critical Incident Report was not amended with any of the investigation results.

The results of the staff to resident verbal abuse investigation were not reported to the Director as required by this section. [s. 23. (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 to ensure that every alleged, suspected or witnessed incident of staff to resident abuse or neglect that the Licensee knows of or that is reported, is immediately investigated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment of care of resident #031 that resulted in harm or a risk of harm, immediately report the suspicion and the information upon which it was based to the Director. (Log #006500-18)

On a specified day in 2018, the Licensee reported an incident of alleged staff to resident verbal abuse towards resident #031 that occurred the previous day. This incident was immediately reported to charge RN #121 by RPN #111 the day of the incident. RN #121 did not report this incident immediately to the Director and provided a written incident report to the Director of Care who received this only the following day. As such, the Licensee reported this alleged incident of staff to resident verbal abuse 17 hours after the incident occurred in the home.

This finding is not part of the home's duty to protect Compliance Order (CO) #001 as this incident was reported on a specified day in 2018 prior to CO #002 from inspection #2018_619550_0004 with compliance date of July 6, 2018. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director

regarding abuse of resident #033 by dietary aide #132 that resulted in harm or risk of harm. (Log #004640-18)

Verbal abuse is defined as per O.Reg.79/10 s.2 (1)a as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

On a specified day in 2018, the Licensee reported a Critical Incident Report (CIR) of alleged staff to resident verbal abuse that occurred in the home two (2) days before sending in the CIR, after a meal service. PSW #140 reported this immediately to RN #133 who reported to the Food Service Supervisor (FSS) and interviewed resident #033 the day of the report. Resident #033 reported the incident of verbal abuse from dietary aide #132 that had occurred in the dining room, that same day. The FSS indicated to inspector #547 having suspected dietary aide #132 verbally abused resident #033 which hurt the resident causing the resident to cry uncontrollably by using inappropriate tone of voice, words and actions.

As such, the FSS had reasonable grounds to suspect that an incident of staff to resident abuse occurred on a specified day in 2018, however was not reported to the Director until approximately 27 hours after the incident occurred in the home.

It is noted this incident was not added to the current order for duty to protect as this incident occurred on a specified day in 2018 which was prior to previous order Compliance Order (CO) #002 from report 2018_619550_0004. [s. 24. (1)]

3. The licensee has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment of care of resident #023 that resulted in harm or risk of harm, has occurred immediately report the suspicion and the information upon which it was based to the Director.

On a specified day in 2018, PSW #129 and resident #023's SDM witnessed PSW #141 neglect to care for resident #023's needs for transfer and toileting that was reported to the Director of Care by Incident Report form however was not immediately reported to the Director.

On a specified day in 2018, nineteen days after the above incident occurred, RN

#121 was made aware of an incident of staff to resident #023 neglect by the PSW staff working that evening and the resident's SDM, however did not report this to the DOC or to the Director as required by this section. [s. 24. (1)]

4. The licensee has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment of care of resident #012 occurred, immediately report the suspicion and the information upon which it was based to the Director.

On September 6, 2018 the DOC provided an investigation package related to an incident involving PSW #141. Included in this investigation package, was an incident report form dated on a specific day in 2018, from PSW #129 reporting an incident of alleged verbal abuse towards resident #012 by PSW #141 that occurred after a meal service on the same day as that of the report. PSW #129 reported that resident #012 requested to go outside for a cigarette after the lunch meal, however PSW #129 indicated that the resident required personal care before going outside as the resident had soiled themselves. PSW #141 made derogatory comments about resident #012's personal hygiene and behaviours.

PSW #129 indicated to inspector #547 to have completed this incident report form on the day the incident occurred, as resident #012 was upset about what PSW #141 said to the resident. As indicated above, PSW #129 proceeded to bring resident #012 to the bathroom to provide personal care assistance, and resident #012 indicated that what PSW #141 made the resident feel bad, and embarrassed. PSW #129 indicated that the resident requires assistance, and that PSW #141 should not have spoken in such a manner to the resident. PSW #129 indicated no follow-up to this incident report was ever discussed by the DOC and found this to be verbal abusive towards resident #012.

The DOC indicated that the incident report provided by PSW #129 on the specified day in 2018, regarding resident #012 was not reported as required to the Director, as the DOC must have been filed in the wrong folder and then forgot about this incident. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment of care that resulted in harm or a risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #9: 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:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care based on an interdisciplinary assessment of the resident's communication abilities.

Resident #002 was admitted to the home on a specified day in 2018, with several medical diagnoses including dementia. The resident's plan of care identified the resident to require assistance with all activities of daily living and is known to resist personal care daily. Resident #002 is followed by an external medical service provider.

On a specified day in 2018, the resident's Substitute Decision Maker (SDM) indicated the resident often demonstrates behaviours as there are too many staff members providing assistance to the resident, and with the resident's impaired communication, this causes aggression in the resident as the resident cannot understand what is being discussed. The resident's SDM indicated having taken the resident's specific communication assistance devices home as the resident no longer used them but that nursing staff were aware of the resident's impaired communication.

Inspector #547 reviewed the resident's plan of care that did not have any indication of resident #002's impaired communication. Chart review identified the pre-screener for the resident, prior to admission, identify the use of specific communication assistance devices. Interviews with nursing staff in the home indicated the resident never had the specified communication assistance devices in the home, and they had no idea the resident had impaired communication and assumed the resident could understand everything. The resident's minimum data set (MDS) assessment completed at admission indicated no communication issues. Specific communication assistance devices were not identified.

As such, resident #002's plan of care was not based on an interdisciplinary assessment of the resident's communication abilities as required by this section. [s. 26. (3) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care based on an interdisciplinary assessment of the resident's communication abilities, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that if there is no Family Council, to convene semi-annually with meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council.

On August 31, 2018 the Administrator indicated to Inspector #547 that the home has not had a Family Council since at least 2015 when the previous Administrator was in the home. The Administrator indicated that they last had a meeting in September in 2017 to try to recruit resident family members to form a Family Council, and there was no interest at that time. They provide monthly information in the home's newsletter, however they have not received any interest. They have not had any meetings this year to date, and plan to have the first one some time in October 2018.

As such, the Licensee has failed to convene semi-annually with meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council as required by this section. [s. 59. (7) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that if there is no Family Council, to convene semi-annually with meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a weight monitoring system to measure and record each residents' body mass index (BMI) at admission and height annually.

As part of the Resident Quality Inspection, twenty (20) residents' height and weights were reviewed on August 20, 21, 23 2018. It was noted that 15 of the 20 residents have not had their heights taken annually.

1. Resident #1 last recorded height was taken in 2013.
2. Resident #3 last recorded height was taken in 2013.
3. Resident #4 last recorded height was taken in 2014, on the day of the resident's admission.
4. Resident #5 last recorded height was taken in 2016, a few days after the resident's admission.
5. Resident #6 last recorded height was taken in 2013.
6. Resident #7 last recorded height was taken in 2017, a few days after the resident's admission.

7. Resident #8 last recorded height was taken in 2016, a few days after the resident's admission.
8. Resident #9 last recorded height was taken in 2015, a few days after the resident's admission.
9. Resident #11 last recorded height was taken in 2015, on the day of the resident's admission.
10. Resident #12 last recorded height was taken in 2017, on the day of the resident's admission.
11. Resident #13 last recorded height was taken in 2015, on the day of the resident's admission.
12. Resident #14 last recorded height was taken in 2015.
13. Resident #16 last recorded height was taken in 2013.
14. Resident #17 last recorded height was taken in 2013.
15. Resident #19 last recorded height was taken in 2015, on the day of the resident's admission.

Upon further review of the above identified residents health care records, it was noted that the same above residents' have not had their Body Mass Index (BMI) measured and recorded at admission and on a yearly basis.

The home's Food Service Supervisor (FSS) and Administrator confirmed that the home did not have a process in place to measure and record annually the residents' height. They also said that at this time, the FSS does not measure and record the BMIs for any of the home's residents. The Administrator said that the home's Registered Dietitian (RD) is the person who is responsible to ensure that resident BMIs are measured and recorded. The Administrator and FSS were not aware that the residents BMIs and heights had to be measured and recorded annually.

The RD indicated in email correspondence that they did not calculate the residents BMIs and did not record these in the residents' health care records as they thought that the home's Point Click Care documentation and assessment system automatically calculated and recorded resident's BMIs during annual and quarterly nutritional risk assessments.

As such, the licensee does not have a weight monitoring system to measure and record each residents' body mass index (BMI) at admission and height annually. [s. 68. (2) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a weight monitoring system to measure and record each residents' body mass index (BMI) at admission and height annually, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

On September 5, 2018 the Director of Care provided a copy of a staff list for the home and indicated that two Personal Support Workers (PSW's), a Registered Practical Nurse (RPN) and a Registered Nurse (RN) that were new to the home or returning of extended leave of absence since July 2018 had not received training on the home's policy to promote Zero Tolerance of Abuse and Neglect to date. The DOC indicated these nursing staff members are currently working with resident's in the home, performing their responsibilities without this required training as the home had not ensured that this training be provided to each staff member prior to the start of their responsibilities. The DOC indicated inspector #547 that due to nursing staff shortages, they had to have these nursing staff members work on the resident units as soon as possible, and their mandatory training regarding the Zero Tolerance of Abuse and Neglect policy and procedure was not trained as required. [s. 76. (2) 3.]

2. The licensee has failed to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities.

On September 5, 2018 the Director of Care provided a copy of a staff list for the home and indicated that two Personal Support Workers (PSW's), a Registered Practical Nurse (RPN) and a Registered Nurse (RN) that were new to the home or returning of extended leave of absence since July 2018 had to date, not received the mandatory reporting training regarding any improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential of harm to a resident. The DOC indicated these nursing staff members are currently working with resident's in the home, performing their responsibilities without this required training as the home had not ensured that this training be provided to each staff member prior to the start of their responsibilities. The DOC indicated inspector #547 that due to nursing staff shortages, they had to have these nursing staff members work on the resident units as soon as possible, and their mandatory training regarding the reporting requirements under section 24 of the Act, was not trained as required. [s. 76. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities and to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of

the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The Licensee has failed to ensure that the required information regarding the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

On August 20, 2018 during the initial tour of the home, it was noted that the policy to promote zero tolerance of abuse and neglect was not posted in any conspicuous and easily accessible location in the home.

On September 10, 2018 the DOC indicated that the home had a bulletin board that had a message to indicate that policy and procedure regarding Zero Tolerance of Abuse and Neglect existed in the home, and to contact the DOC to obtain a copy. The DOC further indicated that the home did not have any posted policy and procedure, in any conspicuous and easily accessible location as if the DOC is not in the home at the time when anyone would request this policy, it would not be easily accessible to that person. The DOC indicated they would have to get a copy of the current policy and procedure and ensure that it gets posted on this bulletin board as required by this section. [s. 79. (3) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the required information regarding the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of emotional abuse of resident #033 that caused distress to the resident that could potentially be detrimental to the resident' s health or well-being. (Log #004640-18)

The licensee reported a critical incident of alleged witnessed emotional abuse of resident #033 by a dietary aide #132 that occurred on a specified day in 2018. The resident's SDM was not immediately notified by the Food Service Supervisor, who was made aware of this incident immediately after it occurred.

It is noted this incident was not added to the current order for duty to protect as this incident occurred on a specified day in 2018, which was prior to previous order Compliance Order (CO) #002 from report 2018_619550_0004. [s. 97. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of emotional abuse that caused distress to the resident that could potentially be detrimental to the resident' s health or well-being, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense. (Log #004640-18)

An incident of alleged witnessed staff to resident verbal abuse occurred on a specified day in 2018. The Food Services Supervisor (FSS) was immediately informed of this incident and began an investigation.

On September 10, 2018 the FSS indicated to inspector #547 having suspected this incident to be witnessed verbal abuse of resident #033 by dietary aide #132. The FSS further indicated that to this date, the police force had not been notified about this incident.

It is noted this incident was not added to the current order for duty to protect as this incident occurred on a specified day in 2018, which was prior to previous

order Compliance Order (CO) #002 from report 2018_619550_0004. [s. 98.]

2. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

On a specified day in 2018, an incident of staff to resident neglect was witnessed by PSW #129 and reported to the Director of Care via Incident Report form. However, this incident was not reported to any police force as per the DOC to date.

On a specific day in 2018, three (3) days after the above incident, another incident of verbal and physical abuse of resident #023 by PSW #141 occurred in the home. This has not been reported to any police force to date.

On a specific day in 2018, nineteen (19) days after the first incident occurred, another incident of staff to resident neglect was identified to RN #121 by the PSW staff and the resident's SDM. However this incident was not reported to the DOC nor reported to any police force, to date.

As such, these three incidents of alleged staff to resident abuse and neglect were not reported immediately to the appropriate police force as required by this section. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it. (Log #004640-18)

The Licensee reported a Critical Incident on a specified day in 2018, regarding an incident of alleged witnessed staff to resident abuse that occurred two (2) days prior, on a specified day in 2018.

On September 7, 2018 the Director of Care indicated to inspector #547 that no analysis of this incident of abuse of resident #033 was undertaken to date after the Licensee became aware of this incident on the specified day in 2018.

It is noted this incident was not added to the current order for duty to protect as this incident occurred on a specified day in 2018, which was prior to previous order Compliance Order (CO) #002 from report 2018_619550_0004. [s. 99. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Resident #001 was diagnosed as having a medical condition on a specified day in 2018. The resident's attending physician prescribed two (2) medications that were to be immediately administered and continued as per the medical prescription. One of the two medications was prescribed as follows: a double dose to be administered immediately and then a single dose be administered once a day for four (4) consecutive days. The medication was to be administered as a single

dose on four specified consecutive days in 2018.

Two (2) days after the last medication was to have been administered, the RN # 102 reviewed resident #001's medication administration records (MAR) and the medication blister pack for the prescribed medication. The RN noted that the resident had not received the prescribed medication dose for one of the specified four (4) days. An internal incident report and progress notes documented that the resident was assessed on the day that the missed medication dose was noted and no adverse effects were noted. The RN notified the resident's attending physician and the resident's substitute decision maker of the missed medication dose. The physician did not re-order the prescribed medication.

Since July 2017, the home has implemented a protocol as part of their medication management system, whereby the RN in charge is to review at each shift the medication count and eMAR documentation for each narcotic, controlled substance and antibiotic prescribed to be administered to residents in the home. The protocol was implemented to ensure that all residents receive their prescribed medication. The protocols state the following:
- DAY RN - Daily shift Duties Checklist: Complete incident reports, medication incidents reports as required. POA made aware of incidents as needed.
- EVENING RN- Daily shift Duties Checklist: Complete incident reports, medication incidents reports as required. POA made aware of incidents as needed.
- NIGHT RN - Daily shift Duties Checklist: Complete incident reports, medication incidents reports as required.

When a medication error is identified, such as a medication not being administered as per the direction provided by the prescriber, the RN is to complete an internal medication incident report, assess the affected resident's health status and notify the attending physician and the resident's SDM of the medication error.

A review of resident #001's medication incident report indicated that the medication error was identified on a specified day in 2018, three (3) days after the medication incident occurred. RN # 121 said to the inspector that it is the RN in charge's responsibility that at every shift the eMAR and medication count for each residents' prescribed narcotics, controlled substances and antibiotics is reviewed. RN# 121 said that it is the charge RN's responsibility to immediately report any

medication incident, such as a prescribed medication not being administered. As per RN #121, the medication incident should have been reported on the day of the missed medication dose, by the night time RN.

The DOC informed the inspector that they were not made aware of any medication incident regarding resident #001's missed medication until a specified day in 2018, 3 days after the medication was to have been administered. As per the DOC, the RNs who worked on three (3) specified days in 2018, did not follow the home's medication incident policy and did not report resident #1's missed medication until 72 hours / 3 days after the medication was identified to not having been administered. [s. 114. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policies and protocols related to the home's Medication Management System must be developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #001 was diagnosed as having medical condition on a specified day in 2018. The resident's attending physician prescribed two (2) medications that were to be immediately administered and continued as per the medical prescription. One of the two medications was prescribed as follows: a double dose to be administered immediately and then a single dose be administered once a day for four (4) consecutive days. The medication was to be administered as a single dose on four specified consecutive days in 2018.

Two (2) days after the last medication was to have been administered, the RN # 102 reviewed resident #001's medication administration records (MAR) and the medication blister pack for the prescribed medication. The RN noted that the resident had not received the prescribed medication dose for one of the specified four (4) days. An internal incident report and progress notes document that the resident was assessed on the day that the missed medication dose was noted and no adverse effects were noted. The RN notified the resident's attending physician and the resident's substitute decision maker of the missed medication dose. The physician did not re-order the prescribed medication. As per RN #102 and the DOC, they are not aware of the reason why resident #001 did not receive their prescribed medication on a specified day in 2018.

As such, resident #001's medication was not administered on a specified day 2018, in accordance with the directions for use specified by the prescriber. [s. 131. (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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

The home has an infection control and prevention policy and measures regarding the cleaning and disinfection of tub baths to prevent the transmission of infections.

The policy "Infection Control 6.1 Environmental Controls", revised 03/17, states under Principles for Effective Disinfection: The most important thing to remember for effective disinfection is to follow the manufactures instructions" (page 2 of 15).

Residents # 004, #028, and #035 all have wounds with dressings. A review of the residents' health care records indicated that the residents developed infected wounds in a specified month in 2018. Resident #035 is also identified as having a medical condition, requiring contact precautions. It was also noted that as part of their plans of care for personal hygiene and bathing, that residents #004, #028 and #035 were given full tub baths twice weekly during two identified months in 2018. As per PSWs # 116, #104 and #136 the residents were given full tub baths, while their dressings were in place, with no interventions in place to prevent the wounds and dressings from becoming wet and saturated with water during the baths. (see WN # 5, s. 6 (10) b) - Plan of Care)

When asked about tub cleaning and disinfecting procedures post bath, PSW #116 and #136 said that they spray the tub and tub chairs with the cleaning/disinfectant product that is connected to the tub. They then proceed to scrub the interior of the tub and tub chair for approximately one minute with a designated scrub brush used for this purpose. They then rinse the tub and tub chair with clean water. They then refill the tub with water to get ready for the next scheduled resident's bath.

It is noted that the tub has water jets. PSW #116, #104 and #136 said that they did engage the water jets to give a whirlpool bath to residents #004 and #028 when they were in the tub. The PSWs said to the inspector that they were not aware of have any processes for the cleaning and disinfecting of the tub water jets other than scrubbing the exterior of the jet output valves, visible inside the tubs.

The home has two RS8 Geneva (height adjustable) RANE tubs. Beside both West wing and South wing tubs is a large plasticised manufacturer's instruction sheet for the operating and disinfecting procedures for the RS8 Geneva (height adjustable) RANE tubs used in the home. The manufacturer's Disinfecting Procedures are as follows:
• Open the "Disinfecting cabinet"
• Remove the "Disinfecting wand" from its holder and hold it over the tub, point the spray into the tub.
• Turn the "Disinfecting valve" to "Disinfect"
• Spray the interior of the tub. You may use a brush or sponge to clean the wall of the tub.
• Turn off the disinfecting system by turning the "Disinfecting valve" off.
• Let the disinfecting solution remain on the surface of the tube for the recommended bacteria killing time given by the manufacturer of the disinfecting solution you are using. See distributor for product information.
• Turn "Disinfecting valve" to rinse while holding "Disinfecting wand" over the tub. Turn on Air Spa while rinsing to blow disinfectant out of jets. When finished, turn the "Disinfecting valve" to the off position. Hang up the "Disinfecting wand" and lock the "Disinfecting cabinet" door. Turn off Air.

The cleaning / disinfecting solution used by the home to cleanse the tubs is the AloeMED Disinfectant 5 Cleaner. This is the cleaning / disinfecting solution that is present and used in the tubs disinfecting cabinets. As per the product label this product is a "Disinfectant - Cleaner - Fungicide- Mildewstat - Deodoriser for

hospitals, health care facilities, food processing establishments and other institutions." The disinfecting solution guidelines for the AloeMed Disinfectant 5 Cleaner indicated that the solution has to be in contact with the surface to be cleaned for 10 minutes for good disinfection.

As per the above the home's Infection Control policy, the RANE tub and AloeMed Disinfectant 5 Cleaner manufacturers' directions, the home's staff are not disinfecting the tubs and as such are not implementing the home's infection control program. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (5) The licensee shall ensure that the emergency plans address the following components:
1. Plan activation. O. Reg. 79/10, s. 230 (5).
2. Lines of authority. O. Reg. 79/10, s. 230 (5).
3. Communications plan. O. Reg. 79/10, s. 230 (5).
4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

s. 230. (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information. O. Reg. 79/10, s. 230 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the emergency plans address the following components the activation, the lines of authority, the communications plan as well as the specific staff roles and responsibilities for when there is an electrical or power outage at the home.

On August 29 and 31 2018, the home experienced two episodes of electrical power outages. On August 29, 2018 that home lost electrical power from 1420 hours to 1535 hours. On August 31, 2018 the home lost electrical power from 1206 hours to 1250 hours. In both instances, the home's emergency back-up generator provided limited electrical services to the home. The home has 48 licensed LTC home beds. At the time of both electrical power outages, there were 45 residents in the home.

During the August 29, 2018 electrical power outage, residents were noted to be located in various areas of the home, including the main activity lounge, by both the West and South nursing stations. It was also noted that, several residents were resting in their rooms. Nursing staff were observed to verify the residents' locations and monitor the main front entrance. It was noted that all doors leading to the exterior of the building were unlocked as the door "maglock" security systems were non-functional during the power outage. As soon as the power outage occurred, RN #121 gave direction to PSW staff to check the status of the maglock doors leading to the outside of the home. PSW staff were noted to report back to RN #121. This was observed to occur at the start of the power outage. During the outage, staff were observed to return to their regular tasks, with the exception of the home's administrative assistant who continued to monitor the home's front entrance door. When the electrical power was returned, staff continued their normal work routines. Staff did not verify the location of the residents, account for the number of residents in the home and did not verify the security status of doors leading to the outside of the home.

During the August 31, 2018 electrical power outage 40 / 45 residents of the home were noted to be located in the home's dining rooms for the lunch time meal services. The five (5) other residents were resting in their rooms. Nursing staff were observed to verify the residents' locations and monitor the main front entrance. It was noted that all doors leading to the exterior of the building were unlocked as the door "maglock" security systems were non-functional during the power outage. Five minutes after the start of the power outage, the RN #102 gave

direction to PSW staff to verify the location of all residents and the status of the "maglock" doors leading to the outside of the home. PSW staff were noted to report back to RN #102, who then completed a "Resident Fire Drill Check List" form. This was observed to occur at the start of the power outage. During the outage, staff were observed to return to the dining rooms to continue with the provision of the lunch time meal, with the exception of the home's administrative assistant who continued to monitor the home's front entrance door. As of 1230 hours, several residents were observed to leave the dining rooms and go to various locations in the home e.g. their rooms, activity room, by the nursing stations. No staff were observed to verify or monitor the residents' whereabouts after the lunch time meal. When the electrical power was returned, staff were observed to continue with their normal work routines. Staff did not verify the location of the residents, account for the number of residents in the home and did not verify the security status of doors leading to the outside of the home. The home's maintenance staff #108 was noted to go to the home's electrical panel and reset the "maglock" doors powers. Inspector #117 asked maintenance staff #108 if they would be verifying the security of doors leading to the outside, post electrical power return. The staff #108 said that there was no need as the electrical panel showed that the "maglock" system was activated. No other verification of the status of the "maglock" doors was observed to be done.

During both power outages, the home's Administrator and DOC were both present in the home. They were observed to come to the home's main nursing station but did not participate in the monitoring of the residents.

Inspector #117 inquired with RN #102 and #121 as to the home's emergency plans for when there is an electrical power outage. Both RN #102 and #121 said that they were not aware of any plan or process to follow when there is an electrical power outage.

RN #121 said that he/she asked that staff verify the status of doors leading to the outside of the home and the location of the residents at the start of the electrical power outage of August 29, 2018. They were not aware of any plan, form or directions to follow in case of this type of emergency. RN #121 did show the home's "Resident Fire Drill Checklist" form to the inspector but was unsure that this is the form that needed to be used for this type of emergency.

RN #102 said that he/she used and completed the home's "Resident Fire Drill Checklist" form to identify how many residents and other persons were present in

the home on August 31 2018. The RN did ask that staff verify the status of doors leading to the outside of the home and the location of the residents at the start of the electrical power outage. They said that they were not aware of any other plan or directions that were to be implemented during an electrical power outage. The completed form was given to the home's DOC after the electrical power returned to the home.

The Administrator reviewed the home's Fire Safety and Evacuation Manual, updated October 2017 with the inspector. The manual identifies fire and emergency situations. Section #13 of the manual addresses Electrical Outage or Blackouts.

This section identifies that the home has an emergency generator that will "provide power to the nurse call system, hot water heaters, a few electrical receptacles at the main nurse's station, one base board heater in resident rooms, some lights in main areas and 1 washer and 1 dryer. …The Following General Steps Should Be Followed:
• All doors should be closed to keep in heat during the winter and out in summer
• When a blackout has occurred, the staff should advise and attempt to prevent residents from panicking.
• The administrator or designee will order an evacuation from the building when factors require it. Generally, the facility has been designed to accommodate and support all residents even during a prolonged power outage (e.g. Ice Storm '98) " (page 37 of 41)

The home's administrator confirmed that the home's Fire Safety and Evacuation Manual did not have any plans to address the activation, the lines of authority, the communications plan as well as the specific staff roles and responsibilities for when there is an electrical or power outage at the home. [s. 230. (5)]

2. The licensee has failed to ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information.

On August 29 and 31 2018, the home experienced two episodes of electrical power outages. On August 29, 2018 that home lost electrical power from 1420 hours to 1535 hours. On August 31, 2018 the home lost electrical power from 1206 hours to 1250 hours. In both instances, the home's emergency back-up generator provided limited electrical services to the home. The home has 48

licensed LTC home beds. At the time of both electrical power outages, there were 45 residents in the home.

The Administrator reviewed the home's Fire Safety and Evacuation Manual, updated October 2017 with the inspector. The manual identifies actions to be taken during fire and emergency situations. As part of the manual, there is an organizational chart dated April 11, 2011 (page 4 of 41). This chart identifies management and staff persons who no longer work at the home or who have changed their work positions within the home. The Emergency Contact Flow Chart (page 29 of 41) does not include a staff telephone contact list. The flow chart also still identifies the name of the home's previous attending physician who retired over one year ago.

The Administrator confirmed that although the manual had been updated in October 2017, all of the emergency contact information had not been updated. [s. 230. (6)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the emergency plans address the following components the activation, the lines of authority, the communications plan as well as the specific staff roles and responsibilities for when there is an electrical or power outage at the home and to ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

Over the course of this inspection, it was noted that shared bathroom for two (2) identified resident rooms had a lingering offensive odour of urine.

On a specified day in 2018, resident #002's Substitute Decision Maker (SDM) indicated the resident's shared bathroom smells of urine all the time.

Two (2) days later, housekeeper #107 indicated to inspector #547, after having cleaned the shared bathroom, that they have to return to clean this room frequently throughout the day, related to continence issues with the resident in an identified room, however they cannot get rid of the odour.

That same day, PSW #104 and PSW #106 indicated that the odours in the bathroom have been a long standing problem in this shared bathroom related to the continence management and behaviour management of one of the resident's using this space. PSW's will flag to housekeeping staff the need to clean the spills, however the odours do not go away.

On a specified day in 2018, the Administrator indicated to inspector #547 that the home did not have any procedures developed to be implemented for addressing incidents of lingering offensive odours in the home at this time. As such, procedures will be required to be developed and implemented in the home as required by this section. [s. 87. (2) (d)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 23rd day of January, 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

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 LYNE DUCHESNE (117) - (A1)
Inspection No. / No de l'inspection :	2018_583117_0007 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	021324-18 (A1)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 23, 2019(A1)
Licensee / Titulaire de permis :	Mohawk Council of Akwesasne P.O. Box 579, CORNWALL, ON, K6H-5T3
LTC Home / Foyer de SLD :	Tsiionkwanonhsote 70 Kawehnoke Apartments Road, Akwesasne, ON, K6H-5R7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Vincent Barry Lazore

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

To Mohawk Council of Akwesasne, 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2018_619550_0004, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 of the LTCHA 2007.

Specifically the licensee shall develop a plan to ensure:

1. The written policy titled "Resident Services 4.1 Resident Rights and Safety, 4.2 Abuse" is effectively implemented by:

• Ensuring that all newly hired staff, and staff returning to work after a prolonged absence, receive training on the home's above identified policy in relation to their Zero Tolerance of Abuse and Neglect Policy and keep a documented record of this,

• Verifying that staff demonstrate knowledge of all aspects of the policy, with a focus on the definitions of abuse and the Residents' Bill of Rights, and,

• By ensuring that all nursing staff demonstrate knowledge of the Residents' Bills of Rights when providing personal toileting and hygiene care to residents.

2. That every incident of alleged, suspected or reported abuse or neglect to residents is immediately investigated. The licensee is to ensure that the investigation is documented, as well as contacts with resident substitute decision makers at the start and end of the investigation, notification of

appropriate police force, as well as the outcome of the investigation. An analysis of every incident of abuse of neglect or a resident shall be undertaken promptly after the licensee become aware of it and this analysis shall be documented.

3. That every incident of suspected abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident shall be immediately reported to the Director.

This plan must be submitted in writing by November 12, 2018 to Lyne Duchesne, LTCH
Inspector Nursing at 347 Preston Street, 4th floor, Ottawa Ontario K1S 3J4
OR by fax at
613-569-9670.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #023 was protected from abuse by anyone and free from neglect by the Licensee or staff in the home. (Logs # 020961-18 and 006500-18)

In accordance with O.Reg.79/10 s.2 (1) defined physical abuse as:
a) the use of physical force by anyone other than a resident that causes physical injury or pain.

In accordance with O.Reg.79/10 s.2(1) defined verbal abuse as:
a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

On April 20, 2018 the Licensee was issued a compliance order (CO) #002 regarding duty to protect s.19(1) whereby the Licensee was to protect residents from abuse by anyone and shall ensure that residents are not neglected by the Licensee or staff with a compliance date of July 13, 2018. Inspector #547 completed a follow-up to this compliance order which specified the following:

1. Specific actions were to be taken by the Licensee to ensure that every alleged, suspected or witnessed incidents of abuse of a resident by anyone was immediately reported to the Director.

Resident #023 had two of the three incidents identified in WN # 8, LTCHA s. 24, of this report, that were not immediately reported to the Director as required.

2. The revised policy required by this order was required to be communicated to staff and their level of knowledge to be assessed to ensure compliance with s.24 of the LTCHA by developing a monitoring process to ensure staff training was completed.

As identified in WN # 12, LTCHA s. 76, of this report, two nursing staff member as well as four other nursing staff members new to the home or returning to work from an extended leave of absence, were not communicated this revised policy, or the requirements for mandatory reporting as required.

The DOC indicated that education and communication of the revised policy and procedure for Zero tolerance of Abuse and Neglect was not communicated to three nursing staff in the home being a Personal Support worker, an RPN and an RN. The DOC was supposed to follow-up with these nursing staff members regarding this mandatory training however has not done this to date. The DOC indicated these staff members have been working with residents in the home since the mandatory training took place, but has not taken the time to follow-up with these three staff members.

This area of the compliance order also required that staff report every alleged, suspected or witnessed incidents of abuse or a resident as required. As identified in WN # 11, LTCHA s. 20, of this report, two incidents of staff to resident neglect of residents care needs that the Licensee and staff were aware of, was not reported as required.

Further to this compliance order:
- Resident #023 had incidents of staff to resident neglect of personal care needs that was not investigated as identified in WN # 13, LTCHA s. 23,
- These incidents of neglect were not reported to the appropriate police force as identified in WN # 15, O.REG. s. 98,
- The licensee or staff in the home did not follow the Licensee's policy and procedure for Zero Tolerance of Abuse as identified in WN # 11, LTCHA s. 20, and

- The licensee did not follow-up to investigations with the resident's SDM as identified in WN #14, O.REG. s. 97.
- The licensee failed to ensure that the home's policy to promote Zero Tolerance to Abuse and Neglect of residents is posted in the home. WN # 13 LTCHA s. 79 (3) (c)

As such, resident #023 was not protected from verbal and physical abuse by PSW #141 or free from neglect by the Licensee or staff on three separate occasions in the home between two specified dates in 2018 as identified in this report

It is noted that a compliance order CO #002 for LTCHA s. 19 Duty to Protect was issued under inspection # 2018_619550_0004 on April 20, 2018 with a compliance due date of July 6, 2018. It is noted that based on the above information, this order is being re-issued.

The risk is identified as a level 3 actual harm, as a staff member was verbally abusive to the same resident on two identified dates.
The scope is a level 2 isolated incident involving a pattern of abuse towards a resident. The home‘s compliance history is a level 4 as there has been ongoing non-compliance with a VPC or CO in the same related area.

Inspection # 2018_619550_0004 – A compliance order was issued on April 2018 for LTCHA. s. 19 related to Duty to Protect with a compliance due date of July 6, 2018 (547)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2019

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. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 15 (1)

Specifically the licensee shall be compliant by:

1) Ensuring that bed rail use, for resident #007 and all other residents in the home,
are assessed and implemented in accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003). This includes, but is not limited to:

a) A documented individual resident assessment by an interdisciplinary team, including all specified factors prior to any decision regarding bed rail use or removal from use. The specified factors are: medical diagnosis, conditions, symptoms, and/or behavioral symptoms; sleep habits; medication; acute medical or surgical interventions; underlying medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling.

b) A documented risk benefit assessment, following the resident assessment by the interdisciplinary team, where bed rails are in use. The documented risk benefit assessment, as prescribed, is to include: identification of why other care interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident; a final conclusion indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that the risk of bed rail use is lower that of other interventions or of not using them.

c) Documented approval of the use of bed rails for an individual resident by the interdisciplinary team that conducted the resident's assessment and the final risk benefit assessment. The names of the team members are to be documented.

2) Update the written plan of care based on the resident's assessment/reassessment by the interdisciplinary team. Consider the factors referenced with regards to the sleeping environment assessment, the treatment programs/care plans section and the risk intervention section of the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003) when updating the written plan of care. The written plan of care is reflect the assessed use and position of bed rails with intermediate locking and stopping positions should these be an assessed needs for residents.

3) Evaluate all resident's bed systems where bed rails are used in the home, in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" to minimize risk to the resident. Ensure that bed rails with intermediate locking and stopping positions are evaluated in all positions as prescribed by the above document.

4) Implement appropriate interventions to mitigate the risk of entrapment for all residents who use one or more bed rails where a bed system is known to

have failed the testing of one or more zones of entrapment.

Grounds / Motifs :

1. The licensee has failed to ensure where bed rails are used, the residents are assessed and bed systems are evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

During the stage one observations, the inspectors noted of the twenty residents observed, that nineteen residents utilized quarter or three-quarter bed rails at all times when in bed. Residents #002, #007 and #012 health care records were reviewed and observations were made. The bed rails for these three residents were observed to be used daily when the residents are in bed and the care plans indicated the need for bed rails for mobility of these resident's while in bed.

In August 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones one -seven), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones one -- four), and prescribes test tools (cone and cylinder tool with spring scale) and methods to measure and assess gaps in some of the potential entrapment zones (Zones one - four).

The HC guidance document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the HC guidance document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making.

One of the companion documents is titled "Clinical Guidance for the Assessment and

Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003) (FDA 2003 clinical guidance document). This document provides necessary guidance in establishing a clinical assessment where bed rails are used and directs that the automatic use of bed rails is to be avoided as this may pose unwarranted hazards to resident safety.

The inspector was directed to speak with maintenance staff #108 in regards to bed rails as RPN #100 indicated that nursing staff are not required to assess residents for entrapment zones related to bed systems. RPN #100 indicated the residents are all assessed for their personal need for rails, and added to the plan of care accordingly. The inspector requested the documented assessment of the resident bed system including any steps to prevent bed entrapment. Maintenance staff #108 was unaware of any assessment completed related to the use of bed rails and stated the home does not complete these assessments.

The DOC and the Administrator were both interviewed and indicated to inspector #547 they were unaware these assessments were required for residents that utilize bed rails. They further indicated there has been no bed system evaluation completed to include prevention of resident entrapment. The DOC confirmed the majority of the residents in the home utilize bed rails as they are attached to the bed frames.

As such, the Licensee has failed to ensure that where bed rails are used, that the resident's bed system is evaluated in accordance with evidence- based practices and, if there are none, in accordance with prevailing practices, to minimize risk to residents including steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment with bed rails as required by this section.

The risk is identified as a level 2 as there is minimal harm or potential for actual harm related to the use of bed rails. The scope is a level 3 widespread as this affects all residents with a bed system in the home. The home's compliance history is a level 2 as there are one or more unrelated non-compliance in the last 3 years in the home.

(547)

2. The licensee has failed to ensure where bed rails are used, the residents are assessed and bed systems are evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Resident #007's plan of care indicated the resident requires the use of two full bed rails when in bed to prevent falling out of bed as restraint.

Resident #007 indicated to inspector #547 on August 29, 2018 they use the bed rails when turning from side to side during the provision of personal care by nursing staff.

PSW #120 indicated the resident is not known to climb out of bed and does not move in bed unless nursing staff ask the resident to grab the bed rails. PSW #120 indicated the resident's bed rails have always been attached to the resident's bed and they have always been placed in the up position when the resident went to bed since admission. PSW #120 further indicated resident #007 does not have the force to get of bed anymore independently and possibly no longer requires the bed rails.

As such, resident #007's was not assessed and their bed system was not evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.
. (547)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2019

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

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. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) 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. 31 (3).

Order / Ordre :

The Licensee must be compliant with O.Reg. 79/10 s. 31 (3) a, d, e.

Specifically the licensee shall:

1) Ensure that the home's staffing plan is evaluated and updated immediately to ensure that the staffing mix is consistent with the assessed care and safety needs of the residents, and afterwards annually, in accordance with evidence based practices. The evaluation, the suggested changes and their implementation date will be documented to facilitate the annual evaluation.

2) Ensure that the staffing plan is updated to provide for a staffing mix that is consistent with residents assessed care and safety needs specifically that there be enough staff is available:

a) To ensure that residents #001, #024, #026 and any other residents, are transferred in and out of their mobility devices, as per their plans of care which identified the use of a 2-person mechanical lift transfer.

b) To ensure that residents #015, #016, #018, #017, #010 and #028, as well as any other resident receive their morning care as identified in their plans of care, and

3) Ensure that there is a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come into work

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan: (a) provide for a staffing mix that is consistent with residents' assessed care and safety needs, (d) include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage) (e) get evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's staffing plan was reviewed with the DOC. The home's staffing plan indicated that the following number of staff are to work during a 24 hours period of time:
- RNs work 12 hour shifts, from 0700 hours to 1900 hours, and then 1900 hours to

0700hours
- Day Shift – 0700 hours to 1500 hours : 2 RPNS and 5 PSWs
- Evening Shift – 1500 hours to 23 hours : 2 RPNS and 5 PSWs
- Night Shift – 2300 hours to 0700 hours : 3 PSWs

On August 31, 2018, it was noted by inspectors #117 and #547 that the home was working short staffed (less staff that what is identified in their staffing plan) during the day shift. Both inspectors had been conducting interviews with residents and staff when it was noted that the home had 1 RN, 1 RPN and 3 PSWs working the day shift. There was no staff present to cover for 1 RPN and 2 PSWs positions that day shift.

RN #102, who was the RN in charge, was aware that the day shift was short 3 staff members. The RN #102 said to the inspectors that they had not attempted to contact any staff on the home's staffing list to replace some or all of the open shifts, as they assumed the role and functions of the missing RPN to provide resident care instead of trying to try to find replacement staff. The RN #102 said that they had not advised either the DOC or the home's Administrator when they arrived at the home of the staffing issues. RN #102 said that the RN in charge do not report on a daily basis any staffing issues e.g. missing staff, to the home's DOC or Administrator. It is noted that the home's DOC and Administrator were made aware by the inspectors that the home was short staffed by 1 RPN and 2 PSWs shortly after becoming aware of the situation. Both the DOC and Administrator said that they were not aware of the home being short staffed that day and that they do not inquire with the RN in charge as to the status of the daily nursing staffing plan. It is noted that the DOC did contact various staff members on their staffing list and was able to get a PSW to arrive within one hour to come and work one of the unfilled PSW shifts.

On August 31, 2018, the home's day shift staffing mix (O.Reg. s. 31 (3) a)) was not consistent with the assessed care and safety needs of several residents. RPN #115, PSW# 136, #104, and # 123 said to the inspectors that the following residents care was not given as per their plans of care.

- Residents #001, #024, #025 and #026 all require a 2 person mechanical lift transfer to get up from bed to their mobility devices. They all reside on a resident care unit where there are usually 2 PSWs to provide care and services. On August 31, 2018,

the home only had 1 PSW working on this unit as the home was short staffed. The above residents were transferred into their mobility devices with the use of a mechanical lift by PSW #104. No other staff came to assist PSW #104 with these transfers. It is noted that the residents did not sustain any injuries during the transfers.

- Residents #015, #016, # 018, #027, #010 and #028 are all cognitively impaired and cannot or have difficulties expressing their personal care wishes. The residents plans of care identify that the residents morning care are to given by the day shift. On August 31, 2018, the above residents were washed, dressed and returned to bed by the night shift, prior to the start of the day shift. As per RPN #115 this was done to assist the day shift with the provision of resident care as the home was short staffed that day.

On September 6 and 7, 2018, the RNs in charge #102 and#121, were aware that the home was going to be short 3 evening PSW positions for the weekend shifts of September 8 and 9, 2018. The one of the two other staff members scheduled to work that weekend was identified as requiring modified work provisions and was not able to assist with the lift and transfers of residents. The RNs did communicate the staffing issue to the DOC on both days. The actual staffing complement for the evening shifts of September 8 and 9, 2018 was as follows:

September 8, 2018
- 1 RN from 1900 hours to 0700 hours
- 2 RPN from 1900 hours to 2300 hours
- 4 / 5 PSWs present – One evening PSW shift was not replaced. It is noted that 1 PSW did a double shift, 2 worked from 0700 hours until 2000 hours and the 4th PSW was on modified work duties.
- Only 2/4 PSWs were present from 2000 hours until 2300 hours.

September 9, 2018
- 1 RN from 1900 hours to 0700 hours
- 1 RPN from 1900 hours to 2300 hours – one RPN position not replaced
- 5 PSWs present – it is noted that 2 were doing double shifts, 2 worked until 2000 hours and the 5th PSW was on modified work duties.
- Only 3/5 PSWs were present from 2000 hours until 2300 hours.

On September 8 and 9, 2018, the home's evening shift staffing mix (O.Reg. s. 31 (3) a)) was not consistent with the assessed care and safety needs of several residents. PSWs #106, #138, #123 and #129 said to the inspector that the following residents care were not given care as per their plans of care.

- Residents #036, #016, #023, #037, #038, #013, #039, #015, #002, #008, #028, #024, #030, #025 all require a 2 person mechanical lift transfer from their beds to their mobility devices. The above residents were transferred to their beds with the use of a mechanical lift operated by one either PSWs # 106, #138 or #123 as they were working short staff and staff # 139 is unable to assist with transfers. It is noted that the residents did not sustain any injuries during the transfers.

The staffing plan was reviewed with the home's DOC. As per the DOC, the DOC plans the monthly nursing staffing schedule. Once the monthly schedule is completed, it is the RN in charge who is then responsible to ensure that any new staff leave or unfilled shift is staffed.

RN #102 and #121, who are regularly the RN in charge, said that they have to adjust on a daily basis their nursing responsibilities to the residents and the need to ensure that the home has a full nursing staffing complement on each shift. The RNs expressed concern that they do not have time to do their nursing responsibilities when they have to oversee staffing replacement needs. On September 7th, RN #102 expressed this concern to the inspector when resident #040 required post fall assessments and but the RN also needed to contact some PSWs to see if they could fill one or more evening shifts for September 8 and 9 2018 (see above re September 8 -9 staffing). The DOC, RNs #102 and #121 said that they do not communicate with each other on a daily basis to discuss or review the home's daily nursing staffing plan.

As per the DOC, the home has a fixed number of nursing staff both full time and part time. The home does not have any staff that have a "casual" designation on their staffing list, nor do they use an external staffing agency should they be short staffed.

When asked when was the home's nursing staffing plan and associated roles and responsibilities were last reassessed, the DOC said that to their knowledge the

staffing plan has not been reassessed for several years. The DOC also said that the division of roles and responsibilities of the DOC and the RN in regards to the development, overseeing and management of the nursing staffing schedule has also not been reviewed or revised for several years.

As such, the home's staffing plan has not been evaluated and updated at least annually.

Further to this compliance order:

- a finding of non-compliance is being issued under WN # 12 LTCHA s. 76 (2) (3 &4) as it relates to staff did not receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities

The risk is identified as a level 2 as there is minimal harm or potential for actual harm related to the staffing plan issues identified. The scope is a level 3 widespread as this affects all residents within the home. The home's compliance history is a level 2 as there are one or more unrelated non-compliance in the last 3 years in the home. (117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019(A1)

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 O. Reg. 79/10, s. 50 (2) b.

Specifically, the Licensee shall:

1. Ensure that residents #004, #028 and any other resident presenting with skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument designed for skin and wound assessment.

2. Ensure that residents #004 and #035, and any other resident presenting with skin breakdown, pressure ulcers, skin tears or wounds receive immediate treatment and interventions, including specifically prescribed interventions, to promote healing and prevent infection.

3. Ensure that resident #035, and any other resident presenting with skin breakdown, pressure ulcers, skin tears or wounds, is reassessed weekly by a member of the registered nursing staff, if clinically indicated and that this assessment be documented and communicated to the attending physician during the weekly physician visits.

Grounds / Motifs :

1. The licensee has failed to 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).

As it relates to r. 50. (2) (b) (i), the licensee has failed to ensure that 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.

1) Resident #028 sustained a skin integrity injury to an identified body part that required a medical intervention on a specified day in 2018. The resident's plan of care was reviewed and revised post injury to include a skin and wound care treatment and dressing 9 days later by the home's RAI Coordinator. Further review of the resident's health care record shows that the resident's wound was assessed by the attending physician two days after the injury. No other information was found in the resident's health care record indicating the resident's wound was assessed using a clinically appropriate instrument upon return from the hospital on a specified day in 2018. Progress notes document that the resident's wound was noted to have a change of condition on a specified day. The attending physician was notified that same day and a medication and new dressing treatment were ordered and implemented. The first wound assessment to be documented using the home's weekly wound assessment was done 12 days and then 23 days after the injury occurred.

The home's DOC said that nursing staff are to assess resident wounds immediately upon start of the wound, in the care of resident #028 when the resident returned from hospital and then weekly thereafter. The DOC said that home's nursing staff are to use to weekly wound assessment in Point Click Care (PCC). The home's DOC said that resident #028's wound was not assessed upon return from hospital on a specified day in 2018 nor weekly thereafter. r. 50. (2) (b) (i) (547)

2) Resident #004's health care records were reviewed by inspector #547 on August 29, 2018 regarding skin and wound care related to a pressure ulcer. Resident #004's Treatment Administration Record (TAR) documented the physician's order to have a wound treatment to cleanse the wound with normal saline, then apply a specific treatment product and to cover with another type of dressing daily, for two identified months in 2018. Documented weekly wound assessments were reviewed in the home's electronic documentation system with the Director of Care (DOC) whereby for the two identified months wound assessments using the Licensee's clinically appropriate assessment instrument were completed on two days in one month and then on two days in the second month. These weekly skin assessments identified deterioration to the resident's wound between two identified dates over a six week period.

The DOC indicated to inspector #547 on September 4, 2018 if the assessment was not documented in the electronic documentation system, that the assessment was not completed. The DOC indicated the weekly wound assessments are supposed to be documented every Wednesday. The home's expectation was to have weekly wound assessments for follow up with treatment plan with the weekly visits with the home's physician.

As such, resident #004 who exhibited altered skin integrity of a wound did not receive weekly assessments using the clinically appropriate assessment instrument for three identified weeks in 2018. A Skin assessment instrument was completed on a specified day in the second month, however was not completed again until 13 days later which was the last assessment documented in the home, to date during the review period. r. 50. (2) (b) (i) (547)

As it relates to r. 50. (2) (b) (ii), the licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required r. 50. (2) (b) (ii)

1) Resident #035 was admitted to the home in on a specified day in 2018 with a pressure ulcer to an identified region. Over the next two months, new pressure ulcers developed, one to an identified region noted on a specified day and one to another identified region that was noted 14 days later.

The resident's plan of care was reviewed and revised on the day the last pressure ulcer was identified to include changes to the skin and wound care treatment. The previous wound treatment dressing q2 days was discontinued. A new treatment order for cleansing the wound with NSS with the application of a specialised dressing q2 days was prescribed by the attending physician. A review of the resident's electronic Treatment Administration Record (eTAR) indicated that the new treatment and dressing order was changed on four (4) identified dates that were not at q2 day intervals. No other documentation was found in the resident's health care record to indicate that the wound care treatment and dressing was done as per the medical order.

On a specified date, resident #035's wound, which was assessed as having progressed and was presenting with drainage, was reassessed by the attending

physician. A new skin and wound care treatment with a specialized dressing to be done daily was ordered. A review of the resident's eTAR showed that the new treatment and dressing was not done during the next four days. No other documentation was found in the resident's health care record to indicate that the wound care treatment and dressing was done as per the medical order.

RN #102 and the DOC said that on both the two identified days that new wound treatments were ordered, the home did have the necessary treatment and dressing supplies in the home to initiate the new skin and wound care orders. They also said that the first wound treatment and dressing order, ordered on a specified day, was identified in the eTAR that same day. However as per RPN staff #113 and #115, the eTAR identified the treatment as "being on order" and nursing staff could not document when dressing changes were done in the eTAR. The only way to document would be to document in the progress notes. RN #102 and the DOC said that they could not recall and have no information as to if the new wound treatment and dressing order was done other than on the documented on four identified days. In regards to the second wound treatment and specialized dressing, the order was clearly documented in the eTAR as being "active". RN #102 and the DOC said that they could not recall and have no information as to if the new wound treatment and dressing order was done on the four days post change of the wound treatment order.

As such, resident #035 did not receive immediate treatment and interventions to their wounds, as per two specified medical orders. r. 50. (2) (b) (ii) (547)

2) Resident #004's health care records were reviewed regarding a wound for two identified months in 2018. The Treatment Administration record (TAR) documented the physician's orders for the wound to cleanse the wound with normal saline, then to apply a specific treatment dressing and to cover with another type of dressing daily that was due at 2000 hours daily. The TAR indicated that the resident's dressing was not completed and unsigned on 13 of 31 days for specified month and on six of the 29 days reviewed in another month.

RN #102 indicated the wound assessments are to be completed weekly by the Registered Practical Nurses working with resident #004 during the evening shifts. RN #102 indicated that the TAR is required to be signed once the wound treatment is completed as ordered. RN #102 further indicated if the TAR is unsigned, that the

dressing was not completed as ordered.

Inspector #547 observed on August 27, 2018 with RN #102 and RPN #126 to not have the appropriate medical product for resident #004's wound care treatment as ordered. RPN #126 indicated that the medical treatment product required was a specific product, however the home did not have this product in stock and were replacing this product with a another product that the RPN's are altering to dress the resident's wound. RPN #126 indicated concern for resident #004's wound as it was deteriorating.

On August 31, 2018 the Director of Care (DOC) indicated not being aware that the registered nursing staff were not utilizing the appropriate medical product for resident #004's wound treatment and likely ordered the wrong product. The DOC confirmed that the last time the resident would have received the appropriate treatment product would have been on a specified date in 2018. DOC indicated that they did not provide any direction to staff what to use in the interim. The DOC indicated the registered nursing staff adapted the treatment product without informing the DOC or the physician. The resident's physician was informed by RN #102, on a specified date, who then ordered to hold the resident's specific wound treatment and would reassess the resident's wound the following day.

As such, the resident's treatment and interventions ordered for a wound was not completed daily or with the appropriate medical product as prescribed. r. 50. (2) (b) (ii) (117)

As it relates to r. 50. (2) (b) (iv), the licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #035 was admitted to the home on a specified date in 2018 with a stage 2 pressure ulcer to an identified region. Over the next two months, new pressure ulcers developed, one to an identified region noted on a specified day and one to another identified region that was noted 14 days later. Nineteen (19) days later, one of the wounds was noted to have a deteriorating change in condition.

The resident's plan of care was reviewed and revised on the day the last pressure

ulcer was identified, to include changes to the skin and wound care treatment and dressing and again 19 days later to include a medication treatment and a specialized dressing for the wound. Further review of the resident's health care record shows that the resident's wound was assessed by the attending physician on a specified day after the development of the last pressure ulcer as well as 19 and 26 days later when one of the wounds presented with foul odours and drainage.

As part of the home's skin and wound care program, residents exhibiting altered skin integrity, including pressure ulcers and wounds are to be assessed and reassessed by a member of the home's registered nursing staff using a clinically appropriate assessment tool on a weekly basis, if clinically indicated. A review of the resident's health care record found that the resident's wound was assessed at the time of admission. The resident was not assessed for the next 10 days until a specified day in 2018. The wound was then assessed four (4) days and then 16 days after the specified day of assessment. The next documented wound assessment by registered nursing staff was done on a specified day, one month after the last weekly skin assessment was done and also when the pressure ulcers were noted to have foul odours and drainage.

The home's DOC said that the home's nursing staff are to use weekly wound assessment in PCC. The home's DOC said that resident # 035's pressure ulcers should have been assessed weekly as the resident was admitted with a pressure ulcer and was identified as being at risk for increased skin integrity alterations. The DOC said that the development and progression of the new pressure ulcers should have been reassessed weekly to ensure the appropriate treatments and monitoring of the resident's wounds. r. 50. (2) (b) (iv) (117)

Further to this compliance order

- findings of non-compliance under WN # 5 LTCHA s. 6 (10) b) are issued in regards the licensee failed to ensure that when the residents are reassessed and the plan of care reviewed and revised, at least every six months and at any other time, when the residents care needs change or care set out in the plan is no longer necessary as it relates to three residents that have skin and wound care issues.

- findings of non-compliance under WN #19 O.REG. s. 229 (4) are issued in regards

that the licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

The risk is identified as a level 3 as there is actual harm or risk of harm related to the skin and wound issues identified. The scope is a level 3 widespread as this affects three residents out of three. The home's compliance history is a level 4 as despite MOHLTC action (VPC, Order) non-compliance continues with the original area of non-compliance.

Inspection # 2016_380593_0028 – a VPC was issued for O.REG. s. 50 (2) b) (iv)) related to skin and wound

Inspection # 2015_200148_0034 – a WN was issued for O.REG. s. 50 (2) b) (iv)) related to skin and wound
(117)

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

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 23rd day of January, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by LYNE DUCHESNE (117) - (A1)

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 : Ottawa Service Area Office