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 sions de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 13, 2016	2016_325568_0006	036087-15	Complaint

Licensee/Titulaire de permis

STEEVES & ROZEMA ENTERPRISES LIMITED
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

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

ST ANDREW'S TERRACE LONG TERM CARE COMMUNITY
255 St. Andrew's Street CAMBRIDGE ON N1S 1P1

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

DOROTHY GINTHER (568)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 16, 17, 18 and 19, 2016

This inspection was conducted in conjunction with log #035968-15, 032425-15. 032249-15, and 001474-16.

During the course of the inspection, the inspector(s) spoke with the Administrator, Corporate Director of Clinical Services & Education, Resident Care Manager, and three Registered Practical Nurses.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

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

- **1 WN(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Documentation review revealed that resident #001 was identified as having an area of altered skin integrity. Nine days later, resident #001 was transferred to hospital. During the eight day period prior to the identified transfer to hospital. Resident's records identified the following signs of a change in condition:

a) Resident #001 required increasing assistance for transfers, was unable to weight bear, and became bed bound.

b) Resident #001 was identified as being lethargic and food and fluid consumption began to decline, commencing seven days before being transported to hospital. There were 14 entries documenting that resident #001 refused to eat and was consuming just fluids over a two day period. During the two days prior to the resident's transfer to hospital they were refusing all food and fluids.

c) During the seven days prior to the resident's transport to hospital they had a temperature of more than 37.5 degrees Celsius at some point each day. During the last few days when the resident refused medication their temperature remained high.

d) On two occasions, the area of altered skin integrity was noted to have changed and required treatment. The resident complained of pain related to the area of altered skin integrity on more than one occasion. There was no documentation by the Registered

Nurse to indicate that they had assessed the resident after being notified of these changes.

Record review revealed that a wound assessment was conducted which identified an area of altered skin integrity. The Treatment Administration Record (TAR) indicated that treatment was provided to the area of altered skin integrity three times prior to the resident's transfer to hospital. The day before resident #001 was taken to hospital, an assessment indicated that the area of altered skin integrity remained a similar size and there were no signs of infection. The day of resident #001's transfer to hospital the physician documented that resident #001's area of altered skin integrity showed signs of infection and the physician recommended transfer to hospital.

Staff interview with two Registered Practical Nurses revealed that when a resident has an identified area of altered skin integrity, they consult with the Registered Nurse or Wound Care Nurse regarding treatment. In addition, they would make a note in the doctors' book asking them to assess. Documentation by the physician seven days prior to resident #001's admission to hospital did not reference the area of altered skin integrity. There was no documentation available to indicate that the physician was made aware of the area of altered skin integrity prior to the day the resident was transferred to hospital.

Staff interview with the Corporate Director of Clinical Services and Education #102 revealed that with a change in resident condition the home's expectation would be that the Registered Nurse (RN) be notified. The RN would then assess the resident. Change in condition would include signs of infection, decline in mobility, reduced intake, and change in wound status. In the case of resident #001, progress notes indicated that the RN was made aware on three occasions of a change in resident #001's altered skin integrity. The RN was also made aware of the resident's reduced intake, however, there was no documentation that the RN assessed the resident with respect to these changes. The Director of Clinical Services and Education also indicated that when the altered skin integrity changes the physician and Substitute Decision Maker (SDM) should be notified, and a note placed in the clinical record to identify the reason for the notification. There was no documentation to indicate whether the physician was notified, and family were advised six days after the change in altered skin integrity.

The Director of Clinical Services was unable to account for the change in assessment findings during the the 24 hours prior to resident #001's admission to hospital. They confirmed that the RN should have been requested to assess the resident given their

decline in health status and other signs and symptoms of infection.

The licensee failed to ensure that resident #001 was properly cared for in a manner consistent with their needs. [s. 3. (1) 4.]

2. The licensee failed to ensure that every resident was afforded privacy in treatment and in caring for his or her personal needs.

During the inspection resident #002 was observed sitting in a common area occupied by six other residents and where staff were noted to be walking through the area on their way to provide care to other residents. Registered Practical Nurse #105 was observed kneeling on the floor in front of resident #002 removing bandages to expose an area of altered skin integrity. The RPN was observed to conduct a complete dressing change.

During an interview with the Resident Care Manager (RCM) they shared that the home's expectation was that treatments, including dressing changes, were conducted in a private area using proper infection control practices. The RCM confirmed that resident #002 was not afforded privacy during treatment.[s. 3. (1) 8.]

Additional Required Actions:

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

Issued on this 13th day of April, 2016

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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568)
Inspection No. / No de l'inspection :	2016_325568_0006
Log No. / Registre no:	036087-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 13, 2016
Licensee / Titulaire de permis :	STEEVES & ROZEMA ENTERPRISES LIMITED 265 NORTH FRONT STREET, SUITE 200, SARNIA, ON, N7T-7X1
LTC Home / Foyer de SLD :	ST ANDREW'S TERRACE LONG TERM CARE COMMUNITY 255 St. Andrew's Street, CAMBRIDGE, ON, N1S-1P1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARK VAN DYKE

To STEEVES & ROZEMA ENTERPRISES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that resident #001 and all other residents are properly cared for in a manner consistent with his or her needs when the resident demonstrates a change in condition, by ensuring the following are done:

i) the resident is reassessed,
ii) changes are communicated to staff and the SDM,
iii) referrals are made to appropriate resources, and
iv) the plan of care is updated.

Grounds / Motifs :

1. 1. The licensee failed to ensure that every resident was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Documentation review revealed that resident #001 was identified as having an area of altered skin integrity. Nine days later, resident #001 was transferred to hospital. During the eight day period prior to the identified transfer to hospital. Resident's records identified the following signs of a change in condition:

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refused to eat and was consuming just fluids over a two day period. During the two days prior to the resident's transfer to hospital they were refusing all food and fluids.

c) During the seven days prior to the resident's transport to hospital they had a temperature of more than 37.5 degrees Celsius at some point each day. During the last few days when the resident refused medication their temperature remained high.

d) On two occasions, the area of altered skin integrity was noted to have changed and required treatment. The resident complained of pain related to the area of altered skin integrity on more than one occasion. There was no documentation by the Registered Nurse to indicate that they had assessed the resident after being notified of these changes.

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resident #001, progress notes indicated that the RN was made aware on three occasions of a change in resident #001's altered skin integrity. The RN was also made aware of the resident's reduced intake, however, there was no documentation that the RN assessed the resident with respect to these changes. The Director of Clinical Services and Education also indicated that when the altered skin integrity changes the physician and Substitute Decision Maker (SDM) should be notified, and a note placed in the clinical record to identify the reason for the notification. There was no documentation to indicate whether the physician was notified, and family were advised six days after the change in altered skin integrity.

The Director of Clinical Services was unable to account for the change in assessment findings during the the 24 hours prior to resident #001's admission to hospital. They confirmed that the RN should have been requested to assess the resident given their decline in health status and other signs and symptoms of infection.

The licensee failed to ensure that resident #001 was properly cared for in a manner consistent with their needs.

The severity of this area of noncompliance was a level 3 - actual harm/risk. The scope was isolated. The compliance history was a level three - one or more related noncompliance in the last three years. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2016

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 sions 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 sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 13th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dorothy Ginther

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