Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

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


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

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

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

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


## Amended Public Copy/Copie modifiée du public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 29, 2019 | 2019_805638_0014 (A1) | 011613-19 | Resident Quality Inspection |

### Licensee/Titulaire de permis

Jarlette Ltd.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

The Villa Care Centre
689 Yonge Street MIDLAND ON L4R 2E1

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

Amended by SYLVIE BYRNES (627) - (A1)

### Amended Inspection Summary/Résumé de l'inspection modifié

**An extension to compliance order #001 is granted to allow the home to achieve sustainable compliance. New compliance due date is October 7, 2019.**

**Issued on this 29th day of August, 2019 (A1)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

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


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The Villa Care Centre
689 Yonge Street MIDLAND ON L4R 2E1

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

Amended by SYLVIE BYRNES (627) - (A1)

## Amended Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): June 17 - 21 and 24 - 28, 2019.**

**The following intake was completed in this resident quality inspection:**

**-One log related to a fall, which resulted in an injury in which the resident was sent to hospital.**

**A follow up inspection #2019_805638_0015 was conducted concurrently with this resident quality inspection.**

**PLEASE NOTE: A compliance order related to section 6 subsection 10 of the Long-Term Care Homes Act, 2007, was identified in this inspection and has been re-issued in the follow up inspection report #2019_805638_0015, which was conducted concurrently with this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Staff Educator, Resident and Family Service Coordinator, Restorative Care Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aides, residents and family members.**

**The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs, relevant training and health care records.**

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

**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Skin and Wound Care**
**Sufficient Staffing**

**During the course of the original inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

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

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #005 was identified as having had a fall in a Minimum Data Set (MDS) assessment.

Inspector #627 reviewed resident #005's progress notes which identified a fall assessment on a specific date. The summary of the post fall huddle identified that the fall was "due to resident #005 not wearing their [support device]".

Inspector #627 reviewed the resident's care plan in effect at the time of the fall and at the time of the inspection and could not identify any interventions regarding the use of the specific support device. The Inspector reviewed a typed admission summary created by the Social Worker, which indicated that resident #005 had a specific diagnoses and used a specific type of support device.

Inspector #627 interviewed resident #005, who stated that when they had fallen they could not recall if they had been wearing their specific support device. The Inspector observed that the resident was wearing the specific support device, at the time of the interview. The resident stated that they required assistance from staff to put on their support device.

Inspector #627 interviewed PSW #100, who stated that the resident required assistance with certain aspects of care which included the application of the specific support device. PSW #100 stated that the planned care for a resident was identified in the resident's care plan, the kardex and from signage at the head of the residents' beds. The PSW could not identify any interventions in resident #005's care plan, indicating that the resident was to wear the support device and that staff assisted the resident in applying their support device. The PSW stated resident #005's last fall occurred because they had not been wearing their specific support device and the intervention to assist the resident to apply the support device should have been identified in the resident's care plan.

The home's policy titled "Resident Rights, Care and Services - Plan of care" last revised March 13, 2018, indicated that the purpose of the written plan of care for each resident was to provide clear direction to staff and others providing care.

Inspector #627 interviewed the DOC who acknowledged that the care plan should have indicated that resident #005 was to wear their specific support device and to provide assistance to apply the device, if required. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

As a result of a family interview, insufficient staffing was identified as a potential risk for resident's in the home by the Inspectors.

Inspector #638 requested a record of times the home worked short staffed over a one month period in 2019. The Inspector reviewed three dates in which the home worked short at least two PSWs on a shift. The Inspector reviewed the specific dates and identified that on the;

a) first date, evening shift with two PSWs short, the staff failed to complete documentation on 68 out of 114 residents (60 per cent). The Inspector reviewed resident #005, #018 and #019, Point Of Care (POC) documentation records for the evening shift and identified missing documentation related to nutrition intake, pain, behaviours, skin integrity, continence care, activities of daily living assistance, application of topical treatment, hourly checks and a specific airway intervention.

b) second date, day shift with 2 PSWs short, the staff on the third unit failed to complete documentation on 25 out of 53 residents (47 per cent), while the second unit staff failed to document on 60 out of 60 residents (100 per cent), on that shift. The Inspector reviewed resident #020, #021 and #022, POC documentation records for the day shift and identified missing documentation related to nutrition intake, pain, behaviours, housekeeping, skin integrity, continence care, activities of daily living assistance, restraint positioning and fall interventions.

c) third date, day shift with 4 PSWs short, the staff failed to complete documentation on 112 out of 112 residents (100 per cent). The Inspector reviewed resident #014, #023 and #024, POC documentation records for the day shift and identified missing documentation related to continence care, pain, nutrition intake, behaviours, application of topical treatment, bathing, activities of daily living assistance, housekeeping and skin integrity.

Inspector #638 interviewed PSW #124, who indicated that they documented all

care provided in POC. The PSW indicated that when they worked short staff, they prioritized resident care over documentation. The Inspector reviewed the POC documentation records with the PSW, who indicated that the missing documentation was most likely because resident care was prioritized and there was not enough time to complete documentation when short staffed.

Inspector #638 interviewed RPN #101, who indicated that staff documented resident care in POC. The RPN stated they would remind staff to complete documentation if they identified that it was not completed. However, the RPN stated that when short staffed, the PSWs indicated that they weren't able to complete documentation due to prioritizing resident care. The RPN stated that the staff were "amazing" at ensuring care was completed, the issue was that they'd either forget or not have the time to complete the documentation.

The home's policy titled "Personal Support Worker - Position Descriptions - Long Term Care" last revised January 5, 2017, indicated that their main duties and responsibilities included the requirement to complete resident records accurately to reflect the resident care provided complying with legislative and home requirements.

During an interview with Inspector #638, the Administrator indicated that direct care staff documented provided care electronically on POC and had access to portable computers to document care provided throughout the shift. The Inspector reviewed the third date, day shift, where the home worked short staffed, with the Administrator. The Administrator indicated that it appeared as though the planned care had not been provided for the residents, however, they knew that the staff were completing care and indicated they were most likely unable to get to the documentation. [s. 6. (9) 1.]

3. During a record review, Inspector #684 noted in the physicians orders section of the electronic care records that resident #002 was identified as having two areas of altered skin integrity.

Physician orders were reviewed for resident #002 by Inspector #684 which indicated specific treatment interventions for both areas of altered skin integrity.

Inspector #684 reviewed resident #002's electronic treatment administration record (eTAR) for the first area of altered skin integrity and noted missing documentation for two dates in the one month review period. A review of the

eTAR for the second area of altered skin integrity, noted missing documentation for one date in the one month review period. Resident #002's progress notes were reviewed by Inspector #684 for the dates indicated above; there were no notes present to indicate why the treatments were not signed as completed.

The home's policy titled "Skin and Wound Care - Program," last revised October 17, 2018, stated the following under procedure section "Ensure that in addition, a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has a completed wound progress note, weekly, if altered skin integrity is a wound. This will reflect the weekly assessment of the resident related to wound status. If homes are using the Skin and Wound Module through PCC by use of an electronic device, you must save and lock the Skin and Wound Evaluation assessment and all documentation is generated into a weekly wound progress note."

During an interview with RPN #101, Inspector #684 asked if there ever was a time when the eTAR was not signed off for a wound, RPN stated "It should always be signed for in the eTAR". The Inspector reviewed the eTAR and progress notes for resident #002 with RPN #101. The RPN stated that the assessment and treatment should be documented in the eTAR or documented in the progress notes. The RPN further stated that this documentation was missing for both on three specific dates.

Inspector #684 interviewed the DOC regarding the process staff were to follow when a resident had an area of altered skin integrity. The DOC stated staff are to document in progress notes, use the electronic device that gives you a picture, description, your assessment of the wound and then uploads the assessments to PCC. The DOC stated wound assessments were to be done with each dressing change but there should be a weekly assessment done which would be entered into the PCC notes. The assessment is to be put into the eTAR to indicate when they were due. Inspector #684 and the DOC reviewed the eTAR, physician's order and progress notes for resident #002, DOC confirmed there was missing documentation for the two areas of altered skin integrity. [s. 6. (9) 1.]

4. The licensee has failed to ensure that the outcomes of the care set out in the plan of care were documented.

Resident #014 was identified as having a worsening area of altered skin integrity through their MDS assessment.

Inspector #638 reviewed resident #014's health care records and identified that the resident had two areas of altered skin integrity, which required treatment twice weekly.

The Inspector reviewed the completed wound assessments over a one month period and was able to identify one completed weekly wound assessment note for the resident's two areas of altered skin integrity.

Inspector #684 interviewed RPN #101, who indicated that staff completed wound care assessments using an electronic device which uploaded the completed assessments into Point Click Care (PCC). The RPN indicated that these assessments were completed either weekly or every three days.

In an interview with Inspector #638, RPN #114 indicated that the home utilized an electronic device to take a photograph and document on the wound assessment at the time of care. The RPN stated that the electronic devices had technical issues at times and would not log the assessment into PCC. The RPN indicated that if this occurred, they would not remove the dressing again to complete a written assessment because the care had already been completed. The Inspector reviewed the completed assessments with the RPN who indicated that they were supposed to complete weekly wound assessments, however, they may be missing due to the technical issues with the electronic devices.

During an interview with Inspector #638, the DOC indicated that the home utilized an electronic device to photograph and chart the wound assessment at the time of care. The DOC indicated that they had some technical issues with these devices.

Inspector #638 interviewed Staff Educator #119, who indicated that the home utilized an electronic device to document wound assessments which would upload the assessments to PCC. After reviewing resident #014's documented assessments, the Staff Educator indicated that they weren't positive if the assessment had been completed or not, but stated the wound care was done. The approach in the home was that if care was not documented, it was not considered completed, however, due to the technical issues with the electronic devices, they believed that the device did not record or upload the completed weekly wound assessments. [s. 6. (9) 2.]

***Additional Required Actions:***

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

**(A1)**
**The following order(s) have been amended: CO# 001**

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids**

**Specifically failed to comply with the following:**

**s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,**
**(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).**
**(b) cleaned as required. O. Reg. 79/10, s. 37 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that each resident of the home had their personal items, labelled within 48 hours of admission and of acquiring, in the case of new items.

During a tour of the home, Inspector #684 identified an unlabeled brush in the first spa room and an unlabeled brush and nail clippers in the second spa room.

On another tour, Inspector #684 noted in the first spa room, a nail clipper on the top of the tub and a razor on the side of the sink, both items were not labelled. PSW #122 was shown the items and was unable to identify who the items belonged to, when asked.

Inspector #684 observed an unlabelled hair brush and nail clipper in a basket in the first spa room on another unit. Inspector #684 showed the items to PSW #120 and asked how do you know who these two items belong to, PSW #120 responded "We don't". When asked what the policy was for labelling, they stated "We are to label everything".

While conducting a room observation of a specific room, Inspector #684 noted an unlabelled bar of soap in a dish at the side of the sink in the bathroom. The bathroom was shared between four residents for two rooms. Inspector #684 showed RN #121 the unlabelled bar of soap, RN #121 stated they do not know who the soap belonged to and it should not be there as anyone could use the bar of soap.

The home's policy titled "Resident Rights, Care and Services - Nursing and Personal Support Services - Personal Aids", effective date September 16, 2013, stated "The PSW will ensure that the personal aids of the resident, such as dentures, glasses and hearing aids are labeled upon admission and as new personal aid items are acquired".

Inspector #684 conducted an interview with the DOC and asked what the expectation was for resident items being identified. The DOC stated "the expectation and the home protocol was that all resident personal items are labelled". The DOC confirmed that the unlabelled items which were found in the spa rooms should have been labelled. [s. 37. (1) (a)]

**Issued on this 29th day of August, 2019 (A1)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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

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

## Amended Public Copy/Copie modifiée du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by SYLVIE BYRNES (627) - (A1) |
| **Inspection No. / No de l'inspection :** | 2019_805638_0014 (A1) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 011613-19 (A1) |
| **Type of Inspection / Genre d'inspection :** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Aug 29, 2019(A1) |
| **Licensee / Titulaire de permis :** | Jarlette Ltd.<br>c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1 |
| **LTC Home / Foyer de SLD :** | The Villa Care Centre<br>689 Yonge Street, MIDLAND, ON, L4R-2E1 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Jill Wismer |

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

To Jarlette Ltd., you are hereby required to comply with the following order(s) by the date(s) set out below:

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

**Order / Ordre :**

The licensee must be compliant with s. 6 (9) of the LTCHA, 2007. Specifically, the licensee must;

a) ensure that the provision and outcomes of care to residents are documented; and

b) develop and implement a process to ensure that staff are completing documentation as required, regardless of staffing levels.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

As a result of a family interview, insufficient staffing was identified as a potential risk for resident's in the home by the Inspectors.

Inspector #638 requested a record of times the home worked short staffed over a one month period in 2019. The Inspector reviewed three dates in which the home worked short at least two PSWs on a shift. The Inspector reviewed the specific dates and identified that on the;

a) first date, evening shift with two PSWs short, the staff failed to complete

documentation on 68 out of 114 residents (60 per cent). The Inspector reviewed resident #005, #018 and #019, Point Of Care (POC) documentation records for the evening shift and identified missing documentation related to nutrition intake, pain, behaviours, skin integrity, continence care, activities of daily living assistance, application of topical treatment, hourly checks and a specific airway intervention.

b) second date, day shift with 2 PSWs short, the staff on the third unit failed to complete documentation on 25 out of 53 residents (47 per cent), while the second unit staff failed to document on 60 out of 60 residents (100 per cent), on that shift. The Inspector reviewed resident #020, #021 and #022, POC documentation records for the day shift and identified missing documentation related to nutrition intake, pain, behaviours, housekeeping, skin integrity, continence care, activities of daily living assistance, restraint positioning and fall interventions.

c) third date, day shift with 4 PSWs short, the staff failed to complete documentation on 112 out of 112 residents (100 per cent). The Inspector reviewed resident #014, #023 and #024, POC documentation records for the day shift and identified missing documentation related to continence care, pain, nutrition intake, behaviours, application of topical treatment, bathing, activities of daily living assistance, housekeeping and skin integrity.

Inspector #638 interviewed PSW #124, who indicated that they documented all care provided in POC. The PSW indicated that when they worked short staff, they prioritized resident care over documentation. The Inspector reviewed the POC documentation records with the PSW, who indicated that the missing documentation was most likely because resident care was prioritized and there was not enough time to complete documentation when short staffed.

Inspector #638 interviewed RPN #101, who indicated that staff documented resident care in POC. The RPN stated they would remind staff to complete documentation if they identified that it was not completed. However, the RPN stated that when short staffed, the PSWs indicated that they weren't able to complete documentation due to prioritizing resident care. The RPN stated that the staff were "amazing" at ensuring care was completed, the issue was that they'd either forget or not have the time to complete the documentation.

The home's policy titled "Personal Support Worker - Position Descriptions - Long

Term Care" last revised January 5, 2017, indicated that their main duties and responsibilities included the requirement to complete resident records accurately to reflect the resident care provided complying with legislative and home requirements.

During an interview with Inspector #638, the Administrator indicated that direct care staff documented provided care electronically on POC and had access to portable computers to document care provided throughout the shift. The Inspector reviewed the third date, day shift, where the home worked short staffed, with the Administrator. The Administrator indicated that it appeared as though the planned care had not been provided for the residents, however, they knew that the staff were completing care and indicated they were most likely unable to get to the documentation.

2. During a record review, Inspector #684 noted in the physicians orders section of the electronic care records that resident #002 was identified as having two areas of altered skin integrity.

Physician orders were reviewed for resident #002 by Inspector #684 which indicated specific treatment interventions for both areas of altered skin integrity.

Inspector #684 reviewed resident #002's electronic treatment administration record (eTAR) for the first area of altered skin integrity and noted missing documentation for two dates in the one month review period. A review of the eTAR for the second area of altered skin integrity, noted missing documentation for one date in the one month review period. Resident #002's progress notes were reviewed by Inspector #684 for the dates indicated above; there were no notes present to indicate why the treatments were not signed as completed.

The home's policy titled "Skin and Wound Care - Program," last revised October 17, 2018, stated the following under procedure section "Ensure that in addition, a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has a completed wound progress note, weekly, if altered skin integrity is a wound. This will reflect the weekly assessment of the resident related to wound status. If homes are using the Skin and Wound Module through PCC by use of an electronic device, you must save and lock the Skin and Wound Evaluation assessment and all documentation is generated into a weekly wound progress note."

During an interview with RPN #101, Inspector #684 asked if there ever was a time when the eTAR was not signed off for a wound, RPN stated "It should always be signed for in the eTAR". The Inspector reviewed the eTAR and progress notes for resident #002 with RPN #101. The RPN stated that the assessment and treatment should be documented in the eTAR or documented in the progress notes. The RPN further stated that this documentation was missing for both on three specific dates.

Inspector #684 interviewed the DOC regarding the process staff were to follow when a resident had an area of altered skin integrity. The DOC stated staff are to document in progress notes, use the electronic device that gives you a picture, description, your assessment of the wound and then uploads the assessments to PCC. The DOC stated wound assessments were to be done with each dressing change but there should be a weekly assessment done which would be entered into the PCC notes. The assessment is to be put into the eTAR to indicate when they were due. Inspector #684 and the DOC reviewed the eTAR, physician's order and progress notes for resident #002, DOC confirmed there was missing documentation for the two areas of altered skin integrity.

3. The licensee has failed to ensure that the outcomes of the care set out in the plan of care were documented.

Resident #014 was identified as having a worsening area of altered skin integrity through their MDS assessment.

Inspector #638 reviewed resident #014's health care records and identified that the resident had two areas of altered skin integrity, which required treatment twice weekly.

The Inspector reviewed the completed wound assessments over a one month period and was able to identify one completed weekly wound assessment note for the resident's two areas of altered skin integrity.

Inspector #684 interviewed RPN #101, who indicated that staff completed wound care assessments using an electronic device which uploaded the completed assessments into Point Click Care (PCC). The RPN indicated that these assessments were completed either weekly or every three days.

In an interview with Inspector #638, RPN #114 indicated that the home utilized an electronic device to take a photograph and document on the wound assessment at the time of care. The RPN stated that the electronic devices had technical issues at times and would not log the assessment into PCC. The RPN indicated that if this occurred, they would not remove the dressing again to complete a written assessment because the care had already been completed. The Inspector reviewed the completed assessments with the RPN who indicated that they were supposed to complete weekly wound assessments, however, they may be missing due to the technical issues with the electronic devices.

During an interview with Inspector #638, the DOC indicated that the home utilized an electronic device to photograph and chart the wound assessment at the time of care. The DOC indicated that they had some technical issues with these devices.

Inspector #638 interviewed Staff Educator #119, who indicated that the home utilized an electronic device to document wound assessments which would upload the assessments to PCC. After reviewing resident #014's documented assessments, the Staff Educator indicated that they weren't positive if the assessment had been completed or not, but stated the wound care was done. The approach in the home was that if care was not documented, it was not considered completed, however, due to the technical issues with the electronic devices, they believed that the device did not record or upload the completed weekly wound assessments.

The severity of this issue was determined to be a level 2, as there was the potential for minimal harm or minimal risk to the residents. The scope of the issue was a level 2 as this issue was identified as a pattern. The home had a level 3 compliance history with previous noncompliance in last 36 months with this section of the LTCHA 2007, that included one voluntary plan of correction issued December 27, 2018 (2018_657681_0028). (638)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 07, 2019(A1)

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

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

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

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

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  29th  day of August, 2019 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :**

Amended by SYLVIE BYRNES (627) - (A1)

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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