Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 17, 2018;	2017_530673_0015 (A1)	025630-17	Resident Quality Inspection

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Woodhaven Long Term Care Residence
380 Church Street MARKHAM ON L6B 1E1

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

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

BABITHA SHANMUGANANDAPALA (673) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Changes made were to the compliance date for the order to reflect March 7, 2018..

Issued on this 17 day of January 2018 (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

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

BABITHA SHANMUGANANDAPALA (673) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): November 16, 17, 20, 21, 22, 23, 24,27, 28, 2017.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service and medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with Residents, Families, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), RPN students, Director of Care (DOC), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Resident Care Coordinator (RCC), Manager of Food Services (MFS), Cook, Program and Support Service Manager (PSSM), Registered Dietician (RD), painters, Environmental Supervisor (ES) and Housekeepers (HSK).

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Safe and Secure Home

Skin and Wound Care

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

- **4 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 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. 19. (1)	CO #001	2017_526664_0006	502
O.Reg 79/10 s. 36.	CO #001	2017_632502_0007	502

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During the Resident Quality Inspection (RQI), resident #005 triggered in stage one for altered skin integrity.

Review of resident #005's most recent written plan of care revealed that resident #005 was at risk for altered skin integrity and currently had an area of altered skin integrity. Interventions in resident #005's plan of care to prevent altered skin integrity included the use of a positioning aid and a protective aid when resident #005 is in bed.

i) During resident observations, resident #005 was observed lying in bed; however, the two above mentioned interventions were not in place.

Record review revealed an assessment which stated that resident #005 was at risk for altered skin integrity due to underlying health conditions.

In an interview, staff #127 stated that he/she was aware that resident #005 was at risk for altered skin integrity and was able to identify that the use of a positioning aid and a protective aid were two interventions outlined in the written plan of care. Staff #127 stated that he/she had not implemented the two interventions from the time that he/she had dressed resident #005 that morning, and that the afternoon staff would implement them. Staff #127 acknowledged that he/she should have implemented the two interventions as per resident #005's plan of care.

In an interview, staff #128 and staff #129, stated that skin and wound interventions for resident #005 included the use of a positioning aid and protective aid as identified in the written plan of care. Staff #128 and staff #129 confirmed that staff #127 had not followed these interventions as outlined in resident #005's plan of care related to skin and wound care.

In an interview, staff #103 stated that there are always reasons for interventions outlined in each resident's plan of care and that the expectation was for staff #127 to have provided care to resident #005 as specified in that resident's plan of care, related to altered skin integrity.

ii) On the same date as the above mentioned incident, the inspector observed staff #135 inform resident #005 of the care to be provided, and proceed to provide care to resident #005 alone. During this care, resident #005 displayed nonverbal signs of discomfort, as identified in resident #005's written plan of care, to which staff #135 remained silent. When the inspector questioned staff #135 if he/she thought the resident may be in discomfort, he/she responded that he/she usually informs the registered staff after the care is completed if the resident experienced any discomfort.

Review of resident #005's plan of care revealed that resident #005 demonstrates responsive behaviours due to discomfort, including those witnessed by the inspector during the care provided by staff #135. Interventions included reporting to the registered staff to assess, monitoring for any responsive behaviours during care and administering a prescribed as needed medication prior to care/treatment. Additional interventions noted were to gently redirect activities, provide reassurance or distraction, and to inform resident #005 of each step of care being performed. The plan of care further revealed that two staff are to provide total assistance with all aspects of care as resident #005 is unable to assist due to underlying health limitations.

In an interview, staff #135 stated that he/she had not informed the registered staff #136 before providing care to resident #005. When asked what he/she said to resident #005 throughout the care, staff #135 responded that prior to beginning the care, he/she informed resident #005 of the care to be provided, but did not communicate anything else with the resident during the care. Staff #135 stated that he/she provided care on his/her own, and that during the care, resident #005 exhibited responsive behaviours. Staff #135 could not identify how to communicate to resident #005 during care, or how many staff were to assist with care. After reviewing the plan of care, staff #135 acknowledged that he/she had not provided care to resident #005 as per his/her written plan of care.

In an interview, staff #129, stated that resident #005 exhibits responsive behaviours when experiencing discomfort, and that two staff are to provide

assistance with care due to his/her underlying health conditions. Staff #129 further stated that one person assistance with care would cause resident #005 to exhibit responsive behaviours, and risk to the resident's skin integrity. Staff #129 also stated that staff #135 should have reported to staff #136 prior to providing care. Staff #129 confirmed that staff #135 had not followed the interventions outlined in resident #005's plan of care.

In an interview, staff #103 stated the expectation was for staff #135 to have provided care to resident #005 as specified in that resident's plan of care. [s. 6. (7)] (673)

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During the RQI, resident #003 triggered in stage one for altered skin integrity.

Record review of an assessment completed for resident #003 revealed that he/she is totally dependent on two staff for care needs. Review of resident #003's plan of care also revealed that he/she requires total assistance with care.

Record review revealed that on a specified date, at identified two hour intervals, resident #003 was provided care with one person physical assist by staff #127.

In an interview, staff #127 stated that he/she had provided care to resident #003 on his/her own every two hours. Staff #127 acknowledged that he/she had not followed resident #003's plan of care as two staff are required.

In an interview, staff #135 also stated that he/she had provided care to resident #003 on her own. Staff #135 acknowledged that he/she had not followed resident #003's plan of care as two staff are required when providing care.

In an interview, staff #129, confirmed that staff #127 and staff #135 had independently assisted resident #003 with his/her care needs and had not provided care to resident #003 as specified in the plan of care.

The scope is pattern as it relates to residents #005 and #003 and the severity is actual harm as harm was experienced by resident #005. The home's compliance history indicates that a previous Written Notice was issued with a Voluntary Plan of Correction related to O. Reg 79/10 s.6.(7), plan of care. Due to ongoing

noncompliance and actual harm, a compliance order is warranted. [s. 6. (7)]

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to give or refuse consent to any treatment, care or services for which consent is required by law, and inform the resident of the consequences of giving or refusing consent.

During the RQI, resident #003 triggered in stage one for altered skin integrity.

During observations on a specified date, the inspector heard staff #127 speaking to resident #003 in a raised voice saying we have to provide this particular care because you complained that we don't to the ministry. The inspector was able to hear this from the hallway through the resident's closed door. Upon entering the room, the inspector observed staff #130 by resident #003's bedside with staff #127 also present.

In interviews, resident #003 stated that he/she did not want care to be provided when approached by staff #127 but they provided it anyway. Resident #003 further stated that he/she does refuse care at times, and when this happens, the staff do not explain the consequences of refusing the care.

Review of an assessment completed for resident #003 revealed that his/her cognitive status was intact. He/she had also been identified to exhibit responsive behaviours that were easily altered. Interventions included approaching him/her in a gentle, reassuring manner, listening to his/her requests/needs/concerns, providing an explanation on the importance of the treatment, and re-approaching at a later time.

In an interview, staff #127 stated that when resident #003 was told that they would be providing care, he/she stated that they did not have to do that. Staff #127 stated that in order to convince resident #003, he/she told resident #003 that they had to perform the care, or else resident #003 would complain again. Staff #127 acknowledged that she should have instead explained the consequences of refusing the care. Staff #127 stated that he/she was unsure if his/her voice was raised.

In an interview, staff #130 stated that he/she did not hear exactly what was said by staff #127, but he/she recalled that staff #127 seemed upset, his/her tone of voice was high and that he/she had inappropriately responded to resident #003's refusal

of care by stating that he/she had complained to the ministry.

In an interview, staff #133 stated that resident #003 is aware of his/her surroundings, can express his/her needs, and can exhibit responsive behaviours, but will accept the care if re-approached.

In interviews, staff #125, and staff #129 stated that residents have the right to refuse and in such a case, they should be given an explanation about the importance of the care, and if they continue to refuse, they should be re-approached and the registered staff should be informed. Staff #129 further stated that telling a resident that care must be completed or else the resident will complain is not respecting the resident's right to refuse care.

In an interview, staff #103 stated that staff #127 had already been provided education twice due to previously identified issues in addition to previous disciplinary action.

Staff #103 confirmed that both staff#127 and staff #130 had acted inappropriately in regards to addressing the resident about his/her care, and that resident #003's right to refuse care had not been respected. [s. 3. (1) 11. ii.]

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 residents' right to give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent, are fully respected and promoted, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are locked when they are not being supervised by staff.

Observations conducted during the initial tour of the home revealed an electrical room door on an identified floor to be unlocked.

Further observations conducted on the same day revealed that the latch had been tampered with by being filled with a paper towel and then covered with green painters' tape which allowed the door to close but prevented it from locking. The inspector noted signage on the door which indicated that emergency power outlets, and that in case of power failure, outlets for the generator were located in there. Further observations revealed three electrical panels on the wall, four large containers of paint on the floor, and two long light bulbs leaning up against a wall.

In an interview, staff #104 stated that this electrical door is to be locked at all times for resident safety and was not aware who had tampered with the latch.

In an interview, staff #102 stated there were workers in the home who were using this room. Staff #102 further stated he/she was not aware that the latch had been tampered with by the workers and that he/she had offered a key to this room to the workers, who had refused to take it. Staff #102 also stated that the door to this electrical room had not been monitored to ensure that it was locked.

In interviews, staff #101 and staff #100 stated they had tampered with the latch and that they assumed the home was locking the door after they left. Staff #101 further stated that the latch on the door had been left tampered with for the last two to three days.

Staff #100 stated he/she should have been aware of the risk to residents.

In an interview, staff #102 acknowledged that the home had failed to ensure that all doors leading to non-residential areas are locked when they are not being supervised by staff. [s. 9. (1) 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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if

clinically indicated.

During the RQI, resident #006 triggered in stage one for altered skin integrity.

Review of resident #006's Electronic Medication Administration Record (e-MAR) revealed an order within two specified dates, inclusive of four weeks, to complete weekly skin assessments on resident #006's altered skin integrity, until it was healed.

Review of resident #006's records revealed an initial skin and wound assessment completed for a new skin alteration on an identified date. Review of the documented skin assessments failed to reveal assessments completed for the following two weeks. The next skin assessment completed revealed the altered skin integrity had healed.

Further review of resident #006's records revealed that another initial skin and wound assessment was completed for a new area of altered skin integrity on an identified date. Review of the documented skin assessments failed to reveal assessments completed for a four week period. These four weeks fell in the date range specified in the order mentioned above, related to weekly skin assessments.

In interviews, staff #132 and staff #137 stated that resident #006 is prone to alterations in skin integrity due to a responsive behaviour. Staff #137 further stated that resident #006's skin integrity is also impacted by an identified medication.

In interviews, staff #128 and staff #137 stated that residents who have altered skin integrity are required to be assessed weekly until it is healed. Staff #137 acknowledged that a weekly skin assessment had not been completed for two weeks related to an identified altered skin integrity, and for four weeks related to a second identified altered skin integrity for resident #006.

In an interview, staff #129, stated that resident #006 has had a previous history of skin issues, and is at high risk for altered skin integrity due to underlying health conditions and an identified medication. Staff #129 confirmed that skin assessments for the above mentioned weeks should have been completed, especially as there was an order between the specified dates to complete these skin assessments. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

Issued on this 17 day of January 2018 (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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : BABITHA SHANMUGANANDAPALA (673) - (A1)

Inspection No. / No de l'inspection : 2017_530673_0015 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 025630-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jan 17, 2018;(A1)

Licensee / Titulaire de permis :
Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

LTC Home / Foyer de SLD :
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380 Church Street, MARKHAM, ON, L6B-1E1

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Order(s) of the Inspector

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Ministère 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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jason Gay

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To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, 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 :

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

Order / Ordre :

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

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to residents #003, and #005 as specified in the plan.

The plan will include, at a minimum, the following elements:
1. A documented monitoring process to ensure all appropriate staff receive training to ensure residents #003, #005, and other residents whose plan of care requires the assistance of two staff members for care receive the appropriate assistance as specified in the plan of care.
2. A documented monitoring process to ensure all appropriate staff receive training to ensure resident #005 and other residents whose plan of care requires specific altered skin integrity interventions, receive the appropriate interventions as specified in the plan of care.
3. A documented monitoring process to ensure all appropriate staff receive training to ensure resident #005 and other residents whose plan of care requires specific responsive behaviour interventions, receive the appropriate interventions as specified in the plan of care.
4. Develop and maintain a written record of the monitoring processes outlined in elements #1, 2 and 3, which includes measures implemented if staff do not provide care to all residents specific to their individual plans of care.

Please submit the plan to Babitha.shanmuganandapala@ontario.ca no later than January 31, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During the RQI, resident #003 triggered in stage one for altered skin integrity.

Record review of an assessment completed for resident #003 revealed that he/she is totally dependent on two staff for care needs. Review of resident #003's plan of care also revealed that he/she requires total assistance with care.

Record review revealed that on a specified date, at identified two hour intervals, resident #003 was provided care with one person physical assist by staff #127.

In an interview, staff #127 stated that he/she had provided care to resident #003 on his/her own every two hours. Staff #127 acknowledged that he/she had not followed resident #003's plan of care as two staff are required.

In an interview, staff #135 also stated that he/she had provided care to resident #003 on her own. Staff #135 acknowledged that he/she had not followed resident #003's plan of care as two staff are required when providing care.

In an interview, staff #129, confirmed that staff #127 and staff #135 had independently assisted resident #003 with his/her care needs and had not provided care to resident #003 as specified in the plan of care.
(673)

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During the Resident Quality Inspection (RQI), resident #005 triggered in stage one for altered skin integrity.

Review of resident #005's most recent written plan of care revealed that resident #005 was at risk for altered skin integrity and currently had an area of altered skin integrity. Interventions in resident #005's plan of care to prevent altered skin integrity included the use of a positioning aid and a protective aid when resident #005 is in

bed.

i) During resident observations, resident #005 was observed lying in bed; however, the two above mentioned interventions were not in place.

Record review revealed an assessment which stated that resident #005 was at risk for altered skin integrity due to underlying health conditions.

In an interview, staff #127 stated that he/she was aware that resident #005 was at risk for altered skin integrity and was able to identify that the use of a positioning aid and a protective aid were two interventions outlined in the written plan of care. Staff #127 stated that he/she had not implemented the two interventions from the time that he/she had dressed resident #005 that morning, and that the afternoon staff would implement them. Staff #127 acknowledged that he/she should have implemented the two interventions as per resident #005's plan of care.

In an interview, staff #128 and staff #129, stated that skin and wound interventions for resident #005 included the use of a positioning aid and protective aid as identified in the written plan of care. Staff #128 and staff #129 confirmed that staff #127 had not followed these interventions as outlined in resident #005's plan of care related to skin and wound care.

In an interview, staff #103 stated that there are always reasons for interventions outlined in each resident's plan of care and that the expectation was for staff #127 to have provided care to resident #005 as specified in that resident's plan of care, related to altered skin integrity.

ii) On the same date as the above mentioned incident, the inspector observed staff #135 inform resident #005 of the care to be provided, and proceed to provide care to resident #005 alone. During this care, resident #005 displayed nonverbal signs of discomfort, as identified in resident #005's written plan of care, to which staff #135 remained silent. When the inspector questioned staff #135 if he/she thought the resident may be in discomfort, he/she responded that he/she usually informs the registered staff after the care is completed if the resident experienced any discomfort.

Review of resident #005's plan of care revealed that resident #005 demonstrates responsive behaviours due to discomfort, including those witnessed by the inspector

during the care provided by staff #135. Interventions included reporting to the registered staff to assess, monitoring for any responsive behaviours during care and administering a prescribed as needed medication prior to care/treatment. Additional interventions noted were to gently redirect activities, provide reassurance or distraction, and to inform resident #005 of each step of care being performed. The plan of care further revealed that two staff are to provide total assistance with all aspects of care as resident #005 is unable to assist due to underlying health limitations.

In an interview, staff #135 stated that he/she had not informed the registered staff #136 before providing care to resident #005. When asked what he/she said to resident #005 throughout the care, staff #135 responded that prior to beginning the care, he/she informed resident #005 of the care to be provided, but did not communicate anything else with the resident during the care. Staff #135 stated that he/she provided care on his/her own, and that during the care, resident #005 exhibited responsive behaviours. Staff #135 could not identify how to communicate to resident #005 during care, or how many staff were to assist with care. After reviewing the plan of care, staff #135 acknowledged that he/she had not provided care to resident #005 as per his/her written plan of care.

In an interview, staff #129, stated that resident #005 exhibits responsive behaviours when experiencing discomfort, and that two staff are to provide assistance with care due to his/her underlying health conditions. Staff #129 further stated that one person assistance with care would cause resident #005 to exhibit responsive behaviours, and risk to the resident's skin integrity. Staff #129 also stated that staff #135 should have reported to staff #136 prior to providing care. Staff #129 confirmed that staff #135 had not followed the interventions outlined in resident #005's plan of care.

In an interview, staff #103 stated the expectation was for staff #135 to have provided care to resident #005 as specified in that resident's plan of care.

The scope is pattern as it relates to residents #005 and #003 and the severity is actual harm as harm was experienced by resident #005. The home's compliance history indicates that a previous Written Notice was issued with a Voluntary Plan of Correction related to O. Reg 79/10 s.6.(7), plan of care. Due to ongoing noncompliance and actual harm, a compliance order is warranted.
(673)

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

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

Mar 07, 2018(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:

Health Services Appeal and Review Board and the Director

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

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 17 day of January 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BABITHA SHANMUGANANDAPALA - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Toronto