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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 26, 2016; Feb 2, 2017	2016_328571_0029	013526-16	Resident Quality Inspection

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

REACHVIEW VILLAGE
130 REACH STREET UXBRIDGE ON L9P 1L3

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

PATRICIA MATA (571), BAIYE OROCK (624), CATHI KERR (641), JULIET MANDERSON-GRAY (607), KELLY BURNS (554), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 11, 12, 13, 14, 17, 18, 19, 20, and 21, 2016

During the RQI the following Critical Incident Logs were inspected concurrently:
Re: alleged resident abuse- 002341-16, 0050784-16, 008358-16, 010793-16, 012223-16, 014000-16, 014382-16, 017649-16, 017656-16, 017898-16, 022516-16, 027080-16, 031241-15 and 030176-16.
Re: transfer to hospital-014905-16, 020168-16
Re: alleged neglect-022529-16
In addition, the following complaint logs were inspected:
023771-16 related to insufficient staffing and 025916-16 related to personal care needs.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), the Regional Manager of Clinical Services, Food Service Manager (FSM), Environmental Services Manager (ESM), Physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nursing Administrative Assistant (NAA), Cooks, Dietary Aides, Restorative Aide, Family Council Representative, Substitute Decision Makers (SDM), Resident Assessment Instrument(RAI) Coordinator, Physiotherapist, and Laundry Aide.

In addition, the inspectors reviewed clinical records, administrative records (staffing schedules, training records, etc), policy and procedures and meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **7 VPC(s)**
- **3 CO(s)**
- **2 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. 6. (2)	CO #901	2016_328571_0029	571

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. During the course of this inspection, Skin and Wound care was inspected. Non-compliance was noted related to wound care for resident #014, #019 and #052.

In addition, through observation, record review and interviews, a number of wounds were noted involving other residents. Non-compliance related to resident #014, #019 and #052 was to be issued at a later date (this non-compliance can now be found in this report). In order to minimize the risk for all residents, an immediate order was issued (Inspection # 2016_328571_0029) to the licensee on October 26, 2016, to ensure that the care set out in the plans of care of all residents with wounds is based on an assessment and the needs of those residents. This order was complied on November 9, 2016. [s. 6. (2)]

2. The licensee failed to ensure the resident, substitute decision maker (SDM), if any, and the designate of the resident/SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care.

Related to Intake #025916-16:

Resident #053 has a medical diagnosis which includes chronic pain. Resident #053 is

dependent on staff assistance for activities of daily living.

The clinical health record, specifically the physician's orders, eMAR (electronic medication administration record) and progress notes were reviewed for the period of June to July 2016 by Inspector #554 and indicated the following:

- eMAR – Resident #053 declined prescribed analgesic twenty-five times during a specified month and ten times over a four day period of the next month. The medication was ordered as follows, give analgesic four times daily.
- Physician's Orders, on a specified date - discontinue routine analgesic
- Progress Notes on a specified date indicate – Substitute Decision Maker (SDM) of resident #053 approached the RPN and voiced concerns that the analgesic for resident #053 had been discontinued. The SDM indicated resident #053 needed the medication for a specified diagnosis that causes pain.The RPN advised the SDM that he/she would place the concern in the physician's book to be reviewed on the next clinic day.

RPN #128 indicated the analgesic, for resident #053, was discontinued due to resident declining the medication. RPN #128 indicated family is normally notified when a resident's medications are added or changed and or when a resident's health condition changes.

The SDM indicated to the inspector that he/she were not informed that the analgesic had been discontinued nor had the SDM been informed that the resident was declining the analgesic. The SDM indicated arriving at the long-term care home asking if the resident had received the analgesic and hearing from the nurse that the medication was discontinued.

Inspector #554 was unable to locate any documentation to support that the SDM of resident #053 was informed that the resident had been declining the medication, specifically the analgesic, nor was there documentation to support that the SDM was notified of the analgesic being discontinued.

The analgesic for resident #053 was restarted when re-ordered by the attending physician.

The licensee failed to ensure the SDM of resident #053 was given the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

3. The licensee failed to ensure the plan of care is reviewed, and revised when resident #050's care needs changed related to falls prevention.

Related to Log #020168-16:

A Critical Incident Report was submitted to the Director for an incident that caused an injury to resident #050 for which the resident is taken to hospital and which resulted in a significant change in the resident's health status .

Resident #050 fell on two separate specified dates. As a result of the second fall, the resident was transferred to hospital and admitted. The resident was assessed for risk of falls after the second fall and determined to be a medium risk for falls.

A review of the clinical records by Inspector #570 for resident #050 over a specified three month period indicated no documentation of the plan of care being reviewed or revised, specific to falls risk and prevention, after the resident fell on the two separate occasions. The plan of care was not updated to include a risk of falls or interventions to prevent falls until after the resident fell a third time.

On October 17, 2016, in an interview with the DOC, she indicated to Inspector #570 the plan of care for resident #050 should have been reviewed and updated to include interventions for falls prevention after both of the resident's falls.

The licensee failed to ensure the plan of care was reviewed, and revised when resident #050's care needs changed related to falls prevention. [s. 6. (10) (b)]

4. The licensee failed to ensure the plan of care is reviewed, and revised when resident #043's care needs changed.

Related to Logs #005074-16 and #030003-16:

A CIR was submitted to the Director in February 2016 and indicated that resident #043 had a physical altercation with resident #042. Resident #042 sustained an injury.

A CIR was submitted to the Director in October 2016 and indicated that resident #043 had a physical altercation with resident #056. Resident #056 sustained an injury.

A review of the clinical records for resident #043 indicated the resident was involved in two incidents of physical altercation with two other residents on two separate dates. The record review indicated no documentation to support that the plan of care had been reviewed or revised, specific to responsive behaviours or risk of altercation with other residents until five days after a second incident of altercation with a co-resident.

On October 21, 2016, in an interview with the DOC, she indicated to Inspector #570 that the plan of care for resident #043 should have been updated to reflect responsive behaviours related to risk of verbal and physical aggression after the first incident of physical altercation.

The licensee failed to ensure the plan of care was reviewed, and revised when resident #043's care needs changed related to responsive behaviours. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector". 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 by ensuring that: resident's SDMs are provided the opportunity to participate fully in the development and implementation of the plan of care; and, that resident's plans of care are reviewed and revised when their care needs change related to falls risk and falls and when care needs change related to responsive behaviours resulting in risks of or actual verbal and physical abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure there is at least one registered nurse, who is an employee of the licensee and a member of the regular nursing staff on duty, and present at all times unless there is an allowable exception to this requirement as described for in regulation 45.

O. Reg. 79/10, s. 1. defines registered nursing staff as members of the staff, who are, a) a registered nurse, or, b) a registered practical nurse.

Under O. Reg. 79/10, s. 45 (1) – the following are exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act.

Under O. Reg. 79/10, s. 45 (2) – for homes with a licensed capacity of more than 64 bed and fewer than 129 beds, the following exception exists:
i. in the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or an agreement with the licensee and who is a member of the regular nursing staff may be used,
ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,
a) the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and
b) a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

Related to Intake #023771-16:

Reachview Village is licensed under the Ministry of Health and Long-Term Care Act; the home has 100 licensed beds.The exception under regulation 45 (1) 1, does not apply to Reachview Village.

Registered Nurse (RN) #107 and #108, Nursing Administrative Assistant (NAA), Director

of Care (DOC) and Executive Director (ED) all indicated the home has struggled with RN coverage due to several registered nurses being off on leaves of absences, sickness, and as a result of retention and recruitment issues.

RN #107 and #108, as well as management, indicated that Staff Relief, a nursing agency, is contracted to supply registered nursing staff, specifically RN's as needs arise. All indicated the home does have a back-up staffing plan should the home not be able to fill a RN shift.

The home's 2016 Staffing Plan identifies that the home has a RN on duty days, evenings and nights; the RN shifts range from eight to twelve hour tours.

The DOC indicated the home attempts to cover all shifts (days, evenings, and nights) with a RN. The DOC indicated that if there is no available RN's, then the nursing agency, Staff Relief, is contacted. The DOC further indicated if the agency has no RN's available, then the licensee will then cover the unfilled RN shift with a registered practical nurse (RPN). The DOC indicated the RPN utilized is a member of the regular nursing staff and that she or the ADOC will be on call.

The 2016 Staffing Plan was provided to Inspector #554 by the Executive Director. The Staffing Plan provides confirmation that registered nurses, who are members of the regular nursing staff are employed by the home, and on duty as per the 24/7 requirement. Contained within the 2016 Staffing Plan, are "Alternate Staffing Contingency Plans" which are to be put into operation if needed, especially in case of emergencies. The staffing contingency plan's purpose is to allow staff to quickly adapt to changing circumstances to minimize disruption in the delivery of care. The staffing plan provides direction in situations when vacation positions or shifts occur.

The Alternate Staffing Contingency Plan specific to RN coverage directs the following:
- Call all available RN's;
- Ask RN on shift to stay later, or the oncoming RN in come in early;
- Replace with RPN;
- Replace with Agency or Director of Care;
-Reassignment of Registered Staff on site to cover all units (resident home areas).

The DOC indicated to Inspector #544 the home was initially using two registered nurses from the nursing agency (Staff Relief); the DOC indicated that one of the two registered nurses was not working out, and therefore only one agency registered nurse was used

on a go forward basis. The DOC indicated the home continued to struggle with 24/7 RN coverage, despite agency use; the DOC indicated due to issues with agency staffing, RN shifts were now being filled with registered practical nurses, employed by the home. The DOC indicated being unsure how many shifts were not covered by an RN during the summer months. The DOC directed the inspector to speak with the Nursing Administrative Assistant regarding the dates and times where the home was without an RN on duty and present in the home.

Nursing Administrative Assistant (NAA), who reports to the DOC, indicated her role, was administrative in nature to the nursing department. Her duties included scheduling and replacement of sick calls and/or leaves of absence for the nursing department. The NAA indicated the home lacked RN coverage during the summer months due to regular RN staff being off, due to leaves of absence, resignations and scheduled vacation. The NAA indicated that the home did utilize a nursing agency, called Staff Relief, to cover RN hours, when the home was without RN coverage. However, the availability of agency RN's was inconsistent. The NAA indicated the agency RN's were cancelling or were not showing up for scheduled shifts. The NAA indicated that she was being directed at one point in the summer to stop using the agency RN's and to cover vacant RN shifts with RPNs. The NAA could not recall who had provided her this direction. The NAA indicated when there was no RN on duty in the home, either the ADOC or DOC would be on call.

The nursing schedule, specifically RN 24/7 coverage, was reviewed for the period of April 1, 2016, to October 20, 2016. The schedule was reviewed with the Nursing Administrative Assistant. She identified that there was no RN on duty and present in the home during the following shifts:

April 2016:
- 5th - between 2000 and 2230 hours
- 7, 15, 16, 21- between 0630 and 1830 hours
- 9th – between 1430 to 0630 hours

May 2016:
- 2 - between 0630 and 1830 hours
- 30, 31 - between 0630 and 1430 hours
- 31 - between 0630 and1430 hours

June 2016:
- 4, 16, 17 – between 1830 and 2230 hours

- 9 – between 0630 and 1030 hours
- 14 – between 0630 and 2230 hours
- 15, 20 – between 0630 and 1830 hours
- 18, 19, 21, 23, 24, 29, 30- between 0630 and 0630 hours the next day
- 22, 25 26, 27, 28- between 1830 and 0630 hours
- 28- between 0630 and 1430 hours

July 2016:
- 1 - between 1830 and 2230 hours
- 2, 8, 27– between 1430 and 0630 hours
- 3, 6, 7, 12, 15, 16, 21, 26, 30 - between 0630 and 0630 hours the next day
- 4, 5, 13, 18, 23 - between 0630 and 1830 hours
- 9, 11, 14, 19, 20, 25, 28- between 1830 and 0630 hours
- 10, 17, 24- between 2230 and 0630 hours
- 22- between 1430 and 2230 hours
- 31 - between 1300 hrs and 0630 hours

August 2016:
- 1, 18, 23, 24, 27 - between 0630 and 1430 hours
- 4, 5, 12, 31 - between 1830 and 0630 hours
- 6, 7, 8, 9, 28 - between 2230 and 0630 hours
- 10, 25 - between 1830 and 2230 hours
- 11 - between 1430 and 0630 hours
- 13, 14 – between 0630 and 2230 hours
- 15 - between 0630 and 1830 hours
- 19 - between 1430 and 2230 hours
- 23, 24- between 2230 hrs to 0630 hours

Sept 2016:
- 2, 21, 22 - between 1830 and 2230 hours
- 4, 6 -between 0630 hrs to 2230 hours
- 7 - between 0630 and 0630 hours the next day
- 8- between 0630 and 1215 hours; between 1830 and 0630 hours
- 10, 17, 18- between 0630 and 1830 hours
- 14, 30- between 1430 and 2230 hours
- 20, 23, 28- between 2230 and 0630 hours
- 26- between 0630 and 1430 hours

October 2016:
- 8, 9, 10 - 0630 hrs to 1430 hrs

In summary, the licensee did not have a RN on duty and present in the home for approximately 100 days, during the period of April 01, through to October 20, 2016. The Nursing Administrative Assistant indicated she was directed to fill shifts not covered by an RN with a Registered Practical Nurse.

The Executive Director indicated being unaware that the Nursing Administrative Assistant was directed to fill Registered Nurse shifts with a Registered Practical Nurse, instead of using agency staff. The Executive Director indicated the shifts not covered with an RN, were not covered by either the Director of Care, nor the Associate Director, but that one of the Nursing Managers would have been on call.

NOTE: A Compliance Order with a Director's Referral has been issued with this non-compliance under the LTCHA., s. 8 (3) due to the large period of time and the number of shifts that a Registered Nurse was not on duty and present in the home and the potential negative outcome this non-compliance may have had on resident care and management of the home. [s. 8. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

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

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1 The licensee failed to ensure that their interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented.

Re: Log #022529-16:

Under O. Reg. s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).
(2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2)

The licensee's skin and wound program LTC-E-90 revised August 2015 was reviewed by Inspector #571. To summarize, the program gives directions including the following:

- each home will have an interdisciplinary skin and wound care team that is led by the Wound Care Champion (WCC)/designate accountable for the skin and wound care outcomes for the home
-the team is to include but, is not limited to: Wound Care Nurse (WCC), Physician/Nurse Practitioner (NP); Nurse; unregulated care provider; MDS-RAI Coordinator; Rehab services (OT/PT); Nutritional team/Dietitian; Regional Clinical Support and external wound care consultants as necessary.
-the interdisciplinary team is to review documentation, assessments, outcomes, and resident assessment protocols (RAPS) to develop individualized resident care plan's based on the resident's needs
-the interdisciplinary skin and wound team will develop, review and update the residents care plan goals, and interventions in collaboration with the SDM to address prevention strategies, skin care and wound management
-staff are to notify the physician and refer to members of the interdisciplinary team if breakdown/healable wounds are not improving in 3 weeks or sooner if required as determined by the assessment
- the treatment observation record (TOR) is to be completed with every dressing change, but minimum every seven days
-the treatment regimen is to be recorded on electronic medication/treatment record (eMAR/eTAR)
-wounds will be photographed monthly
-the interdisciplinary skin and wound care team is to have a process in place to review and document the resident's wound care status and plan of treatment on a regular and as need basis
-the team is to conduct monthly meetings
-the "Monthly Skin Integrity Report" must be completed monthly and communicated to the Physicians/NP, DOC, Dietitian, Rehab team, and regional staff by the 10th of each month

Appendix "A" of the licensee's skin and wound program LTC-E-90 lists the responsibilities of the WCC. These responsibilities include:
-conduct weekly skin and wound care clinical rounds in the home
-assess all skin impairment/wounds and provide treatment recommendations for all new and worsening areas
-discuss treatment recommendation with the resident's Physician and or NP
-provide communication and follow-up to the interdisciplinary team, including the DOC, most responsible nurses and the Physician/NP

-compare list of all residents with altered skin integrity weekly utilizing "High Risk Profile" and monthly tracking report to ensure all residents are being monitored
-completes the "Monthly Skin Integrity Report" by the 10th of each month and shares report with the interdisciplinary skin and wound care team and regional support

Appendix "B" of the licensee's skin and wound program LTC-E-90 lists the responsibilities for other staff members. These responsibilities include:
-Physician/NP-review suggestions from WCC and/or Nurse; assess complex wounds as necessary; documents as required
-Nurse-completes skin and wound assessments and documents; to perform treatments and dressing changes as per the eTAR; dates and initials the dressings each time a new dressing is applied; informs WCC, Physician/NP of any new or worsening skin breakdown and as needed
-monitors all wounds, with every dressing change

A CIR was submitted to the Director for improper/incompetent treatment of a resident that resulted in harm or risk of harm of resident #052. The CIR indicated that a specified wound #1 was originally found in on a specific date and was assessed by the Wound Care Nurse and entries made on Resident Care Plan and electronic treatment administration record (eTAR) for treatment. The wound treatment was changed by the physician the day after the wound was discovered and then four days later. The DOC and ADOC became aware of the decline in resident #052's wound status approximately one month later and upon initial investigation believed the resident did not receive appropriate care/treatment or follow-up for the resident's specified wound #1.

Resident #052 was dependent on staff for care.

The resident's clinical health records and the licensee's administrative records regarding resident #052 were reviewed and interviews conducted by inspector #571.

A review of the clinical health records for resident #052 indicated the following documentation related to the following wounds over a seven month period. To summarize:
-resident #052 was noted to have wound #1 with symptoms of infection in a specified month;
-after review of the health care record, no mention of this wound could be located until two months later; during that month, in addition to wound #1, resident #052 was discovered to have wound #2, #3, and #4

-the next month, resident #052 was noted to have wound #5 and #6 as well; wound #1 worsened and increased in size and is causing resident #052's health to deteriorate; a telephone order is obtained from the NP for an antibiotic for possible infection of wound #1

Resident #052 was sent to the hospital one day after the NP ordered the antibiotics and returned the home the next day. The resident had multiple wounds; all wounds were photographed and dressings changed. Resident #052 passed away the next day.

A review of the treatment observation records (TOR) for resident #052 indicated that a TOR was initiated for the wound #1 on a specified date. No documentation of a TOR being completed weekly could be located.

A TOR was initiated by WCC RPN #156 for wound #5 which included measurements and a description of the wound. WCC RPN #156 changed the dressing intervention. The TOR for wound #5 was filled out on two specific dates, by RPN #109 however no documentation of measurements could be located; RPN #109 documented that wound #5 had a foul odour one day before the NP ordered antibiotics for wound #1.

A review of the clinical health records did not support weekly photographing of resident #052's wounds. One photograph of wound #1 and wound #5 was located before the resident was hospitalized. Inspector #571 observed photographs of the wounds that were taken after resident #052 returned from the hospital. The photographs included 11 separate wounds in total.

No documentation of any other orders related to wounds, with the exception of wound #1, was found until an antibiotic was ordered for wound #1 by NP #157.
No evidence that the Physician or NP assessed any wounds during the last two months previous to resident #052's death could be located.

In separate interviews on October 20, 2016, RPN #109 indicated that he/she only provided care for resident #052 "once or twice" in the two months prior to the residents death; he/she recalled wound #1 and another bad wound on a specified body location. RPN #148 indicated that he/she provided care for resident #052 and that the resident had some skin impairment on a specified body location and when RPN #148 worked a later shift, the wound was "worse". RPN #148 indicated that in the month preceding resident #052's death, the resident had several open areas; one unidentified wound; wound #5 and another unidentified wound.

An interview was conducted with the ED, DOC, and Regional Manager of Clinical Services (RMCS) on October 19, 2016 with Inspector #571 and #641. Inspector #571 indicated to the licensee that the documentation related to wounds in resident #052's clinical health record was difficult to follow, interpret and analyze due to inconsistencies, inaccuracies, and incompleteness. Inspector #571 requested that the ED, DOC and RMCS clarify how many wounds resident #052 had before the resident was sent to the hospital and the exact location of these wounds. It was indicated that resident had wound #5 and wound #1. Inspector #571 inquired about the wounds noted in the clinical health record. It was indicated that these wounds could have been acquired at the hospital. The resident was hospitalized for 38 hours.

In addition, the DOC indicated in the same interview as above, that the multidisciplinary skin and wound team met monthly. The following members are on the team: DOC or ADOC, wound care champion, RAI co-ordinator, Registered Dietitian if available, physiotherapist may be invited, floor nurses if there was "something to speak to" and the RMCS if she is in the building will attend but is not on the team.

The monthly skin integrity reports for a specific four month period were reviewed by Inspector #571. The following was indicated:
-for three specified months (including the month that resident #052 passed away)-no wounds noted in the report for resident #052 despite documentation to the contrary
-for one specified month (the month before resident #052 passed away)-the report indicated one wound noted in the report for resident #052: wound 1; two scabbed areas; new wound

The meeting minutes for the multidisciplinary skin and wound care team for the month resident #052 passed away were reviewed by Inspector #571. Resident #052's name is under the heading "issues/discussion/decisions/rationale". Under the heading "action outcome" the minutes indicate: wound #1…treatment not effective; discontinued; reissued and restarted. No documentation of any of resident #052's other wounds being discussed can be located.

A review of written communication from the DOC to the Licensee after resident #052 passed away indicated that there were issues in the home and stated "a resident who has significant wounds that were poorly cared for, poorly documented and ultimately the staff failed to do their jobs (several RPN staff to varying degrees)" was one of the issues. The written communication further indicated that although the resident had wound #1

that progressively worsened, a follow up was not completed. After the wound began to cause significant pain to the resident to the point that an analgesic had to be ordered and despite five progress notes that indicated the resident was in "excruciating" pain, that the wound care nurse did not assess the wounds, make a referral or document about the status of the wound. The DOC further indicated that the wound became so bad the resident became very ill, had a fever and was hospitalized and from the hospital the DOC learned that the resident had many other wounds; the resident passed away.

A review of the admission note from a Physician at the hospital indicated that resident #052 was sent to the hospital after resident #052's health declined. The Physician examined the resident and noted several wounds. The Physician indicated that he was more concerned about wound #5. The Physician indicated that wound #5 was cause of the resident's decline in health.

Re: resident #014:

Resident #014 is immobile and requires extensive assistance for all activities of daily living.

A review of resident #014's progress notes indicated that the resident had specified wound #1 over five to seven month period.

A review of the TOR for resident #014 indicated the assessment form was completed twice in that time period. No documentation of weekly assessments completed on the TOR could be located by the inspector.

Re: resident #019

Resident #019 is totally dependent on staff for bed mobility.

A review of the progress notes by Inspector #571 for resident #019 indicated the resident had a specified wound, wound #1. A review of the electronic treatment administration record (eTAR) indicated that during a specified two month time period, the dressing for resident #019's wound #1 was to be completed daily. The dressing was not changed on 11 days during this specified two month period as per the progress notes and eTAR.

Related to Log #022516-16:

Resident #051 has a medical diagnosis which includes cognitive impairment, and is reliant on staff for activities of daily living.

A review of the progress notes by Inspector #554 for resident #051 indicated that on a specified date, the resident was noted to have a wound, wound #1. The wound was assessed by an agency RPN and a dressing was applied.

The clinical health record, for resident #051 was reviewed for a specified 11 day period by Inspector #554. No documentation to support that a referral was forwarded to the home's Registered Dietitian specific to resident #051's altered skin integrity could be located.

In an interview with Inspector #554, RN #107, as well as the home's Registered Dietitian indicated that a referral to the Registered Dietitian is to be completed for any resident exhibiting altered skin integrity so that the plan of care can be reviewed and revised as needed.

To summarize, the licensee's skin and wound care program LTC-E-90 was reviewed. Documentation could not be located to support that the licensee ensured the following elements of the program were implemented for resident #052, #019, #051 and #014:

-TOR's were completed weekly for resident #052 and #14
-photographs of resident #052's wounds were taken monthly
-the interdisciplinary team reviewed documentation, assessments, outcomes for resident #052-the DOC or physician were aware of all of the wounds for resident #052
-the interdisciplinary skin and wound team were notified of all of resident #052's wounds; the team developed, reviewed and updated the residents care plan goals, and interventions
-notification to the physician and referral to members of the interdisciplinary team when resident# 052's wounds were not improving
-the "Monthly Skin Integrity Report" which is to be completed by the 10th of each month-no documentation of any resident #052's wounds were on the report except for wound #1
-staff discussed treatment recommendation with the resident's Physician and or NP-no documentation that this was done any time any of resident #052's wounds before the resident was sent to the hospital
-WCC conducted weekly skin and wound care rounds in the home-no documentation to

support weekly skin and wound care rounds occurred
-WCC assessed all skin impairment/wounds and provide treatment recommendations for all new and worsening areas-no documentation to indicate that this occurred
-WCC compared list of all residents with altered skin integrity weekly utilizing "High Risk Profile" and monthly tracking report to ensure all residents are being monitored
-Nurse-completed skin and wound assessments and documents; to perform treatments and dressing changes as per the eTAR; dates and initials the dressings each time a new dressing is applied; informs WCC, Physician/NP of any new or worsening skin breakdown and as needed-evidence supports that not all dressings for resident #019 and #052 were being changed as indicated in the eTAR; that not all wounds were assessed and documented on weekly for resident #052 and #014;
-Nurse monitored all wounds, with every dressing change-no documentation to support this was done for resident #052
-Nurse/WCC completed a referral to the Registered Dietitian for all residents exhibiting altered skin integrity-no evidence to support that this was done for resident #051

The licensee failed to ensure that their interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented.

NOTE: A Compliance Order with a Directors referral has been issued with this non-compliance under O. Reg. 79/10, s. 48 (1) 2. based on the severity and negative outcome it had on resident #052; non-compliance related to wound care was also found with resident #051, #014 and #019.
[s. 48. (1) 2.]

Additional Required Actions:

CO # - 002 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 #4: 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 is complied with.

Related to Log # 010793-16:

A CIR was submitted to the Director for an alleged resident to resident physical abuse that occurred on a specified date between resident #045 and #065, where resident #065 was inappropriately touched by resident #045.

A review of the licensee's Resident Non-Abuse-Ontario- policy (#LP-C-20-ON) dated May 2014 (pages 5-6 of 15) indicate the following:

Definition:
Any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member
- does not include touching, behaviour or remarks of a clinical nature that are appropriate to the provisions of care or assisting a resident with activities of daily living.
-does not include consensual touching, behaviour or remarks of a sexual nature between a resident and a licensee or staff member that is in the course of a sexual relationship that began before the resident was admitted to the home or before the licensee or staff member became a licensee or staff member
e.g. -Sexual speech, unwanted touching or molestation that is sexual in nature, engaging residents in conversation about sexual acts without clinical justification, sexual assault, sexual harassment and rape.
Immediate interventions following allegations or resident abuse
-In cases of physical and or sexual abuse, it is imperative to preserve potential evidence

as the complaint may result in criminal charges. Staff is to ensure that:
- Accurate detailed description of injuries/condition is documented in the Resident's Chart

The clinical health care record for resident #065 was reviewed by Inspector #607. The inspector could not locate any documentation related to the above identified incident in the resident's clinical health record.

During an interview with RN #126 on October 17, 2016, she indicated to Inspector #607 that she did not document in the residents clinical health record on resident #065 who was the recipient of the alleged abuse by resident #045 as she may have forgotten.

In a separate interview with the DOC on October 17, 2016, she indicated that the expectation is when there is an incident of abuse involving two residents; staff are to ensure that there is documentation in both of the residents clinical health record.

The licensee failed to ensure that staff followed the Resident Non-Abuse-Ontario policy. [s. 20. (1)]

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

The policy, Resident Non-Abuse-Ontario, directs the following:
-Any staff member or person, who becomes aware of and or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the Executive Director of the home or, if unavailable, to the most senior supervisor on shift at that time.
- Mandatory reporting under the LTCHA (Ontario), section 24 requires a person to make an immediate report to the Director where there is a reasonable suspicion that certain incidents occurred or may occur (includes, abuse of a resident by anyone).
- The resident's substitute decision maker (if any) and/or any other person specified by the resident, will be notified immediately of the home becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a resident that has resulted in 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.

Related to Log #022516-16:

The DOC submitted a CIR to the Director on a specified date, regarding alleged improper

care/incompetent treatment of a resident that resulted in harm or risk of harm. This CIR was amended by the DOC on a later date; the DOC changed the category to resident to resident alleged physical abuse.

The DOC indicated that during the home's investigation PSW #160 stated that on a specified date, during care, resident #051 was noted to have two injuries, one that had been treated. PSW #160 stated that resident #051 had indicated that two men had beaten him/her. PSW #160 indicated resident #051 was crying in pain when asked what had happened.

The clinical health record for resident #051 was reviewed by Inspector #554 and indicated the following:

- Point of Care (the home's electronic resident flow records) indicated that on a specified date, resident #051 was noted as having a new injury; this was signed by PSW #160.
-the inspector was unable to locate any documentation in resident #051's progress notes specific to resident #051's specified injuries to the resident for that date; nor was there any documentation of the SDM being notified of the injuries noted to resident #051.

The DOC indicated that PSW #160 had indicated in the licensee's investigation statement that he/she had reported resident #051's injuries to RN #161 at shift report the day following the incident. The DOC could not recall if PSW #160 indicated reporting the abuse allegation to RN #161.

The DOC indicated that RN #161 denied receiving any reports from PSW #160 specific to the altered skin integrity and or the alleged abuse incident.

The DOC indicated that she learned of the injuries to resident #051 four days after it was noted by PSW #160, when the concern was brought to her attention by resident #051's SDM. The SDM had just discovered the injuries on resident #051 that day.

PSW #160 and RN #161 were unavailable for an interview during this inspection.

The licensee's policy, Resident Non-Abuse-Ontario was not complied with as RN #161 indicated that PSW #160 did not report the allegation of physical abuse, as reported by resident #051 on a specified date; nor is there documentation to support resident #051's substitute decision maker was notified of resident's injuries or of resident being upset on the same date.

The DOC indicated it is the expectation, that all staff follow the licensee's policy and procedure, specifically zero tolerance of abuse and neglect of residents. The DOC indicated that it is her belief PSW #160 did not follow the home's policy, in reporting the abuse allegation as reported by resident #051. [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 by ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: 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 failed to ensure that a person who had reasonable grounds to suspect abuse of a resident, by anyone, has occurred or may occur, immediately report the

suspicion and the information upon which it was based to the Director.

Related to Log #027080-16:

Resident #054 requires the assistance of staff for activities of daily living.

Police attended Reachview Village on a specified date, indicating that they were investigating an incident reported to them by a Community Social Worker for resident #054 that had allegedly occurred the day before. Police indicated the following was alleged to have occurred:

- Resident #054 alleges that he/she was "spat on, grabbed by the arm, pushed out of the way and had his/her feet kicked out from under him/her", by PSW #136, during morning care on specified date.

An investigation of resident #054's allegation was initiated after the police attended the home, by members of the management team, including Executive Director, and Nursing Management.

It was determined during the licensee's investigation that the Associate Director of Care (ADOC) who was on site the day of the alleged incident, had received a report from resident #054 regarding a staff to resident interaction and completed a Client Service Response Form indicating the following:

- Resident #054 came to ADOC and indicated having concerns about morning care which was provided by PSW #136. Resident indicated to the ADOC, that there had been three incidents in which PSW #136 was mean to the resident. Resident indicated that PSW #136 made a derogatory comment to resident #054. Resident #054 was said to be upset and crying.

The ADOC, who was the supervisor on site on the day of the incident, indicated that resident #054 voiced care concerns, that PSW #136 was mean but did not mention physical abuse had allegedly occurred. The ADOC did not immediately report the allegation of staff to resident verbal abuse to the Director.

A CIR regarding the alleged staff to resident abuse incident was not reported to the Director until the day after the incident was reported. [s. 24. (1)]

2. The licensee failed to comply with LTCHA, 2007, s.24 (1), by not ensuring that 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: 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.

Related to Log #017898-16:

A CIR was submitted on a specified date. The CIR indicated that three days earlier, PSW #116 allegedly purposefully bypassed and did not offer resident #049 any morning nourishment. The family member of resident #049 submitted a written letter of complaint to the licensee the date of the alleged incident with concerns related to PSW #116 not offering the resident a drink or a snack.

On October 19, 2016, in an interview the DOC indicated to Inspector #570 that the Director had not been immediately notified related to the allegation of neglect involving resident #049 by PSW #116. A CIR was submitted three days after the incident. [s. 24. (1)]

3. The licensee failed to ensure that an allegation of physical abuse of resident #032 was reported immediately to the Director.

Related to log #017649-16:

According to a CIR, on a specified date PSW #137 reported to the ADOC that he/she witnessed PSW #138 forcibly restrained resident #032 during care. This allegation of physical abuse of resident #032 was not reported to the Director until three days later when the ED submitted a CIR.

In an interview with the Administrator on October 19, 2016 by Inspector #624, the ED indicated that the licensee's expectation regarding reporting to the Director is for any suspected alleged or witnessed abuse to be reported immediately. She further acknowledged that the report to the Director related to resident #032's alleged abuse was not reported immediately. [s. 24. (1)]

4. The licensee failed to comply with LTCHA, 2007, s. 24. (1), by not ensuring that 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: 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.

Related to Log #030003-16:

A CIR was submitted on a specified date for an incident of resident to resident alleged physical abuse occurring five days earlier. The CI indicated that on a specified date, resident #043 allegedly struck resident #056. Resident #056 complained of pain. A small bruise was noted.

On October 20, 2016 during an interview with RPN #148, the RPN indicated to Inspector #570 that he/she did not call the manager on call to inform of the incident however she/he informed RN #106 who was in charge at the time.

On October 21, 2016 in an interview with the DOC, she indicated to Inspector #570 that the licensee became aware of the alleged resident to resident abuse on a specified date. The incident was not reported to the Director until five days later.

The licensee failed to immediately report an allegation of resident to resident physical abuse to the Director. [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 by ensuring that 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: 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure the behavioural triggers had been identified for resident #045 demonstrating responsive behaviours (where possible), and strategies were identified and implemented to manage the behavioural triggers where possible.

Re: Log #010793-16:

A CIR was submitted to the Director for an alleged resident to resident physical abuse that occurred on a specified date, between resident #045 and #065, where resident #065 was inappropriately touched by resident #045.

Observation of resident #045 by Inspector #607 indicated no responsive behaviours were observed during the inspection by the Inspector.

A review of the progress notes for resident #045 and in an interview, RN #126 indicated to Inspector #607 that resident #045 was sexually inappropriate towards resident #065 on the specified date. RN #126 indicated that he/she had witnessed the incident.

In interviews with PSW #116 on October 18, 2016 and PSW #125 on October 17, 2016, they indicated that they heard that the resident was sexually inappropriate but were unaware of the resident triggers.

A review of the plan of care for resident #045 (in place at the time and after the above identified incidents) indicated the resident demonstrated identified responsive behaviours. The plan of care failed to identify triggers related to the resident being sexual inappropriate towards other resident and strategies of how to manage the triggers.

In an interview with the DOC, she indicated to Inspector #607 that it is the expectations of the licensee are that if there is an identified behaviour, the plan of care should have strategies and interventions of how to manage the inappropriate sexual behaviours of resident #045.

The licensee has failed to ensure the behavioural triggers had been identified for resident #045 demonstrating inappropriate sexual behaviour and strategies identified and implemented to manage the behavioural triggers where possible. [s. 53. (4) (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 the behavioural triggers are identified for resident #045 and any other resident who is demonstrating sexual behaviours, and strategies are identified and implemented to manage the behavioural triggers where possible, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs.

In separate interviews with Inspector #554 over the course of the inspection, PSW #120, Restorative Aide #149 and the Food Services Manager all indicated that there were eight residents assigned seating in the activity room for meal service.
Residents were observed by Inspector #554 over the course of the inspection to be seated in the activity room for meals included resident #053, #068, #069, #070 and #071.

On October 12, 13, 14, and October 17, 2016, the breakfast and/or lunch meal service was observed in the activity room, by inspector #554. Nursing and or Restorative Staff, along with a RPN or the Executive Director were observed, during the above dates, assisting residents at meal times.

The following observations were made:

- October 12, 2016 – lunch service – residents were served a tuna sandwich with a garden salad; other residents served tortiere and lima beans; dessert consisted of strawberries or a tart. All meal courses were placed on tables simultaneously.
- October 13, 2016 – breakfast service – residents were served oatmeal, toast, cheese and sliced peaches. Meal courses were placed on tables simultaneously. At lunch, residents were served, soup, a salad with a roll or stew; dessert consisted of fruit or a brownie. Meal courses were placed on tables simultaneously.
- October 14, 2016 – breakfast service – residents were served oatmeal, eggs, toast and a banana. Meal courses were placed on tables simultaneously. At lunch, residents were served, soup, with a roast beef sandwich with salad or frittata with peas; dessert consisted of chocolate ice cream. Meal courses were placed on tables simultaneously.
- October 17, 2016 – breakfast service – residents were served oatmeal, toast with cheese and fruit. Meal courses were placed on tables simultaneously. At lunch, residents were served soup, sausages and pancakes or a cold plate with salad; dessert consisted of fruit or pudding. Meal courses were placed on tables simultaneously.

The plan of care, for resident's #053, #068, #069, #070 and #071 were reviewed, and such indicated that all identified residents, except resident #053 "eat meals in the activity room". The plan of care does not indicate that the identified residents had been assessed to have all courses served simultaneously.

PSW #120 and Restorative Aide #149 indicated that all courses are served at one time, as it saves staff time, versus the staff running to and from the main dining room for food.

The ED indicated that this has been a past practise that all food items are served at the same time and not course by course, in that particular room.

The Food Services Manager indicated residents are to be served course by course. [s. 73. (1) 8.]

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 by ensuring that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs, to be implemented voluntarily.

WN #8: 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).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff do not perform their responsibilities before receiving training in the following areas:

- The Residents' Bill of Rights
- The home's policy to promote zero tolerance of abuse and neglect of residents
- The duty, under section 24, to make mandatory reports
- The protections afforded under section 26
- Fire prevention and safety
- Emergency and evacuation procedure
- Infection prevention
-all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities
-any other areas provided for in the regulations

The registered nursing schedule was reviewed for the period of April 1, through to October 21, 2016; the schedule demonstrated that agency RN's #162, 163, 164, as well as RPN #154, were scheduled and worked as registered nursing staff at the long-term care home during the identified time period.

Registered Nurse's #162, 163 and 164 were not available for interviews during this inspection.

Registered Practical Nurse # 165, who works for the agency Staff Relief, and has been contracted by Reachview Village, indicated working as a registered nursing staff in the home since July 2016. RPN #154 indicated she had "not received training, regarding Resident Bill of Rights, the home's zero tolerance of abuse, mandatory reporting and or whistle-blowing protections" prior to working with residents.

The DOC, who oversees the operations of the nursing department, indicated we do not orientate agency nursing staff to our policies and or procedures; the actual agency who supplies the registered nursing staff would do that. The DOC indicated that any training and or orientation records would be on file with the Nursing Administrative Assistant.

NAA, who reports to the DOC, indicated being unable to locate any records to support that agency RN's #162, 163 or 164 and or RPN #154 were provided training and or orientation, regarding: Resident Bill of Rights; the home's policy to promote zero

tolerance of abuse and neglect of residents; duty to make mandatory reports; whistle-blowing protections under section 26; fire prevention and safety; emergency and evacuation procedure; and or infection prevention and control.

The NAA indicated she did not provide information, policies or procedures to agency nursing staff. The NAA indicated there were no training records on file in the home specific to Agency Registered Nursing Staff; the NAA indicated Staff Relief, the contracted agency, was also not able to locate the specific training records mentioned earlier for the identified registered nursing staff. (554) [s. 76. (2)]

2. The licensee failed to ensure that all staff received annual retraining, specifically, the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protection.

The 2015 annual mandatory retraining statistics for staff of the home was provided by the DOC. The statistical records provided were reviewed by Inspector #554. The records indicated that there were eighty-three staff and managers employed and on site at Reachview Village in 2015. Seventy-three of the eighty three staff received annual retraining.

To summarize, twelve percent of the long-term care home’s staff did not receive annual retraining in 2015. [s. 76. (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 by ensuring that all staff received annual retraining, specifically, the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protection, to be implemented voluntarily.

WN #9: 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 participates in the implementation of the infection prevention and control program.

On October 19, 2016, Inspector #607 observed PSW #133 in the dining room at lunch. The PSW was assisting resident #026 and #031 with their meals. The PSW got up from assisting the residents with feeding and went to clear soiled dishes from another resident's table. The inspector observed PSW #133 return to assist resident #026 ad #031 with their meals without cleaning his/her hands. During the same meal service, Dietary Aide #143 was observed by Inspector #607 clearing soiled dishes from multiple tables and then proceed to serve multiple residents dessert without cleaning his/her hands.

In an interview with Dietary Aide #145 and PSW #133 on October 19, 2016, with Inspector #607, they indicated that the expectation of the licensee is that staff are to clean hands in between clearing dishes and serving residents.

In an interview with the DOC and FSM on October 20, 2016, it was indicated to Inspector #607 that the above mentioned observations revealed that staff were not participating in the implementation of the infection preventions and control program.

The DOC further indicated that the expectation is that staff should be cleaning hands in between serving meals and clearing soiled dishes.

The licensee has failed to ensure that staff participates in the implementation of the infection prevention and control program related to hand hygiene while assisting residents in the dining room. [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 by ensuring that staff participates in the implementation of the infection prevention and control program related to hand hygiene while assisting residents in the dining room, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident shower has at least two easily accessible grab bars; one grab bar located on the same wall as the faucet and one grab bar located on the adjacent wall.

On October 14, 2016 during an observation of the bathing area located at the Cedar Grove home area, Inspector #570 noted the shower area did not have a shower grab bar located on the adjacent wall of the faucet.

On October 14, 2016 PSW #118 indicated to Inspector #570 that the shower was being used to provide showers to residents residing on the Cedar Grove home area.

On October 17, 2016 Environmental Services Manager (ESM) indicated to the Inspector that he was aware that two grab bars are required but was not aware that a shower grab bar is required at the adjacent wall of the faucet. [s. 14.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg.79/10, r. 71. (3) (b) by not ensuring that resident #049 was offered a between-meal beverage in the morning.

Related to Log #017898-16:

A review of clinical records by Inspector #570 for resident #049 indicated the resident was considered a moderate nutritional risk.

A CIR submitted on a specific date indicated that PSW #116 purposefully bypassed and did not offer resident #049 any morning nourishment. Family member of resident #049 submitted a written letter of complaint to the licensee with concerns related to PSW #116 not offering the resident a drink or a snack.

Review of PSW documentation record for the specified date, under nutrition/snack, indicated that PSW #116 documented that the resident refused the 1100 hours beverage.

On October 19, 2016, in an interview with PSW #116, he/she indicated to inspector #570 that he/she was doing the nourishment cart on a specified date. The PSW indicated resident #049 was not offered a drink that morning as the resident was getting ready to go out with a family member and the resident had juices left at the bed side from breakfast. PSW #116 further indicated that he/she should have offered a drink to the resident. [s. 71. (3) (b)]

WN #12: 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 failed to ensure that resident #032's Substitute Decision Maker (SDM) was immediately notified of an allegation of physical abuse of the resident.

Related to log #017649-16:

According to a CIR submitted on a specified date, PSW #137 reported to the ADOC that he/ she witnessed PSW #138 forcibly restrain resident #032 during care.The SDM of resident #032 was not immediately notified of this allegation of physical abuse of the resident until three days later when the Administrator submitted the CIR to the Director.

In an interview with the ED on October 19, 2016 by Inspector #624, the ED indicated that the resident's SDM was not notified until three days after the incident, on when she became aware of the incident and submitted the CIR . She also indicated that the home's expectation is to notify the SDM immediately upon becoming aware of the allegation. [s. 97. (1) (a)]

2. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) was immediately notified of an allegation of physical abuse of resident #063.

Related to Intake #031241-16:

According to the clinical health record, resident #063 has an identified SDM. A review of the clinical health record, for an identified period of time, provides support that the

assigned SDM, for resident #063, has been contacted, by the long-term care home's staff since admission for both care and financial decisions.

On a specified date, resident #063 approached the DOC to voice care concerns; the resident alleged that he/she was being abused, verbally and physically, by three staff. Resident #063 alleged the incidents of abuse occurred that morning as well as over the previous weekend.

According to the home's investigation notes, resident #063 provided the names of the three PSW's, which he/she alleged were abusing, him/her to the DOC.

Resident #063 indicated to the DOC, that PSW #134 spoke to me in a condescending manner and pointed a finger in my face; PSW #116 abused him/her continuously while performing care; and that PSW #123 was rough when providing care on the Sunday of the specified weekend.

The DOC submitted a Critical Incident Report to the Director, under the Ministry of Health and Long-Term Care; the police were notified of the allegations.

After review of the home's investigation notes, as well as resident #063's clinical health record, no documentation to support that the resident's SDM was notified of the abuse allegations. (554) [s. 97. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a final report was made to the Director, specific to an allegation of staff to resident abuse.

Related to Intake #031241-15:

The DOC submitted a Critical Incident Report to the Director on a specified date, regarding an allegation of staff to resident abuse. The Critical Incident Report indicated investigation pending.

A final report regarding the outcome of the investigation of the alleged staff to resident abuse was not submitted to the Director. [s. 104. (3)]

Issued on this 9th day of February, 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) :	PATRICIA MATA (571), BAIYE OROCK (624), CATHI KERR (641), JULIET MANDERSON-GRAY (607), KELLY BURNS (554), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2016_328571_0029
Log No. / Registre no:	013526-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 26, 2016; Feb 2, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT,8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	REACHVIEW VILLAGE 130 REACH STREET, UXBRIDGE, ON, L9P-1L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marilynne Gordon

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 : 901

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee is ordered to immediately:
-ensure a member or members of the nursing staff complete a head to toe assessment for all residents to assess skin integrity, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment
-ensure all residents identified with altered skin integrity receive appropriate treatment and interventions to reduce pain, promote healing, and prevent infection, as required
-reassess all existing wounds to ensure correct location, description and appropriate treatment and documentation

All parts of this order are to be complied by November 4, 2016.

Grounds / Motifs :

1. A Resident Quality Inspection was conducted from October 11, 2016 through to October 21, 2016. During the course of this inspection, skin and wound care was reviewed. Several issues were noted related to the assessment and needs for wound care for resident #014, 019 and 052. Non-compliance related specifically to skin and wound care assessments and needs for these residents will be issued at a later date.

In addition the licensee utilizes a ``Monthly Skin Integrity Report``. These reports were reviewed monthly by the Home's Interdisciplinary Skin and Wound Care Team. A review of these reports for a specified five month period by Inspector #571 indicated that the licensee failed to include the following wounds in the reports: in two specified months one wound for resident #052 was missing; in another specified month, one wound for resident #014 was missing; in that same specified month, all wounds for resident #052 were missing. As a result of inconsistencies in the licensee`s tracking of residents with impaired skin integrity, an immediate order was being issued to ensure that all residents with altered skin integrity are identified and the assessments are current in order to ensure the needs related to altered skin integrity for these residents are met.

(571)

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that the home has at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times, except as provided for in the regulations. The plan shall clearly describe in detail the implementation of: a) strategies to recruit and retain registered nurses; b) strategies to manage absenteeism and support prompt return to work; and c) staffing re-deployment and short-term workforce replacement strategies to manage unplanned and/or planned absences.

This plan must be submitted in writing to Patti Mata, LTCH Inspector by fax at 613-569-9670 on or before February 17, 2017 .

Grounds / Motifs :

1. The licensee failed to ensure there is at least one registered nurse, who is an employee of the licensee and a member of the regular nursing staff on duty, and present at all times unless there is an allowable exception to this requirement as described for in regulation 45.

O. Reg. 79/10, s. 1. defines registered nursing staff as members of the staff, who are, a) a registered nurse, or, b) a registered practical nurse.

Under O. Reg. 79/10, s. 45 (1) – the following are exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the

home at all times, as required under subsection 8 (3) of the Act.

Under O. Reg. 79/10, s. 45 (2) – for homes with a licensed capacity of more than 64 bed and fewer than 129 beds, the following exception exists:
i. in the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or an agreement with the licensee and who is a member of the regular nursing staff may be used,
ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,
a) the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and
b) a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

Related to Intake #023771-16:

Reachview Village is licensed under the Ministry of Health and Long-Term Care Act; the home has 100 licensed beds.The exception under regulation 45 (1) 1, does not apply to Reachview Village.

Registered Nurse (RN) #107 and #108, Nursing Administrative Assistant (NAA), Director of Care (DOC) and Executive Director (ED) all indicated the home has struggled with RN coverage due to several registered nurses being off on leaves of absences, sickness, and as a result of retention and recruitment issues.

RN #107 and #108, as well as management, indicated that Staff Relief, a nursing agency, is contracted to supply registered nursing staff, specifically RN's as needs arise. All indicated the home does have a back-up staffing plan should the home not be able to fill a RN shift.

The home's 2016 Staffing Plan identifies that the home has a RN on duty days, evenings and nights; the RN shifts range from eight to twelve hour tours.

The DOC indicated the home attempts to cover all shifts (days, evenings, and

nights) with a RN. The DOC indicated that if there is no available RN's, then the nursing agency, Staff Relief, is contacted. The DOC further indicated if the agency has no RN's available, then the licensee will then cover the unfilled RN shift with a registered practical nurse (RPN). The DOC indicated the RPN utilized is a member of the regular nursing staff and that she or the ADOC will be on call.

The 2016 Staffing Plan was provided to Inspector #554 by the Executive Director. The Staffing Plan provides confirmation that registered nurses, who are members of the regular nursing staff are employed by the home, and on duty as per the 24/7 requirement. Contained within the 2016 Staffing Plan, are "Alternate Staffing Contingency Plans" which are to be put into operation if needed, especially in case of emergencies. The staffing contingency plan's purpose is to allow staff to quickly adapt to changing circumstances to minimize disruption in the delivery of care. The staffing plan provides direction in situations when vacation positions or shifts occur.

The Alternate Staffing Contingency Plan specific to RN coverage directs the following:
- Call all available RN's;
- Ask RN on shift to stay later, or the oncoming RN in come in early;
- Replace with RPN;
- Replace with Agency or Director of Care;
-Reassignment of Registered Staff on site to cover all units (resident home areas).

The DOC indicated to Inspector #544 the home was initially using two registered nurses from the nursing agency (Staff Relief); the DOC indicated that one of the two registered nurses was not working out, and therefore only one agency registered nurse was used on a go forward basis. The DOC indicated the home continued to struggle with 24/7 RN coverage, despite agency use; the DOC indicated due to issues with agency staffing, RN shifts were now being filled with registered practical nurses, employed by the home. The DOC indicated being unsure how many shifts were not covered by an RN during the summer months. The DOC directed the inspector to speak with the Nursing Administrative Assistant regarding the dates and times where the home was without an RN on duty and present in the home.

Nursing Administrative Assistant (NAA), who reports to the DOC, indicated her

role, was administrative in nature to the nursing department. Her duties included scheduling and replacement of sick calls and/or leaves of absence for the nursing department. The NAA indicated the home lacked RN coverage during the summer months due to regular RN staff being off, due to leaves of absence, resignations and scheduled vacation. The NAA indicated that the home did utilize a nursing agency, called Staff Relief, to cover RN hours, when the home was without RN coverage. However, the availability of agency RN's was inconsistent. The NAA indicated the agency RN's were cancelling or were not showing up for scheduled shifts. The NAA indicated that she was being directed at one point in the summer to stop using the agency RN's and to cover vacant RN shifts with RPNs. The NAA could not recall who had provided her this direction. The NAA indicated when there was no RN on duty in the home, either the ADOC or DOC would be on call.

The nursing schedule, specifically RN 24/7 coverage, was reviewed for the period of April 1, 2016, to October 20, 2016. The schedule was reviewed with the Nursing Administrative Assistant. She identified that there was no RN on duty and present in the home during the following shifts:

April 2016:
- 5th - between 2000 and 2230 hours
- 7, 15, 16, 21- between 0630 and 1830 hours
- 9th – between 1430 to 0630 hours

May 2016:
- 2 - between 0630 and 1830 hours
- 30, 31 - between 0630 and 1430 hours
- 31 - between 0630 and1430 hours

June 2016:
- 4, 16, 17 – between 1830 and 2230 hours
- 9 – between 0630 and 1030 hours
- 14 – between 0630 and 2230 hours
- 15, 20 – between 0630 and 1830 hours
- 18, 19, 21, 23, 24, 29, 30- between 0630 and 0630 hours the next day
- 22, 25 26, 27, 28- between 1830 and 0630 hours
- 28- between 0630 and 1430 hours

July 2016:

- 1 - between 1830 and 2230 hours
- 2, 8, 27– between 1430 and 0630 hours
- 3, 6, 7, 12, 15, 16, 21, 26, 30 - between 0630 and 0630 hours the next day
- 4, 5, 13, 18, 23 - between 0630 and 1830 hours
- 9, 11, 14, 19, 20, 25, 28- between 1830 and 0630 hours
- 10, 17, 24- between 2230 and 0630 hours
- 22- between 1430 and 2230 hours
- 31 - between 1300 hrs and 0630 hours

August 2016:
- 1, 18, 23, 24, 27 - between 0630 and 1430 hours
- 4, 5, 12, 31 - between 1830 and 0630 hours
- 6, 7, 8, 9, 28 - between 2230 and 0630 hours
- 10, 25 - between 1830 and 2230 hours
- 11 - between 1430 and 0630 hours
- 13, 14 – between 0630 and 2230 hours
- 15 - between 0630 and 1830 hours
- 19 - between 1430 and 2230 hours
- 23, 24- between 2230 hrs to 0630 hours

Sept 2016:
- 2, 21, 22 - between 1830 and 2230 hours
- 4, 6 -between 0630 hrs to 2230 hours
- 7 - between 0630 and 0630 hours the next day
- 8- between 0630 and 1215 hours; between 1830 and 0630 hours
- 10, 17, 18- between 0630 and 1830 hours
- 14, 30- between 1430 and 2230 hours
- 20, 23, 28- between 2230 and 0630 hours
- 26- between 0630 and 1430 hours

October 2016:
- 8, 9, 10 - 0630 hrs to 1430 hrs

In summary, the licensee did not have a RN on duty and present in the home for approximately 100 days, during the period of April 01, through to October 20, 2016. The Nursing Administrative Assistant indicated she was directed to fill shifts not covered by an RN with a Registered Practical Nurse.

The Executive Director indicated being unaware that the Nursing Administrative

Assistant was directed to fill Registered Nurse shifts with a Registered Practical Nurse, instead of using agency staff. The Executive Director indicated the shifts not covered with an RN, were not covered by either the Director of Care, nor the Associate Director, but that one of the Nursing Managers would have been on call.

NOTE: A Compliance Order with a Director's Referral has been issued with this non-compliance under the LTCHA., s. 8 (3) due to the large period of time and the number of shifts that a Registered Nurse was not on duty and present in the home and the potential negative outcome this non-compliance may have had on resident care and management of the home. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 21, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

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

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

Order / Ordre :

The licensee is ordered to prepare, submit and implement a plan to ensure that all registered nursing staff, including agency staff, receive education on the licensee's Skin and Wound Care Program LTC-E-90 revised August 2015. Specifically, by the end of the education period, through a combination of clinical bedside teaching, individualized directed reading and interactive case-based discussions, every registered nurse shall demonstrate the knowledge and skill to:

1. Identify residents at risk for skin and wound complications/problems
2. Provide preventative measures to promote skin integrity
3. Carry-out the prescribed treatment plan if and when skin and wound problems develop.
4. Document accurately the entire nursing process relating to wounds, including, assessments, interventions, treatments and re-evaluations
5. Use a multidisciplinary approach to devise effective strategies and interventions to resolve complex skin/wound problems, including referrals as required and,
6. To recognize the early signs of septicemia to avoid further complications

In addition, the licensee shall ensure that that the Skin and Wound Care Program LTE-E-90 revised August 2015 is monitored, reviewed and analyzed on an ongoing basis to determine the need for further corrective actions as part of the licensee's quality improvement program.

Furthermore, the licensee shall maintain a detailed written account of all the steps taken and the results achieved during each of the planning, implementation and evaluation phases of this education strategy and monitoring process.

This plan must be submitted in writing to Patti Mata, LTCH Inspector by fax at 613-569-9670 on or before February 17, 2017.

Grounds / Motifs :

1. 1 The licensee failed to ensure that their interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented.

Re: Log #022529-16:

Under O. Reg. s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).
(2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2)

The licensee's skin and wound program LTC-E-90 revised August 2015 was reviewed by Inspector #571. To summarize, the program gives directions including the following:

- each home will have an interdisciplinary skin and wound care team that is led by the Wound Care Champion (WCC)/designate accountable for the skin and wound care outcomes for the home
-the team is to include but, is not limited to: Wound Care Nurse (WCC), Physician/Nurse Practitioner (NP); Nurse; unregulated care provider; MDS-RAI Coordinator; Rehab services (OT/PT); Nutritional team/Dietitian; Regional Clinical Support and external wound care consultants as necessary.
-the interdisciplinary team is to review documentation, assessments, outcomes, and resident assessment protocols (RAPS) to develop individualized resident care plan's based on the resident's needs
-the interdisciplinary skin and wound team will develop, review and update the residents care plan goals, and interventions in collaboration with the SDM to address prevention strategies, skin care and wound management
-staff are to notify the physician and refer to members of the interdisciplinary team if breakdown/healable wounds are not improving in 3 weeks or sooner if required as determined by the assessment
- the treatment observation record (TOR) is to be completed with every dressing

change, but minimum every seven days
-the treatment regimen is to be recorded on electronic medication/treatment record (eMAR/eTAR)
-wounds will be photographed monthly
-the interdisciplinary skin and wound care team is to have a process in place to review and document the resident's wound care status and plan of treatment on a regular and as need basis
-the team is to conduct monthly meetings
-the "Monthly Skin Integrity Report" must be completed monthly and communicated to the Physicians/NP, DOC, Dietitian, Rehab team, and regional staff by the 10th of each month

Appendix "A" of the licensee's skin and wound program LTC-E-90 lists the responsibilities of the WCC. These responsibilities include:
-conduct weekly skin and wound care clinical rounds in the home
-assess all skin impairment/wounds and provide treatment recommendations for all new and worsening areas
-discuss treatment recommendation with the resident's Physician and or NP
-provide communication and follow-up to the interdisciplinary team, including the DOC, most responsible nurses and the Physician/NP
-compare list of all residents with altered skin integrity weekly utilizing "High Risk Profile" and monthly tracking report to ensure all residents are being monitored
-completes the "Monthly Skin Integrity Report" by the 10th of each month and shares report with the interdisciplinary skin and wound care team and regional support

Appendix "B" of the licensee's skin and wound program LTC-E-90 lists the responsibilities for other staff members. These responsibilities include:
-Physician/NP-review suggestions from WCC and/or Nurse; assess complex wounds as necessary; documents as required
-Nurse-completes skin and wound assessments and documents; to perform treatments and dressing changes as per the eTAR; dates and initials the dressings each time a new dressing is applied; informs WCC, Physician/NP of any new or worsening skin breakdown and as needed
-monitors all wounds, with every dressing change

A CIR was submitted to the Director for improper/incompetent treatment of a resident that resulted in harm or risk of harm of resident #052. The CIR indicated that a specified wound #1 was originally found in on a specific date and was

assessed by the Wound Care Nurse and entries made on Resident Care Plan and electronic treatment administration record (eTAR) for treatment. The wound treatment was changed by the physician the day after the wound was discovered and then four days later. The DOC and ADOC became aware of the decline in resident #052's wound status approximately one month later and upon initial investigation believed the resident did not receive appropriate care/treatment or follow-up for the resident's specified wound #1.

Resident #052 was dependent on staff for care.

The resident's clinical health records and the licensee's administrative records regarding resident #052 were reviewed and interviews conducted by inspector #571.

A review of the clinical health records for resident #052 indicated the following documentation related to the following wounds over a seven month period. To summarize:
-resident #052 was noted to have wound #1 with symptoms of infection in a specified month;
-after review of the health care record, no mention of this wound could be located until two months later; during that month, in addition to wound #1, resident #052 was discovered to have wound #2, #3, and #4
-the next month, resident #052 was noted to have wound #5 and #6 as well; wound #1 worsened and increased in size and is causing resident #052's health to deteriorate; a telephone order is obtained from the NP for an antibiotic for possible infection of wound #1

Resident #052 was sent to the hospital one day after the NP ordered the antibiotics and returned the home the next day. The resident had multiple wounds; all wounds were photographed and dressings changed. Resident #052 passed away the next day.

A review of the treatment observation records (TOR) for resident #052 indicated that a TOR was initiated for the wound #1 on a specified date. No documentation of a TOR being completed weekly could be located.

A TOR was initiated by WCC RPN #156 for wound #5 which included measurements and a description of the wound. WCC RPN #156 changed the dressing intervention. The TOR for wound #5 was filled out on two specific

dates, by RPN #109 however no documentation of measurements could be located; RPN #109 documented that wound #5 had a foul odour one day before the NP ordered antibiotics for wound #1.

A review of the clinical health records did not support weekly photographing of resident #052's wounds. One photograph of wound #1 and wound #5 was located before the resident was hospitalized. Inspector #571 observed photographs of the wounds that were taken after resident #052 returned from the hospital. The photographs included 11 separate wounds in total.

No documentation of any other orders related to wounds, with the exception of wound #1, was found until an antibiotic was ordered for wound #1 by NP #157. No evidence that the Physician or NP assessed any wounds during the last two months previous to resident #052's death could be located.

In separate interviews on October 20, 2016, RPN #109 indicated that he/she only provided care for resident #052 "once or twice" in the two months prior to the residents death; he/she recalled wound #1 and another bad wound on a specified body location. RPN #148 indicated that he/she provided care for resident #052 and that the resident had some skin impairment on a specified body location and when RPN #148 worked a later shift, the wound was "worse". RPN #148 indicated that in the month preceding resident #052's death, the resident had several open areas; one unidentified wound; wound #5 and another unidentified wound.

An interview was conducted with the ED, DOC, and Regional Manager of Clinical Services (RMCS) on October 19, 2016 with Inspector #571 and #641. Inspector #571 indicated to the licensee that the documentation related to wounds in resident #052's clinical health record was difficult to follow, interpret and analyze due to inconsistencies, inaccuracies, and incompleteness. Inspector #571 requested that the ED, DOC and RMCS clarify how many wounds resident #052 had before the resident was sent to the hospital and the exact location of these wounds. It was indicated that resident had wound #5 and wound #1. Inspector #571 inquired about the wounds noted in the clinical health record. It was indicated that these wounds could have been acquired at the hospital. The resident was hospitalized for 38 hours.

In addition, the DOC indicated in the same interview as above, that the multidisciplinary skin and wound team met monthly. The following members are

on the team: DOC or ADOC, wound care champion, RAI co-ordinator, Registered Dietitian if available, physiotherapist may be invited, floor nurses if there was "something to speak to" and the RMCS if she is in the building will attend but is not on the team.

The monthly skin integrity reports for a specific four month period were reviewed by Inspector #571. The following was indicated:
-for three specified months (including the month that resident #052 passed away)-no wounds noted in the report for resident #052 despite documentation to the contrary
-for one specified month (the month before resident #052 passed away)-the report indicated one wound noted in the report for resident #052: wound 1; two scabbed areas; new wound

The meeting minutes for the multidisciplinary skin and wound care team for the month resident #052 passed away were reviewed by Inspector #571. Resident #052's name is under the heading "issues/discussion/decisions/rationale". Under the heading "action outcome" the minutes indicate: wound #1…treatment not effective; discontinued; reissued and restarted. No documentation of any of resident #052's other wounds being discussed can be located.

A review of written communication from the DOC to the Licensee after resident #052 passed away indicated that there were issues in the home and stated "a resident who has significant wounds that were poorly cared for, poorly documented and ultimately the staff failed to do their jobs (several RPN staff to varying degrees)" was one of the issues. The written communication further indicated that although the resident had wound #1 that progressively worsened, a follow up was not completed. After the wound began to cause significant pain to the resident to the point that an analgesic had to be ordered and despite five progress notes that indicated the resident was in "excruciating" pain, that the wound care nurse did not assess the wounds, make a referral or document about the status of the wound. The DOC further indicated that the wound became so bad the resident became very ill, had a fever and was hospitalized and from the hospital the DOC learned that the resident had many other wounds; the resident passed away.

A review of the admission note from a Physician at the hospital indicated that resident #052 was sent to the hospital after resident #052's health declined. The Physician examined the resident and noted several wounds. The Physician

indicated that he was more concerned about wound #5. The Physician indicated that wound #5 was cause of the resident's decline in health.

Re: resident #014:

Resident #014 is immobile and requires extensive assistance for all activities of daily living.

A review of resident #014's progress notes indicated that the resident had specified wound #1 over five to seven month period.

A review of the TOR for resident #014 indicated the assessment form was completed twice in that time period. No documentation of weekly assessments completed on the TOR could be located by the inspector.

Re: resident #019

Resident #019 is totally dependent on staff for bed mobility.

A review of the progress notes by Inspector #571 for resident #019 indicated the resident had a specified wound, wound #1. A review of the electronic treatment administration record (eTAR) indicated that during a specified two month time period, the dressing for resident #019's wound #1 was to be completed daily. The dressing was not changed on 11 days during this specified two month period as per the progress notes and eTAR.

Related to Log #022516-16:

Resident #051 has a medical diagnosis which includes cognitive impairment, and is reliant on staff for activities of daily living.

A review of the progress notes by Inspector #554 for resident #051 indicated that on a specified date, the resident was noted to have a wound, wound #1. The wound was assessed by an agency RPN and a dressing was applied.

The clinical health record, for resident #051 was reviewed for a specified 11 day period by Inspector #554. No documentation to support that a referral was forwarded to the home's Registered Dietitian specific to resident #051's altered

skin integrity could be located.

In an interview with Inspector #554, RN #107, as well as the home's Registered Dietitian indicated that a referral to the Registered Dietitian is to be completed for any resident exhibiting altered skin integrity so that the plan of care can be reviewed and revised as needed.

To summarize, the licensee's skin and wound care program LTC-E-90 was reviewed. Documentation could not be located to support that the licensee ensured the following elements of the program were implemented for resident #052, #019, #051 and #014:

-TOR's were completed weekly for resident #052 and #14
-photographs of resident #052's wounds were taken monthly
-the interdisciplinary team reviewed documentation, assessments, outcomes for resident #052-the DOC or physician were aware of all of the wounds for resident #052
-the interdisciplinary skin and wound team were notified of all of resident #052's wounds; the team developed, reviewed and updated the residents care plan goals, and interventions
-notification to the physician and referral to members of the interdisciplinary team when resident# 052's wounds were not improving
-the "Monthly Skin Integrity Report" which is to be completed by the 10th of each month-no documentation of any resident #052's wounds were on the report except for wound #1
-staff discussed treatment recommendation with the resident's Physician and or NP-no documentation that this was done any time any of resident #052's wounds before the resident was sent to the hospital
-WCC conducted weekly skin and wound care rounds in the home-no documentation to support weekly skin and wound care rounds occurred
-WCC assessed all skin impairment/wounds and provide treatment recommendations for all new and worsening areas-no documentation to indicate that this occurred
-WCC compared list of all residents with altered skin integrity weekly utilizing "High Risk Profile" and monthly tracking report to ensure all residents are being monitored
-Nurse-completed skin and wound assessments and documents; to perform treatments and dressing changes as per the eTAR; dates and initials the

dressings each time a new dressing is applied; informs WCC, Physician/NP of any new or worsening skin breakdown and as needed-evidence supports that not all dressings for resident #019 and #052 were being changed as indicated in the eTAR; that not all wounds were assessed and documented on weekly for resident #052 and #014;
-Nurse monitored all wounds, with every dressing change-no documentation to support this was done for resident #052
-Nurse/WCC completed a referral to the Registered Dietitian for all residents exhibiting altered skin integrity-no evidence to support that this was done for resident #051

The licensee failed to ensure that their interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented.

NOTE: A Compliance Order with a Directors referral has been issued with this non-compliance under O. Reg. 79/10, s. 48 (1) 2. based on the severity and negative outcome it had on resident #052; non-compliance related to wound care was also found with resident #051, #014 and #019.
[s. 48. (1) 2.] (571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 21, 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 26th day of October, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Patricia Mata

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