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

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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
Sep 13, 2017	2017_463616_0011	013174-17	Resident Quality Inspection

Licensee/Titulaire de permis

RIVERSIDE HEALTH CARE FACILITIES, INC.
110 VICTORIA AVENUE FORT FRANCES ON P9A 2B7

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

RAINYCREST
550 OSBORNE STREET FORT FRANCES ON P9A 3T2

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

JENNIFER KOSS (616), DEBBIE WARPULA (577), SHEILA CLARK (617)

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): July 17-21 and 24-28, 2017

The following intakes were also inspected:

-one Critical Incident System (CIS) report the home submitted related to resident to resident abuse;
-two CIS reports the home submitted related to allegations of staff to resident abuse;
-one CIS report the home submitted related to an allegation of improper/incompetent treatment of a resident that resulted in harm or risk to a resident; and
-one CIS report the home submitted related to a resident's fall with injury.

In addition, a Follow Up Inspection to Compliance Order #001 related to LTCHA, 2007, S.O. 2007, c. 8, s. 6 (7) that had been previously issued during Inspection #2017_435621_0011 was erroneously complied in "Other" Inspection report #2017_435621_0017. CO #001 was inspected during this RQI.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, Interim Director of Care, Registered Dietitian, Unit Coordinators, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Assistant to Residents' Council, family members and residents.

During the course of the inspection, the Inspectors observed the provision of care and services to residents, resident to resident and staff to resident interactions, conducted daily tours of resident home areas, reviewed resident health care records, various home policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **2 VPC(s)**
- **3 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

The home submitted a Critical Incident System (CIS) report to the Director on a day in June 2017 for a physical altercation between resident #016 and #003 that occurred the day prior. The home had contacted the Ministry of Health and Long-Term Care "after hours pager" on the date of the altercation that resulted in injury to resident #003. The next day following the altercation, the CIS report was submitted by the home detailing the events of the incident.

According to the CIS report, resident #016’s voice was heard and a staff member witnessed resident #016 physically abuse resident #003. Resident #003 had sustained an injury as a result.

Inspector #616 reviewed resident #016's care plan in effect at the time of the incident. The care plan indicated that a specific type of staff monitoring of the resident was required and to remove resident #016 from situations that contributed to their behaviour.

The care plan for resident #003 was reviewed by the Inspector. A "Behaviour Problem" for resident #003 included specific behaviours.

The Inspector reviewed the home's investigation record where PSW #100 was identified as the staff member assigned to the supervision of resident #016 when the incident occurred. In the home's interview record, PSW #100 verified that they had been aware of resident #016's behaviours and the interventions to manage the behaviours. The PSW had also acknowledged "seeing a memorandum about the level of supervision required for [resident #016]". The investigation record confirmed that the PSW had left resident #016 unattended and during their absence, resident #016 had physically abused resident #003.

The Inspector reviewed the Memorandum from the Interim Administrator (AD) to all staff dated February 8, 2017. The memo detailed the purpose of the specific type of staff monitoring for residents meeting specific criteria.

PSW #100 was unavailable for interview during this inspection.

During the Inspector's interview with PSW #101, they stated that resident #016 had specific responsive behaviours. They stated that it was the responsibility of the staff assigned to monitor resident #016, to intervene when appropriate. The Inspector also interviewed PSW #102 and PSW #103. PSW #102 stated that resident #016 had demonstrated specific responsive behaviours toward other residents. Both PSW #102

and PSW #103 reported that staff needed to follow specific interventions that were in place.

The Interim AD confirmed to the Inspector that PSW #100 had not followed the plan of care for resident #016 and as a result, had failed to protect resident #003 from abuse by resident #016. [s. 19. (1)]

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 LTCHA, 2007 S.O. 2007, c.8, 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 was provided to the resident as specified in the plan.

Inspector #616 followed up on outstanding Compliance Order #001 issued during Inspection #2017_435621_0011 with a compliance date of July 7, 2017. The home was ordered to:

a) ensure that for every resident in the home, staff provide care as specified in each resident's plan of care, including the planned care for resident #016 with respect to responsive behaviour management; and
b) develop and implement an auditing process to ensure care is provided as per the resident's plan of care.

While the home complied with part b) of the order, a finding of non-compliance for s. 6 (7) was identified for part a) which directed the home to ensure that for every resident in the home, staff provided care as specified in each resident's plan of care, including the planned care for resident #016 with respect to responsive behaviour management.

A CIS report had been submitted by the home on a day in June 2017, related to a physical altercation between resident #016 and resident #003 that occurred one day earlier, prior to the compliance due date of July 7, 2017.

See WN #1, CO #001 for further details. [s. 6. (7)]

2. During a staff interview, it was identified that resident #014 had a particular area of impaired skin integrity which required further inspection.

On July 20, 2017, Inspector #577 conducted a record review of resident #014's care plan which included specific nursing interventions related to their area of impaired skin integrity.

During observations one morning, Inspector #577 observed resident #014 while seated and noted that the resident did not have one of the specific interventions in place. The Inspector spoke with PSW #104 who was the resident's assigned care provider. They confirmed that the resident did not have in place one of the care planned interventions and that the night staff had assisted the resident that morning.

During observations, on the afternoon of the same day, Inspector #577 observed resident #014 in bed sleeping, without another specific care planned intervention in place. The Inspector spoke with PSW #105 who reported that they did not implement the intervention as they thought what the resident had in place, was sufficient.

During observations two days later, Inspector #577 observed resident #014 in bed sleeping, without another specific care planned intervention in place. The Inspector spoke with PSW #106 who was the resident's assigned care provider. They reported that they had not transferred the resident back to bed and they would now implement the intervention.

During staff interviews the Interim Director of Care (DOC) and RN Unit Coordinator (UC) #120, both reported to the Inspector that the UC printed updated care plans which were placed in the unit care plan binder and the PSWs were encouraged to review the updated care plans. [s. 6.(7)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During a staff interview, it was identified that resident #014 had an area of impaired skin integrity which required further inspection.

Inspector #577 reviewed resident #014's care plan that identified this skin impairment with interventions for care. A further review of the progress notes and records confirmed the required care of this impaired area.

During a record review of resident #014's physician orders, the Inspector could not find any orders for their impaired skin integrity.

The Inspector reviewed "Skin and Wound Care Committee" meeting minutes dated May 2, 2017. The minutes indicated that a written skin and wound care policy and procedure were needed. The meeting minutes dated June 23, 2017, indicated that a policy and procedure regarding wound prevention and treatment were needed.

During a staff interview with RN UC #120 on July 27, 2017, they confirmed through a record review with the Inspector that there was no order for treatment of resident #014's impaired skin integrity, nor was there a skin and wound care program developed or implemented in the home.

During interviews with the Interim DOC on July 27, 2017, and RN #107 on July 28, 2017, they both confirmed to the Inspector that currently, an interdisciplinary skin and wound care program that promoted skin integrity, prevented the development of wounds and pressure ulcers, and provided effective skin and wound care interventions had not been developed or implemented in the home.

On August 1, 2017, the Inspector interviewed RN #108 who reported that they were the Wound Care Champion and that the home did not currently have an interdisciplinary skin and wound care program developed and implemented in the home. They further reported that the nursing staff relied on their own nursing knowledge for skin and wound care.

On August 1, 2017, Inspector #577 spoke with the Interim AD who confirmed currently, the home had not developed or implemented an interdisciplinary skin and wound care program. They further reported that that the Wound Care Champion #108 and Wound Care Resource #109 made wound care recommendations and the nursing staff obtained a physician order for the wound care recommendations. They further confirmed that without physician orders, nursing staff should not perform treatments for impaired skin care. [s. 48. (1) 2.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director.

During an interview, resident #011 reported to Inspector #617 that previously, a staff member forcibly handled them during care. Resident #011 was unable to remember the name of the nurse and stated that they had continued to provide care to the resident but was no longer rough with them.

Following the interview with resident #011, Inspector #617 reported the resident's allegation to the Interim AD.

The home submitted a CIS report to the Director regarding the incident of improper/incompetent treatment of resident #011 that resulted in risk to the resident six days later.

The Inspector interviewed the Interim AD, who confirmed that resident #011's description of the inappropriate care conducted by staff was an incident of alleged improper/incompetent treatment of the resident that resulted in risk to the resident and was required to be immediately reported to the Director.

A review of the home's policy titled, "Zero Tolerance of Abuse and Neglect Mandatory Reporting-#ORG-III-PAT-10.4", dated November 3, 2016, indicated that when there was reasonable suspicion that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident occurred or may occur, the Administrator/Director of Care was to immediately report to the Director through the Critical Incident System.

In an interview with the Interim AD, they confirmed to the Inspector that the home became aware of the incident on the particular date when resident #011's interview was reported to them. The Interim AD further explained that the home's policy and procedure for reporting had required them to report this incident immediately to the Director when they became aware of the alleged abuse. [s. 24. (1)]

2. During an interview, resident #006 reported to Inspector #617 that during a particular time a staff member made an unsupportive response to the resident’s request for assistance with an activity of daily living. Two staff members then proceeded to assist with the activity, leaving the resident in an inappropriate state for a prolonged period of time, resulting in a negative consequence for the resident. Resident #006 stated that a family member had reported the incident to the head nurse.

Following the interview with resident #006, Inspector #617 reported the resident's allegation to the Interim AD.

Six days later, the home had submitted a CIS report to the Director regarding the incident of improper/incompetent treatment of resident #006 that resulted in risk to the resident.

The Inspector interviewed the Interim AD, who confirmed that resident #006's description of the inappropriate approach and care conducted by staff was an incident of alleged improper/incompetent treatment of the resident that resulted in risk to the resident and was required to be immediately reported to the Director.

In an interview with the Interim AD, they confirmed to the Inspector that the home became aware of the incident when resident #006's interview was reported to them. The Interim AD further explained that the home's policy and procedure for reporting had required them to report this incident immediately to the Director when they became aware of the alleged abuse. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #5: 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 all medication incidents and adverse drug reactions were documented, reviewed and analyzed and a written record was kept.

Inspector #617 reviewed the home's medication incident reports and found that between a date in April 2017, and a date in July 2017, registered staff had reported 17 incidents using the electronic documentation system (Goldcare). The 17 incidents that had not been reviewed or analyzed were related to: all or some scheduled medications (including narcotic and controlled substances) that were missed, that were administered to the wrong resident, or incorrect medication dosages that were administered.

In an interview with the RAI Coordinator they reported to the Inspector that medication incident reports were completed by the registered staff electronically in Goldcare. The RAI Coordinator further explained that once the medication incident was submitted, the Unit Coordinators ran a monthly report of medication incidents, reviewed the incidents and followed up on the incident report electronically in Goldcare.

In an interview with both RN #121 and RN #119, they confirmed to the Inspector that it was their responsibility to have completed the follow up and analysis of medication incident reports. Both RN #121 and RN #119 respectively confirmed that the medication incidents reported between a date in April 2017, and a date in July 2017, were missing follow up and analysis by the UC and DOC.

In an interview with the Interim AD they confirmed that the home was responsible to review and analyze the medication incidents to ensure resident safety and prevent any further occurrences. The Interim AD confirmed that the review and analysis was not completed for the 17 reported medication incidents. [s. 135. (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 in addition to the requirement under clause (1) (a), the licensee shall ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed; and a written record is kept, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response was provided to the Residents' Council within 10 days of receiving concerns or recommendations by the Residents' Council.

During an interview with resident #017, President of the Residents' Council on a date in July 2017, they reported to Inspector #577 that some residents of the Council had voiced concerns during a Council meeting about specific services being discontinued in the home, and had not yet received a response in writing.

The Inspector conducted a record review of the Council minutes from the meetings on a date in April to a date in June 2017. The minutes on a date in April 2017, indicated that multiple residents had concerns about specific services being discontinued and the Assistant to the Council had agreed to discuss this with the Director of Care. There was no record found of a written response to the Council within 10 days of becoming aware of the concern on a date in April 2017.

The Inspector conducted an interview with the Assistant to the Council #118 who reported that the concern about specific services was voiced at the meeting on a date in April 2017, and that they had a verbal discussion with the previous Administrator following the Council meeting on the same day. They further confirmed that the Residents' Council had not yet received the response in writing as of July 27, 2017, 70 days later. [s. 57. (2)]

Issued on this 19th day of September, 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) :	JENNIFER KOSS (616), DEBBIE WARPULA (577), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2017_463616_0011
Log No. / No de registre :	013174-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 13, 2017
Licensee / Titulaire de permis :	RIVERSIDE HEALTH CARE FACILITIES, INC. 110 VICTORIA AVENUE, FORT FRANCES, ON, P9A-2B7
LTC Home / Foyer de SLD :	RAINYCREST 550 OSBORNE STREET, FORT FRANCES, ON, P9A-3T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bonnie Hughes

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that residents are protected from abuse by anyone, specifically that the care plan including techniques and interventions to prevent, minimize or respond to the demonstrated physically responsive behaviours of resident #016 are implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

The home submitted a Critical Incident System (CIS) report to the Director on a day in June 2017 for a physical altercation between resident #016 and #003 that occurred the day prior. The home had contacted the Ministry of Health and Long-Term Care "after hours pager" on the date of the altercation that resulted in injury to resident #003. The next day following the altercation, the CIS report was submitted by the home detailing the events of the incident.

According to the CIS report, resident #016's voice was heard and a staff member witnessed resident #016 physically abuse resident #003. Resident #003 had sustained an injury as a result.

Inspector #616 reviewed resident #016's care plan in effect at the time of the incident. The care plan indicated that a specific type of staff monitoring of the resident was required and to remove resident #016 from situations that contributed to their behaviour.

The care plan for resident #003 was reviewed by the Inspector. A "Behaviour Problem" for resident #003 included specific behaviours.

The Inspector reviewed the home's investigation record where PSW #100 was identified as the staff member assigned to the supervision of resident #016 when the incident occurred. In the home's interview record, PSW #100 verified that they had been aware of resident #016's behaviours and the interventions to manage the behaviours. The PSW had also acknowledged "seeing a memorandum about the level of supervision required for [resident #016]". The investigation record confirmed that the PSW had left resident #016 unattended and during their absence, resident #016 had physically abused resident #003.

The Inspector reviewed the Memorandum from the Interim Administrator (AD) to all staff dated February 8, 2017. The memo detailed the purpose of the specific type of staff monitoring for residents meeting specific criteria.

PSW #100 was unavailable for interview during this inspection.

During the Inspector's interview with PSW #101, they stated that resident #016 had specific responsive behaviours. They stated that it was the responsibility of the staff assigned to monitor resident #016, to intervene when appropriate. The Inspector also interviewed PSW #102 and PSW #103. PSW #102 stated that resident #016 had demonstrated specific responsive behaviours toward other residents. Both PSW #102 and PSW #103 reported that staff needed to follow specific interventions that were in place.

The Interim AD confirmed to the Inspector that PSW #100 had not followed the plan of care for resident #016 and as a result, had failed to protect resident #003 from abuse by resident #016.

The decision to issue a Compliance Order (CO) was based on the severity of actual harm to resident #003 and although the scope was isolated in this inspection, the home's history of related non-compliance is as follows:

- a Voluntary Plan of Correction during inspection #2017_395613_0001;
- a CO during inspection #2016_463616_0026 served February 22, 2017, with a compliance due date of March 10, 2017;
- a WN during inspection #2016_264609_0019;
- a CO during inspection #2016_320612_0018 served October 6, 2016, with a compliance due date of November 3, 2016;
- a CO during inspection #2014_380593_0007 served November 28, 2014, with

a compliance due date of December 26, 2014. (616)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 27, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that for every resident in the home, staff provide care as specified in each resident's plan of care, including the planned skin and wound care for resident #014.

This plan shall be submitted in writing, to:
Jennifer Koss - Long-Term Care Homes Inspector, Long-Term Care Inspections Branch, Ministry of Health and Long-Term Care Homes Division, 159 Cedar Street, Suite 403, Sudbury ON P3E 6A5, by email at SudburySAO.moh@ontario.ca. Alternatively, the plan may be faxed to the Inspector's attention at (705) 564-3133.

This plan must be received by September 27, 2017, and fully implemented by November 1, 2017.

Grounds / Motifs :

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

During a staff interview, it was identified that resident #014 had a particular area of impaired skin integrity which required further inspection.

On July 20, 2017, Inspector #577 conducted a record review of resident #014's care plan which included specific nursing interventions related to their area of impaired skin integrity.

During observations one morning, Inspector #577 observed resident #014 while

seated and noted that the resident did not have one of the specific interventions in place. The Inspector spoke with PSW #104 who was the resident's assigned care provider. They confirmed that the resident did not have in place one of the care planned interventions and that the night staff had assisted the resident that morning.

During observations, on the afternoon of the same day, Inspector #577 observed resident #014 in bed sleeping, without another specific care planned intervention in place. The Inspector spoke with PSW #105 who reported that they did not implement the intervention as they thought what the resident had in place, was sufficient.

During observations two days later, Inspector #577 observed resident #014 in bed sleeping, without another specific care planned intervention in place. The Inspector spoke with PSW #106 who was the resident's assigned care provider. They reported that they had not transferred the resident back to bed and they would now implement the intervention.

During staff interviews the Interim Director of Care (DOC) and RN Unit Coordinator (UC) #120, both reported to the Inspector that the UC printed updated care plans which were placed in the unit care plan binder and the PSWs were encouraged to review the updated care plans.

The decision to re-issue a Compliance Order (CO) was determined by the potential for actual harm as the skin and wound care of resident #014 was not provided as per the plan of care. Although the scope was isolated in this inspection, the home has continued non-compliance related to this section of the legislation. The home's compliance history is as follows:

- a CO and Director Referral during inspection #2017_435621_0011 served May 17, 2017, with a compliance due date of July 7, 2017;
- a CO during inspection #2016_463616_0026 (A3) served February 17, 2017, with a compliance due date of March 10, 2017;
- a CO during inspection #2016_339617_0021 served August 2, 2016, with a compliance due date of August 31, 2017;
- a WN during inspection #2016_320612_0018; and
- a WN during inspection #2014_380593_0007. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 01, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that an interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions is developed and implemented in the home.

Grounds / Motifs :

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

During a staff interview, it was identified that resident #014 had an area of impaired skin integrity which required further inspection.

Inspector #577 reviewed resident #014's care plan that identified this skin impairment with interventions for care. A further review of the progress notes and records confirmed the required care of this impaired area.

During a record review of resident #014's physician orders, the Inspector could not find any orders for their impaired skin integrity.

The Inspector reviewed "Skin and Wound Care Committee" meeting minutes dated May 2, 2017. The minutes indicated that a written skin and wound care policy and procedure were needed. The meeting minutes dated June 23, 2017, indicated that a policy and procedure regarding wound prevention and treatment were needed.

During a staff interview with RN UC #120 on July 27, 2017, they confirmed through a record review with the Inspector that there was no order for treatment of resident #014's impaired skin integrity, nor was there a skin and wound care program developed or implemented in the home.

During interviews with the Interim DOC on July 27, 2017, and RN #107 on July 28, 2017, they both confirmed to the Inspector that currently, an interdisciplinary skin and wound care program that promoted skin integrity, prevented the development of wounds and pressure ulcers, and provided effective skin and wound care interventions had not been developed or implemented in the home.

On August 1, 2017, the Inspector interviewed RN #108 who reported that they were the Wound Care Champion and that the home did not currently have an interdisciplinary skin and wound care program developed and implemented in the home. They further reported that the nursing staff relied on their own nursing knowledge for skin and wound care.

On August 1, 2017, Inspector #577 spoke with the Interim AD who confirmed currently, the home had not developed or implemented an interdisciplinary skin and wound care program. They further reported that that the Wound Care Champion #108 and Wound Care Resource #109 made wound care recommendations and the nursing staff obtained a physician order for the wound care recommendations. They further confirmed that without physician orders, nursing staff should not perform treatments for impaired skin care.

The decision to issue a Compliance Order was based on the scope being a pattern as the lack of a skin and wound care program affects residents requiring skin and wound care. The severity of this non-compliance is the potential for actual harm by the home not having developed and implemented a program

which promotes skin integrity, prevention of wounds and pressure ulcers, and the provision of effective skin and wound care interventions. The home has a history of unrelated non-compliance in this area of the legislation. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 11, 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 13th day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Koss

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