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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 14, 2017	2017_551526_0010	009986-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

WEST OAK VILLAGE
2370 THIRD LINE OAKVILLE ON L6M 4E2

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

THERESA MCMILLAN (526), LYNDA BROWN (111)

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): May 29, 30, 31, June 1, 2, and 6, 2017

The following complaint inspection was conducted simultaneously during this RQI inspection: 005666-17

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Directors of Care (ADRs), Recreation Manager, Environmental Services Manager (ESM), Resident Services Coordinator, Maintenance and Housekeeping staff, Registered Dietitian (RD), Physiotherapist (PT), Physiotherapy Assistant (PTA), the Minimum Data Set (MDS) Coordinator, Behaviour Supports Ontario (BSO) staff, Wound Care Champion staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Ward Clerk, Resident and Family Council representatives, residents and family members.

During the course of this inspection, inspectors toured the home; observed residents and staff; and reviewed health records, maintenance and housekeeping files, policies and procedures, and training records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

9 WN(s)
5 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #021 had new areas of altered skin integrity that were identified over a specified two month time period. Resident #013 developed an area of altered skin integrity on a specified day in 2017.

Review of health records for residents #021 and #013 indicated that registered staff had not assessed these areas using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. This was confirmed by Registered Practical Nurse (RPN) #119 who indicated that the home's policy directed staff to document the presence of areas that were not pressure ulcers or skin tears in the progress notes and details of the skin and wound areas were not described. They stated that registered staff were not using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when assessing and documenting residents who had bruises, rashes, dermatitis or abrasions in any area of the health record.

During interview, the Director of Care (DOC) stated that registered staff should assess all new alterations of skin integrity using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and that was available to staff in the electronic documentation system.

PLEASE NOTE: This area of non compliance was identified during this RQI and complaint inspection, log #005666-17 inspected concurrently during this RQI. [s. 50. (2) (b) (i)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Review of the home's Skin and Wound Care Policy (CARE-12-010.04) "LTC-Bruises, Rashes, Incontinent Associated Dermatitis (IAD) and Abrasions" last reviewed July 31, 2016, directed staff to document the assessment of bruises, rashes, IAD and abrasions in progress notes. However, during interview, the Director of Care (DOC) indicated that all areas of altered skin integrity should be assessed initially using the home's clinically appropriate Head to Toe assessment found in the assessment tab.

Review of resident #013 and #021's health records revealed that they had areas of altered skin integrity that were not assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.. According to Registered Practical Nurse #119, care for these areas fell under the home's "LTC-Bruises, Rashes, Incontinent Associated Dermatitis (IAD) and Abrasions" policy. During interview, they indicated that staff did not assess or document these types of skin alterations using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment because the home's "LTC-Bruises, Rashes, IAD and Abrasions" policy did not direct them to do so and that only pressure ulcers and skin tears were assessed using the home's skin and wound assessment instruments.

During interview, the DOC indicated that the home's practice for assessing all areas of alteration in skin integrity including rashes, dermatitis, abrasions and lesions did not direct registered nursing staff to use a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment for residents who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds.

PLEASE NOTE: This area of non compliance was identified during a complaint inspection, log #005666-17 inspected concurrently during this RQI. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with applicable requirements under the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) Over a two month period, resident #021 developed areas of altered skin integrity that were treated and monitored every shift over specified time periods.

Review of the health record revealed that it did not consistently include assessment information or documentation of the status these areas of altered skin integrity during the specified time periods. During interview, RPN #119 who was the home's Wound Care Champion confirmed that staff had not documented assessments of the alterations in skin integrity during monitoring and this prevented staff from knowing the degree to which areas were improving or worsening.

B) Resident #021 had a health condition that caused increased pain for which they were receiving treatment. Review of health records revealed that a new treatment was initiated but that the reassessments, and the resident's responses to interventions were not documented. This was confirmed by the home's Physiotherapist during interview.

PLEASE NOTE: This area of non compliance was identified during a complaint inspection, log #005666-17 inspected concurrently during this RQI. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: 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. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. A) In accordance with O. Reg. 79/10 s. 221 (1), the licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training in 2016 for all staff,
i) who applied PASDs or who monitored residents with PASDs including application of these PASDs, use of these PASDs, and potential dangers of these PASDs;
ii) for continence care and bowel management; and
iii) for pain management.

Review of the home's training records and interview with the Associate Director of Care (ADOC) responsible for education in training revealed that 31/50 (62%) registered staff and 64/90 (71%) non registered staff attended the home's annual training that included minimizing restraints, skin and wound care, continence and bowel management, and pain management. The Director of Care (DOC) confirmed that not all staff who provided direct care had received annual training for minimizing restraints as required.

B) In accordance with O. Reg. 79/10 s. 221 (1) 2., the licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training in 2016 for skin and wound care.

Review of the home's training records and interview with the Associate Director of Care (ADOC) responsible for education in training revealed that 6/50 (12%) registered staff and 7/90 (7%) non registered staff attended the home's annual skin and wound training. They stated that skin and wound annual education was not part of the 2016 annual training where 31/50 (62%) of registered staff and 64/90 (71%) non registered staff attended. During interview, the Director of Care (DOC) stated that skin and wound was included in the 2016 annual training and that the home's wound care product vendor provided periodic education sessions. The DOC stated that they could not confirm that all staff in the home had received, as a condition of continuing to have contact with residents, annual training in 2016 for skin and wound care as required.

PLEASE NOTE: This area of non compliance was identified during a complaint inspection, log #005666-17 inspected concurrently during this RQI. [s. 76. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 6. Any other areas provided for in the regulations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the licensee's Housekeeping Quality Management Urine Order Audit policy (ES C-25-15) revised January 21, 2015, indicated the purpose was to ensure all lingering urine odours of the home were investigated and eliminated. The procedure directed staff to do the following:
1. When a concern of lingering urine odour is identified the urine odour audit form must be completed by the ESM. This will include the conclusion and suggested action to eliminate the odours.
2. A copy of the completed Urine Odour Audit will be given to the Administrator/Executive Director and Director of Care.
3. A solution to the odour concern will be implemented with corrective action taken, completed date and responsible party recorded on the audit form.
4. The completed Urine Odour Audit Form will be kept on file in the environmental office.

During the course of this inspection, LTC inspectors observed a urine odour in residents #012's and #019's bedrooms. During interview, housekeeping staff (HSK) #117 indicated that the usual process for strong urine odours related to carpets in resident rooms was completed by Heavy Duty Cleaner (HDC). During interview, HDC #115 and HDC #116 indicated the HSK or nursing staff were to contact the HDC with any concerns related to cleaning of carpets or odours in the home. HDC #115 stated that they were not aware of any lingering urine odours in room resident #012's and #019's bedrooms and that they were not aware of how to retrieve any heavy duty cleaning requests through the home’s electronic maintenance management application.

HDC #116 confirmed that they reviewed the maintenance management application for the past week and there was no documentation to indicate any staff had reported the lingering urine odours in either of the two rooms. HDC #116 indicated the lingering urine odour in resident #019's room was from the carpet and was persistent. They indicated that they spoke with ESM over the phone and confirmed that no urine odour audit was completed for either resident #012's or #019's rooms for lingering urine odours. The HDC indicted resident #012's room had been deep cleaned by housekeeping later in the morning as they determined the urine odour was coming from the bathroom which eliminated the odour. The HDC confirmed there were no urine odour audits completed on June 1, 2017, as per the licensee’s policy to address incidents of lingering offensive odours. [s. 87. (2) (d)]

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 ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. Review of the physician orders and the May 2017 electronic treatment administration record (eTAR), indicated resident #022 received two treatment creams.

Observation of the treatment creams as ordered for resident #022 indicated they were stored in a small container in the medication room. The container had several other treatment creams for other residents and two oral inhalation medications also stored in the same container, one of which did not have the cap to cover the mouthpiece.

Interview with RPN #106 by Inspector #111 indicated the oral puffers should not have been stored with the treatment creams and should have been stored with other oral medications. Interview with the DOC by Inspector #111 indicated the expectation from the nurses is that they were able to store treatment creams in a similar container but they should not store treatment creams with oral medications. The DOC indicated the oral medications were to be stored in the individual residents' medication containers. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, (a) drugs are stored in an area or a medication cart, (i) that is used exclusively for drugs and drug-related supplies, (ii) that is secure and locked, (iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and (iv) that complies with manufacturer's instructions for the storage of the drugs within the locked medication cart, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

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

Resident #021 had a health condition that caused pain and for which they were receiving treatment. An additional treatment that could be provided twice per day as needed, was initiated on a specified day in 2017; during interview, the resident reported that the treatment was effective in alleviating pain. Review of the health record revealed that the treatment did not become a part of the written plan of care until approximately three weeks later during which time the resident received it 6 times, rather than every day.

During interview, the Physiotherapist (PT) stated that, when a treatment was initiated, the care plan should be updated. They confirmed that the written plan of care (the care plan) did not set out the planned care for resident #021 over a three week time period.

PLEASE NOTE: This area of non compliance was identified during a complaint

inspection, log #005666-17 inspected concurrently during this RQI. [s. 6. (1) (a)]

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

A) According to the health records, resident #014 was at risk for altered skin integrity and required assistance to reposition. The plan of care for resident #014 directed staff to take varying actions in relation to the resident's needs. During interviews PSW staff reported differing interventions in relation to turning and positioning when asked about care provided. During interview the DOC confirmed that staff had unclear directions regarding resident #013's care in relation to the turning and repositioning. (526)

B) According to the health records, resident #013 was at risk for altered skin integrity and required assistance to reposition. The plan of care for resident #013 directed staff to take varying actions in relation to the resident's needs. During interviews PSW staff reported differing interventions in relation to turning and positioning when asked about care provided. During interview the DOC confirmed that staff had unclear directions regarding resident #013's care in relation to the turning and repositioning. (526)

C) According to health records, resident #010 was incontinent and used continence products. The plan of care indicated a different type of continence than what was identified in the assessment, and also directed staff to refer to the home area's continence product list about the type of continence product to be used. Interview with Personal Support Worker (PSW) #118 by Inspector #111 indicated resident #010's continence that was different than what had been indicated in the plan of care, and the type of continence product used was different than the one indicated on the continence product list. The PSW indicated the home provided adequate supplies of incontinence products in the 'caddies' located in the resident washrooms. The PSW indicated if there were no products available in the caddy, they would review the continence product list (located on the wall in the care cart storage room) to determine which product should be used or they would ask one of the regular staff.

Observation of the resident's bathroom revealed the type of continence product that the resident used, that it was different from the product recommended on the continence product list, and that the list was dated October 29, 2015.

The plan of care was not clear as the assessment and plan of care had different levels of incontinence, and the product to be used was not consistent with the continence product

list (which was also outdated). (#111) [s. 6. (1) (c)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Review of resident #010's health care record indicated the resident sustained a fall on a specified day in 2017, which required treatment outside of the home. Upon return to the home, they were reassessed and the plan of care was updated according to their needs. The written plan of care was reviewed and indicated different interventions and needs than found in the assessment. During this inspection, staff were observed indicating the reason the resident had their type of seating and this was different than what was indicated in their assessment and written plan of care. Observations during this inspection revealed that repositioning was not provided according to their assessed needs. During interviews Registered Practical Nurse RPN #121, indicated a different method and frequency for repositioning than what was originally indicated in the resident's assessment. Personal Support Worker #118, and Physiotherapist Assistant (PTA) stated that they didn't know the frequency for repositioning of resident #010. (PSW) #104 indicated the schedule would be on the Point of Care documentation system (POC) and then confirmed the schedule was not available in POC.

There was no collaboration between assessments, so that the assessments were integrated, consistent with and complemented each other. (#111) [s. 6. (4) (a)]

4. The licensee failed to ensure that staff and others who provided direct care to a resident, were kept aware of the contents of the plan of care and had convenient and immediate access to it.

Review of the most recent documents the home referred to as the plan of care for residents #017 and #014, revealed that Personal Support Worker (PSW) staff were directed to look at the continence product list for current continence care products for these residents. During interview PSW #118 stated that they would also refer to the continence product list if they needed to know what product a resident was using.

When asked to see the continence product list, PSW #104 provided a list which was hung on the wall of a closet PSWs used to store their care cart. Registered Practical Nurse (RPN) #128 who was the Continence Lead in the home confirmed that the continence product list was out of date. Within the past month, the home had begun to

use a new process to calculate the continence product needs for every resident in the home and this triggered a distribution list with the type of continence product that each resident used on each shift. PSW and registered staff in home areas did not have a list to direct them about resident's plans of care regarding the type of product each resident had been assessed as needing/using. Continence products were distributed weekly by staff #129 for each resident to respective caddy storage areas in resident bathrooms.

Observation of resident #017's and #014's bathrooms and interview with PSW #104 revealed that they knew which product to use for a resident based on what was in the drawer of the continence product storage area in the resident's bathroom. However, if the drawer was empty, if the plan of care changed or if a new staff was caring for residents and the continence product list was not in effect, they could not be sure about which product should be used. Continence products listed for resident #017 were different than those in their bathroom caddy, while they were the same for resident #014. RPN #128 confirmed that residents #014 and #017's plan of care had not been updated when the home's system changed.

RPN #128 indicated that staff and others who provided direct care to a resident were not kept aware of the contents of the plan of care and did not have convenient and immediate access to it in relation to continence products for each resident according to their assessed needs because:
i) resident #017's and #014's care plan directed staff to use the continence products list which was no longer in use;
ii) the continence products list available to staff on Howell home area, up to one month prior to this inspection was outdated; and
iii) direct care staff did not have access to the distribution list that outlined the products that were to be used by residents based on their assessed needs in the event that their supply ran out. (#526) [s. 6. (8)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure the resident was dressed appropriately, suitable to the time of day and in accordance with their preferences, in their own clean clothing and appropriate clean footwear.

A) On a specified day during this inspection, resident #009 and resident #024 were observed during the supper meal on a specified home area and could not be interviewed. Review of their plans of care did not reveal the residents' preferences about specified types of clothing to be worn during supper.

Interview with Registered Practical Nurse (RPN) #108 revealed that they gave instruction to Personal Support Workers (PSWs) to dress residents #009 and #024. The RPN also indicated it was the best time for short shift to complete the care.

RPN #108 also indicated resident #009 was dressed as per family request. However, resident #009's family member indicated during interview, that many residents on the home area attended the supper meal inappropriately dressed.They stated that being dressed this way during dinner was not resident #009's preference, and that it prevented family from taking them out of the home after the evening meal.

B) Interview with RPN # 112 and PSW #111 indicated resident #025 was provided care by PSW #111. Both staff indicated the resident was inappropriately dressed during supper as a result of their care needs.Review of the current written care plan under dressing for resident #025 did not indicate the resident's preference for appropriate dressing during the supper meal according to their preference.

Resident #009, #024 and #025 were observed dressed inappropriately for the time of day and were not dressed based on the residents' preferences. [s. 40.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that:
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed
(b) corrective action was taken as necessary, and
(c) a written record was kept of everything required under clauses (a) and (b).

Review of the medication incidents indicated there were two medication incidents over a three month time period. Interview with the Director of Care (DOC) by Long Term Care Homes (LTC) Inspector #111 confirmed this and stated that both incidents were related to transcription errors by the pharmacy. The DOC could not provide documentation to support that the two medication incidents were reviewed and analyzed, and corrective actions were taken as necessary related to pharmacy's transcription errors. [s. 135. (2)]

Issued on this 4th day of August, 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) :	THERESA MCMILLAN (526), LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2017_551526_0010
Log No. / No de registre :	009986-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 14, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000
LTC Home / Foyer de SLD :	WEST OAK VILLAGE 2370 THIRD LINE, OAKVILLE, ON, L6M-4E2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Diane Fitzpatrick

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall do the following:

1) Review and revise the home's Skin and Wound Care Policy "LTC-Bruises, Rashes, Incontinent Associated Dermatitis (IAD) and Abrasions" to comply with O. Reg. 79/10, s. 50. (2).

2) Train all registered staff in the home to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and that it is documented.

3) Train all registered staff in the home to document the status of areas of altered skin integrity that are monitored or assessed.

4) Residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, will receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and will document this assessment.

5) Initiate and document audits of residents with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, to ensure that skin assessments are completed and documented according to the home's policy.

Grounds / Motifs :

1. This Order is being issued based on the application of the factors of severity (2), scope (2) and Compliance history of (4) in keeping with r. 229 of the Regulation. This is in respect to the severity of minimum harm or potential for actual harm that the identified residents experienced, the scope of pattern of incidents and the home's history of noncompliance that included the following: VPC issued July 2015, and December 2014.

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #021 had new areas of altered skin integrity that were identified over a specified two month time period. Resident #013 developed an area of altered skin integrity on a specified day in 2017.

Review of health records for residents #021 and #013 indicated that registered staff had not assessed these areas using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. This was confirmed by Registered Practical Nurse (RPN) #119 who indicated that the home's policy directed staff to document the presence of areas that were not pressure ulcers or skin tears in the progress notes and details of the skin and wound areas were not described. They stated that registered staff were not using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when assessing and documenting residents who had bruises, rashes, dermatitis or abrasions in any area of the health record.

During interview, the Director of Care (DOC) stated that registered staff should assess all new alterations of skin integrity using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and that was available to staff in the electronic documentation system.

PLEASE NOTE: This area of non compliance was identified during this RQI and complaint inspection, log #005666-17 inspected concurrently during this RQI. [s. 50. (2) (b) (i)] (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 13, 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 14th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Theresa McMillan

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