Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 13, 2016	2016_435621_0015	024742-16, 024748-16, 024760-16, 024765-16	Follow up

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

LAKEHEAD MANOR
135 SOUTH VICKERS STREET THUNDER BAY ON P7E 1J2

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

JULIE KUORIKOSKI (621), KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 24 - 28, 2016.

Complaint inspection #2016_435621_0016 and Critical Incident System (CIS) inspection #2016_435621_0017 were conducted concurrently with this inspection.

This Follow Up inspection was related to compliance order (CO) #001, issued during inspection #2016_433625_0003 related to resident rights; CO#002 issued during inspection #2016_433625_0003 related to plan of care; CO#003 issued during inspection #2016_433625_0003 related to accommodation services; and CO#004 issued during inspection #2016_433625_0003 related to duty to protect.

A finding of non-compliance related to LTCHA s.6(1)(c) found during concurrent CIS inspection report #2016_435621_0017 was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director's of Care (ADOC's), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

The Inspectors also reviewed resident health records, the home's policies and procedures, employee files, employee training records, and the home's investigation files. Inspectors completed observations of residents, observed the provision of care and services to residents, and observed resident and staff interactions.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Safe and Secure Home
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **1 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
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #003	2016_433625_0003	625
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #004	2016_433625_0003	625
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2016_433625_0003	625

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

During the inspection, Inspector #625 was following up on outstanding Compliance Order #002, issued during inspection #2016_433625_0003 with a compliance date of August 22, 2016. As part of the order, the home was directed to:

(a) Complete a review of each resident's plan of care and ensure that the plan set out the planned care for each resident and provided clear directions to staff and others who provided direct care to the residents;
(b) Conduct an audit to ensure that all current orders provided clear directions to staff and others who provided direct care to residents, and accurately reflected all components of each resident's plan of care; and
(c) Have the home's leadership team review and approve the content of each resident's plan of care, to ensure that they were current, complemented and were consistent.

During inspection #2016_433625_0003, non-compliance was identified regarding resident #012's (previously #022's) plan of care related to altered skin integrity.

During an interview with Inspector #625 on a specific day in October 2016, resident #012 identified that they had altered skin integrity and were provided medical treatments.

A review by Inspector #625 of resident #012's health care record identified orders entered in Point Click Care (PCC) for the resident's altered skin integrity. The orders were not consistent with respect to the specific type of medical treatment applied or dates that the medical treatments were to be completed. One order entered on a specific day in October 2015, indicated that resident #012 was to have their medical treatment completed on a specified number of days each week, using a specific type of prescription treatment. Another order entered on a day in March 2016, indicated that resident #012 was to have treatments to their altered skin integrity on a different treatment schedule using a another specific type of prescribed treatment.

During interviews with Inspector #625 on a specific day in October 2016, RN #106 and ADOC #111 reviewed the PCC orders for resident #012 and identified that the resident had active orders, dated from October 2015, and March 2016, related to their altered skin integrity treatments. The RN identified that the orders were not consistent for the

frequency of changing of the treatment. Additionally, ADOC #111 acknowledged that documentation for the altered skin integrity treatments was unclear as to the type of prescribed treatment to be used.

In an additional interview on another day in October 2016, ADOC #111 stated to Inspector #625 that the home had not completed an audit, as specified in compliance order #002, to ensure that resident plans of care provided clear directions to staff and others who provided direct care to residents. [s. 6. (1) (c)] (625)

2. During inspection #2016_433625_0003, non-compliance was identified regarding resident #010's (previously resident #024's) plan of care regarding the use of a medical device for a specified medical condition.

During an interview on a specific day in October 2016, with Inspector #625, resident #010 confirmed that they continued to use a medical device which staff changed and provided care for.

A review of resident #010's most current care plan by Inspector #625 on a specific day in October 2016, identified that staff refer to the resident's electronic Treatment Administration Record (eTAR) for care of the medical device. A review of the eTAR by the Inspector identified that the eTAR did not contain information related to this resident's medical device. A review of the resident's eMAR identified an entry to change the medical device when needed. The "Physician's Order Review" dated from August 2016, included an order for a medical device to be changed when needed. Inspector #625 was not able to locate information related to the size of resident #010's medical device in the resident's plan of care.

During an interview with Inspector #625 on a specific day in October 2016, RPN #105 stated that they were responsible for changing resident #010's medical device when needed, and would refer to the order for specific details related to changes to the medical device.

During an interview with Inspector #625 on a specific day in October 2016, RN #106 acknowledged that the current care plan referred staff to the eTAR for details related to care of the medical device, but that no details were located on the eTAR. RN #106 identified that instructions related to the medical device were located on the eMAR, but that the instructions only identified that staff change the medical device when needed, and did not identify details such as the size of the medical device required. RN #106

stated that they would have to ask other staff for directions on how to specifically change the medical device as no specific directions were on the plan of care.

During an interview with Inspector #625 on a specific day in October 2016, ADOC #111 stated that resident #010's medical device information in their plan of care should have included the size of the medical device that staff were to use. [s. 6. (1) (c)] (625)

3. During inspection #2016_433625_0003, non-compliance was identified regarding resident #009's (previously resident #002's) plan of care related to oral care.

Inspector #625 reviewed resident #009's current care plan on a specific day in October 2016, which indicated that Personal Support Workers (PSWs) were to provide specific oral care to this resident after meals and at bedtime. Under another section of the care plan, an intervention indicated that this resident was not wearing a dental device at this time.

A review of resident's #009's most current "Resident Assessment Instrument – Minimum Data Set" dated from October 2016, identified that this resident used a dental device.

During an interview on a specific day in October 2016 with Inspector #625, PSW #107 stated that the resident no longer wore a dental device.

During interviews with RPNs #108 and #109 on another day in October 2016, they stated that resident #009 no longer wore a dental device.

During interviews with Inspector #625 on a specific day in October 2016, PSW #110 stated that resident #009 had a dental device but no longer wore it. PSW #110 stated that the resident's spouse asked the staff not to use the dental device and that the resident had not been wearing the dental device for the past month and a half to two month period. PSW #110 identified that the resident's care plan should have identified that the resident no longer wore a dental device. [s. 6. (1) (c)] (625)

4. Inspector #621 reviewed a Critical Incident System (CIS) report submitted to the Director on a specific day in August 2016, related to an incident of alleged neglect of resident #004, by PSW #104. According to the CIS report, resident #004 asked PSW #104 to provide specific care and they did not perform the requested care. An amendment of the CI report on a specific day in September 2016, identified that the resident and family requested, the home provide the above requested care using a

specific application technique to reduce the onset of the resident's specific medical condition.

The Inspector reviewed the resident's current care plan, last revised in September 2016, which identified that the resident had been complaining of a medical condition which caused the requested care to become necessary. It was identified that the PSW staff were to check once per shift to determine if the specific care was required and perform care as needed. The care plan did not identify that the home would perform the specific care as identified to be effective by the resident and their family. Additionally, the written care plan did not include the resident's preference to use their own items specific to this care.

During an interview on a specific day in October 2016, with resident #004, they reported to Inspector #621 that since the incident, two sets of this specific item were provided to the home, and that "one of the sets" was kept in a specific location for staff to use. Additionally, resident #004 reported that when PSW staff provided the specific care, they now used the specified technique and that this technique had been working and that they did not have further issues with their medical condition.

During an interview with PSW#103 and #102 on a specific day in October 2016, they reported to the Inspector that the PSW's were responsible for providing specific care on identified days twice weekly, and/or as required (PRN). PSW #103 identified that information pertaining to this specific care were kept on record in a binder on the unit. PSW #102 indicated that supplies for this care was kept on a specific cart or in a specified location in the resident's room if it were items the resident had brought from home. When Inspector #621 asked where documentation was kept pertaining to staff utilizing a resident's own items and a special care technique, PSW #103 stated they were not aware of where this information would be kept. PSW #102 reported that they did not refer to any written information.

During an interview with PSW #101 on a specific day in October 2016, they reported to Inspector #621 that resident #004 had provided their own specific supplies to the home. PSW #101 identified that there would be documentation about resident #004's specific care needs in their electronic care plan and Kardex, as well as their written care plan kept on the unit. PSW #101 reviewed resident #004's Kardex on Point of Care (POC), and the most recent written care plan with the Inspector. From this review, PSW #101 indicated that there was no information documented on the electronic Kardex or written care plan regarding this resident's preference to use their own items, or information

outlining to staff the specific care technique that this resident requested to be utilized to support their care needs.

During an interview, the Director of Care (DOC) reported to the Inspector that it was their expectation that information pertaining to a change in resident care needs would be documented in the progress notes and care plan as part of their plan of care. The DOC confirmed that the units had written care plans which all disciplines, including the PSW's had access to and if there were any changes to a resident's care needs, that these changes would be hand written onto the care plan for update. The DOC identified that the written care plan found on the units would be the most current. On review of resident #004's most current written care plan, DOC confirmed that details relating to this resident's preference to use their items, or information outlining the specific care technique that PSW's were to use to support this resident's care needs were not documented in the care plan and therefore the written plan of care did not provide clear direction to staff and others who provided direct care to this resident. [s. 6. (1) (c)] (621)

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

On a specific day and time in October 2016, Inspector #625 observed a door accessing the second floor laundry shoot to be open, unlocked and unsupervised. It was identified by the Inspector that the laundry shoot opened to a drop down passage with no visible bottom to it.

During an interview with PSW #112 on a day in October 2016, they stated to the Inspector that the door should have been closed.

On another day and time in October 2016, Inspector #625 observed a door accessing the sixth floor laundry shoot to be open, unlocked and unsupervised. The laundry shoot was easily opened by the Inspector and led to a passage way leading downwards with no visible bottom to it.

During an interview on the same day in October 2016, with the Director of Care, they stated to the Inspector that the door should have been closed and locked, as residents were not permitted in the laundry shoot area. [s. 9. (1) 2.] (625)

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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they were not being supervised by staff, to be implemented voluntarily.

Issued on this 3rd day of January, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE KUORIKOSKI (621), KATHERINE BARCA (625)
Inspection No. / No de l'inspection :	2016_435621_0015
Log No. / Registre no:	024742-16, 024748-16, 024760-16, 024765-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 13, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	LAKEHEAD MANOR 135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jonathon Riabov

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_433625_0003, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall:

a) review and revise the plans of care for resident #004, #009, #010, and #012, to ensure that they provide clear directions to staff and others who provide direct care to the resident;

b) develop a process to ensure that plans of care provide clear directions and are understood by all staff and others who provide direct care to the residents;

c) develop an auditing process for written plans of care that will identify inaccuracies, so that corrections can be made in order to ensure that the planned care for residents is clearly documented for staff and others who provide direct care to residents; and

d) educate and retrain staff involved in the development of residents' written plans of care, including the risks associated with not providing clear directions for the planned care of residents to staff and others who provide direct care to residents.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Inspector #621 reviewed a Critical Incident System (CIS) report submitted to the Director on a specific day in August 2016, related to an incident of alleged neglect of resident #004, by PSW #104. According to the CIS report, resident #004 asked PSW #104 to provide specific care and they did not perform the requested care. An amendment of the CI report on a specific day in September 2016, identified that the resident and family requested, the home provide the above requested care using a specific application technique to reduce the onset of the resident's specific medical condition.

The Inspector reviewed the resident's current care plan, last revised in September 2016, which identified that the resident had been complaining of a medical condition which caused the requested care to become necessary. It was identified that the PSW staff were to check once per shift to determine if the specific care was required and perform care as needed. The care plan did not identify that the home would perform the specific care as identified to be effective by the resident and their family. Additionally, the written care plan did not include the resident's preference to use their own items specific to this care.

During an interview on a specific day in October 2016, with resident #004, they reported to Inspector #621 that since the incident, two sets of this specific item were provided to the home, and that "one of the sets" was kept in a specific location for staff to use. Additionally, resident #004 reported that when PSW staff provided the specific care, they now used the specified technique and that this technique had been working and that they did not have further issues with their medical condition.

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During an interview with PSW #101 on a specific day in October 2016, they reported to Inspector #621 that resident #004 had provided their own specific supplies to the home. PSW #101 identified that there would be documentation about resident #004's specific care needs in their electronic care plan and Kardex, as well as their written care plan kept on the unit. PSW #101 reviewed resident #004's Kardex on Point of Care (POC), and the most recent written care plan with the Inspector. From this review, PSW #101 indicated that there was no information documented on the electronic Kardex or written care plan regarding this resident's preference to use their own items, or information outlining to staff the specific care technique that this resident requested to be utilized to support their care needs.

During an interview, the Director of Care (DOC) reported to the Inspector that it was their expectation that information pertaining to a change in resident care needs would be documented in the progress notes and care plan as part of their plan of care. The DOC confirmed that the units had written care plans which all disciplines, including the PSW's had access to and if there were any changes to a resident's care needs, that these changes would be hand written onto the care plan for update. The DOC identified that the written care plan found on the units would be the most current. On review of resident #004's most current written care plan, DOC confirmed that details relating to this resident's preference to use their items, or information outlining the specific care technique that PSW's were to use to support this resident's care needs were not documented in the care plan and therefore the written plan of care did not provide clear direction to staff and others who provided direct care to this resident. (621)

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

During this inspection, Inspector #625 was following up on an outstanding Compliance Order #002, issued during inspection #2016_433625_0003 with a compliance date of August 22, 2016. As part of the order, the home was ordered to:

(a) Complete a review of each resident's plan of care and ensure that the plan set out the planned care for each resident and provided clear directions to staff and others who provided direct care to the residents;
(b) Conduct an audit to ensure that all current orders provided clear directions to staff and others who provided direct care to residents, and accurately reflected

all components of each resident's plan of care; and
(c) Have the home's leadership team review and approve the content of each resident's plan of care, to ensure that they were current, complemented each other and were consistent.

During inspection #2016_433625_0003, non-compliance was identified regarding resident #009's (previously resident #002's) plan of care related to oral care.

Inspector #625 reviewed resident #009's current care plan on a specific day in October 2016, which indicated that Personal Support Workers (PSWs) were to provide specific oral care to this resident after meals and at bedtime. Under another section of the care plan, an intervention indicated that this resident was not wearing a dental device at this time.

A review of resident's #009's most current "Resident Assessment Instrument – Minimum Data Set" dated from October 2016, identified that this resident used a dental device.

During an interview on a specific day in October 2016 with Inspector #625, PSW #107 stated that the resident no longer wore a dental device.

During interviews with RPNs #108 and #109 on another day in October 2016, they stated that resident #009 no longer wore a dental device.

During interviews with Inspector #625 on a specific day in October 2016, PSW #110 stated that resident #009 had a dental device but no longer wore it. PSW #110 stated that the resident's spouse asked the staff not to use the dental device and that the resident had not been wearing the dental device for the past month and a half to two month period. PSW #110 identified that the resident's care plan should have identified that the resident no longer wore a dental device. (625)

3. During inspection #2016_433625_0003, non-compliance was identified regarding resident #010's (previously resident #024's) plan of care regarding the use of a medical device for a specified medical condition.

During an interview on a specific day in October 2016, with Inspector #625, resident #010 confirmed that they continued to use a medical device which staff

changed and provided care for.

A review of resident #010's most current care plan by Inspector #625 on a specific day in October 2016, identified that staff refer to the resident's electronic Treatment Administration Record (eTAR) for care of the medical device. A review of the eTAR by the Inspector identified that the eTAR did not contain information related to this resident's medical device. A review of the resident's eMAR identified an entry to change the medical device when needed. The "Physician's Order Review" dated from August 2016, included an order for a medical device to be changed when needed. Inspector #625 was not able to locate information related to the size of resident #010's medical device in the resident's plan of care.

During an interview with Inspector #625 on a specific day in October 2016, RPN #105 stated that they were responsible for changing resident #010's medical device when needed, and would refer to the order for specific details related to changes to the medical device.

During an interview with Inspector #625 on a specific day in October 2016, RN #106 acknowledged that the current care plan referred staff to the eTAR for details related to care of the medical device, but that no details were located on the eTAR. RN #106 identified that instructions related to the medical device were located on the eMAR, but that the instructions only identified that staff change the medical device when needed, and did not identify details such as the size of the medical device required. RN #106 stated that they would have to ask other staff for directions on how to specifically change the medical device as no specific directions were on the plan of care.

During an interview with Inspector #625 on a specific day in October 2016, ADOC #111 stated that resident #010's medical device information in their plan of care should have included the size of the medical device that staff were to use. (625)

4. During inspection #2016_433625_0003, non-compliance was identified regarding resident #012's (previously #022's) plan of care related to altered skin integrity.

During an interview with Inspector #625 on a specific day in October 2016, resident #012 identified that they had altered skin integrity and were provided

medical treatments.

A review by Inspector #625 of resident #012's health care record identified orders entered in Point Click Care (PCC) for the resident's altered skin integrity. The orders were not consistent with respect to the specific type of medical treatment applied or dates that the medical treatments were to be completed. One order entered on a specific day in October 2015, indicated that resident #012 was to have their medical treatment completed on a specified number of days each week, using a specific type of prescription treatment. Another order entered on a day in March 2016, indicated that resident #012 was to have treatments to their altered skin integrity on a different treatment schedule using a another specific type of prescribed treatment.

During interviews with Inspector #625 on a specific day in October 2016, RN #106 and ADOC #111 reviewed the PCC orders for resident #012 and identified that the resident had active orders, dated from October 2015, and March 2016, related to their altered skin integrity treatments. The RN identified that the orders were not consistent for the frequency of changing of the treatment. Additionally, ADOC #111 acknowledged that documentation for the altered skin integrity treatments was unclear as to the type of prescribed treatment to be used.

In an additional interview on another day in October 2016, ADOC #111 stated to Inspector #625 that the home had not completed an audit, as specified in compliance order #002, to ensure that resident plans of care provided clear directions to staff and others who provided direct care to residents.

Non-compliance pursuant to LTCHA, 2007 S.O. 2007, s.6(1) has been previously identified under:
- inspection report 2016_433625_0003 with a compliance order served and subsequent Director's Referral issued;
- inspection report 2015_380593_0020 with a compliance order served and subsequent Director's Referral issued (complied December 24, 2015);
- inspection report 2015_269597-0003 with a compliance order served;
- inspection report 2014_269597_0008 with a compliance order served;
- inspection report 2014_304133_0002 with a voluntary plan of correction issued; and
- inspection report 2013_217137_0056 with a compliance order served (complied April 28, 2014).

The decision to re-issue this compliance order was based on the scope of this issue which was wide-spread for residents' plans of care not providing clear direction to staff providing care; the severity which indicated a potential for actual harm; and the compliance history which in spite of previous compliance orders and Director's Referrals issued, there is continued non-compliance with this area of the legislation. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 03, 2017

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 13th day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Kuorikoski

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