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 sous *la Loi de 2007 sur les foyers de soins de longue durée***


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

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

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

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


## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 14, 2019 | 2019_532590_0013 | 005252-18, 006388-18, 008452-18, 008732-18, 021964-18, 033163-18 | Critical Incident System |

### Licensee/Titulaire de permis

Blackadar Continuing Care Centre Inc.
101 Creighton Road DUNDAS ON L9H 3B7

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

Blackadar Continuing Care Centre
101 Creighton Road DUNDAS ON L9H 3B7

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

ALICIA MARLATT (590), AMBERLY COWPERTHWAITE (435), CHERYL MCFADDEN (745)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): April 15 - 18, 2019.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Services/Food Services Manager, three Registered Practical Nurses (RPN), two Personal Support Workers (PSW), and one Dietary Aide.**

**During the course of the inspection, the inspector(s) observed infection prevention and control practices, dining services, the provision of resident care including resident specific routines and staff and resident interactions.**

**During the course of the inspection, the inspector(s) reviewed residents' clinical records, Critical Incident System reports, policies and procedures related to inspection topics and Food Temperature Records.**

**The following Inspection Protocols were used during this inspection:**
**Dining Observation**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Safe and Secure Home**
**Skin and Wound Care**

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

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

**WN #1: The Licensee has failed to comply with 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,**
**(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,**
**(i) within 24 hours of the resident's admission,**
**(ii) upon any return of the resident from hospital, and**
**(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).**

**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 had failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

A) Critical Incident System (CIS) report was first submitted to the Ministry Of Health and Long-Term Care (MOHLTC) on a specified date, reporting an incident involving resident #001 which resulted in an admission to the hospital. The resident returned to the home 14 days later.

Review of resident #001's clinical record in Point Click Care (PCC) noted no assessments completed on the day the resident returned from the hospital, only that vital signs had been taken.

During an interview with Registered Practical Nurse (RPN) #106, when asked what assessments were completed for residents on their return to the home after hospitalization, they stated that Head to Toe assessments were completed. When asked what the home's policy was related to assessments for residents upon their return to the home post hospitalization, the RPN stated that a Head to Toe assessment was required. When asked where staff documented the Head to Toe assessments, the RPN stated that they were documented under the assessment tab in PCC. When asked if the RPN could show the inspector where the Head to Toe assessment was completed for resident #001 after their return from hospital, they stated that there was no Head to Toe assessment completed and that they would expect the assessment to have been completed.

Review of the homes policy titled "Head to Toe Assessment- RC-23-01-01 A5" last updated in February 2017, stated the "Reason for Assessment" included "Upon any return from hospital for residents with a (Pressure Ulcer Risk Score) PURS >1" and "Upon any return from an absence >24 hours". This policy included questions related to compromised skin areas noted on the body and identification, using diagrams, areas of skin alteration identified during the assessment.

During an interview with Director Of Care (DOC) #102 and Administrator #100, when asked if they would be able to show inspector where the Head to Toe assessment was for resident #001's return from hospital, they stated that there was not one documented as completed. When asked if they would expect this assessment to be documented as completed, they both stated yes.

B) A CIS report was first submitted to the MOHLTC on a specified date, related to an incident involving resident #005, which required them to be sent to the hospital for further assessment. The resident was able to return to the home the same day.

Review of a progress note dated the day of the incident, stated in part, that resident #005 returned to the home from the hospital and vital signs were taken.

Review of resident #005's assessments in PCC showed no Head to Toe assessment completed for the residents return from the hospital.

Review of resident #005's most recent Resident Assessment Instrument-Minimum Data Set (RAI-MDS) quarterly review prior to the incident, indicated the potential for risk of pressure ulcer development.

During an interview with DOC #102 and Administrator #100, when asked when Head to Toe assessments were completed, they stated that they were to be done within 24 hours of resident admission, after hospitalization and if residents are gone from the home longer than 24 hours. When asked who would be responsible for completing these assessments, they stated that the admission nurse or the registered staff on duty would complete this assessment. When asked where this assessment would be documented, they stated that the Head to Toe assessment would be documented in PCC under the assessment tab. When asked if the DOC would be able to show inspector resident #005's Head to Toe assessment upon their return to hospital, they stated that it was not there, and they would expect it to be. When asked if the home's policy titled "Head to Toe Assessment RC-23-01-01 A5" was followed when resident #005 returned from the hospital, they both stated no.

The licensee had failed to ensure that resident #001 and resident #005's skin was assessed by a member of the registered nursing staff upon their return to the home after their hospitalizations. [s. 50. (2) (a) (ii)]

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

A) A CIS report was received by the MOHLTC on a specified date, and reported an incident of improper or incompetent treatment of a resident. The report explained that resident #002 sustained an injury while being fed breakfast.

Review of resident #002's clinical record showed that medical interventions were required to assist the resident to heal. The wound was documented as resolved on a specific date.

A review of resident #002's completed skin and wound assessment tools during the time frame of treatment, showed that two assessments of the wound had been completed. The first assessment was dated the day of the injury and the second assessment was dated when the staff had documented that the wound had resolved. The time frame of treatment provided was 28 days.

B) Review of resident #006's clinical record showed that this resident had a wound that required treatments and monitoring. The treatment was ordered by the physician on a

specific date.

Review of resident #006's skin and wound assessment tools, showed that weekly assessments had been not been completed on four occasions of the 15 weeks treatment was provided.

C) Review of resident #007's clinical record showed that this resident had a wound that required dressing changes and monitoring by the staff. The treatment was ordered by the physician on a specified date.

The inspector reviewed resident #007's completed skin and wound assessment tools for the identified wound. Assessments were reviewed for a 10 week time frame. Skin and wound assessments were not completed for three of those weeks.

A review of the homes' policy titled 'Skin and Wound Program: Wound Care Management', policy number RC-23-01-02 and last updated in February 2017, was completed. The policy stated that a resident exhibiting any form of altered skin integrity, which may include but is not limited to skin breakdown, unexplained bruises, pressure ulcers, skin tears and wounds, will: Be reassessed at least weekly by a Nurse, if clinically indicated. The procedure section of the policy contained a section called Assessment. The Assessment section stated that staff were to 'Monitor resident skin condition with each dressing change. Re-assess at minimum weekly. Re-evaluation and documentation of treatments with creams or other medicated preparations should occur at minimum weekly.'

In an interview with RPN #105, they shared that they were not aware of the requirement to complete weekly skin and wound assessments. The RPN shared that they had not been doing weekly wound assessments on minor wounds, however had been doing weekly assessments on other more complex wounds to monitor them more closely.

In an interview with DOC #102, they shared that the home expected registered staff members to complete weekly assessments on areas of impaired skin integrity until they were resolved.

The licensee had failed to ensure that skin impairments on residents' #002, #006 and #007 were reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

***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 had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) A CIS report was submitted to the MOHLTC on a specific date. The long term care home reported that resident #002 had sustained a wound while being fed breakfast, and that physician's orders were to be followed for treatment until the wound healed.

Review of resident #002's clinical record showed that medical interventions were required to assist the resident to heal. The physician had ordered to apply a medicated ointment twice a day until it healed. Further, the physician ordered that three times a day the wound was to be cleansed and Vaseline was to be applied after each meal. These treatments were to continue until the wound healed.

Review of completed skin and wound assessments showed that an assessment was completed and documented the wound as resolved 28 days later.

Review of resident #002's electronic Treatment Administration Record (eTAR) for a specified month, showed that there were some missing documentation for these treatments. On three specific days, the treatments due were not signed for. Review of the progress notes on these specific days, showed that no progress note documentation was completed about this residents' wound.

B) Review of resident #006's clinical record showed that medical interventions were required to assist the resident in healing their wound. The physician had ordered to clean

the wound and apply a dressing daily and as needed. The wound was to be monitored daily.

Review of resident #006's eTAR for two specified months, showed that there was some missing documentation for these treatments. On six days, the treatments due on days shift were not signed for. Review of the progress notes on these dates, showed that no progress note documentation was completed about this residents' wound.

C) Review of resident #007's clinical record showed that this resident had a wound that required dressing changes and monitoring. The treatment ordered by the physician was due every four days. The wound and dressing was to be monitored daily. This treatment was scheduled to be completed on four identified days in a specific month.

Review of resident #007's eTAR for the specific month, showed that on three days, the number nine was documented along with a staff's initials for this treatment. Nine on the eTAR legend indicated 'Other/See Nurse Notes'. When the inspector reviewed resident #007's progress notes for information about the treatment/wound, there was no documentation about the wound/treatment on these dates.

In an interview with RPN #105 they shared that when a treatment was due the staff were required to provide the treatment and sign their initials on the eTAR, which indicated that the treatment had been provided. They shared that if a signature was missing, that either the treatment had not been provided, or the treatment had been provided and the staff forgot to sign the eTAR when they were finished.

The homes' policy titled 'Skin and Wound Program: Wound Care Management', policy number RC-23-01-01 and last updated in February 2017, was reviewed. In the procedure section of the policy there is a section titled Documentation. The Documentation section provided direction: that treatments were to be recorded on the MAR/eMAR (Medication Administration Record/electronic Medication Administration Record) and/or TAR/eTAR.

In an interview with DOC #102, they reviewed the eTAR and saw that the documentation was incomplete. They shared that when a treatment was provided, that the staff who provided the treatment were expected to sign the appropriate records and to follow the plan of care.

The licensee had failed to ensure that the care set out in the plan of care was provided to resident #002, #006 and #007, as specified in the plan. [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. 49. Falls prevention and management**

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

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).**

**Findings/Faits saillants :**

1. The licensee had failed to ensure that the resident who had fallen, received a post-fall assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for falls.

The MOHLTC received a CIS report on a specific date. The home reported that resident #004 had a fall on an identified day, which caused injury to the resident, transfer to hospital and a significant change in their status.

Review of resident #004's clinical record showed that this resident had a fall risk assessment completed prior to the fall.

Observation by inspector #745 on April 16, 2019, of resident #004's falls interventions, showed that the interventions were in place.

Review of resident #004's health records in PCC identified that a post-fall assessment was not completed for resident #004's fall on the identified date.

Review of the home's policy "Falls Prevention and Management Program" RC-15-01-01 last reviewed in February 2017, directed staff to complete a post-fall assessment as soon as possible after a resident falls.

DOC #102 who is the home's "Falls Lead" confirmed that registered staff were to complete the post-fall assessment immediately or as soon as possible after a resident has fallen.

RPN #106 confirmed that registered staff were to complete the post-fall assessments. The RPN stated they were completed in PCC for a resident that has fallen, as soon as they can be done and before the end of their shift.

Administrator #100 confirmed a post-fall assessment should have been completed after resident #004's fall, and stated it was not completed.

The licensee had failed to ensure that when resident #004 fell, they received a post-fall assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

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

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee had failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

A CIS report was received by the MOHLTC on a specific date, and reported an incident of improper or incompetent treatment of a resident. The report explained that resident #002 sustained an injury when being fed breakfast. The CIS report further explained that an investigation was completed into the incident and the home found that food temperatures were not recorded that morning. The resident required interventions and monitoring of the wound until it healed.

A review of the homes' Food Temperature Records for the day of the incident, showed that the breakfast food temperatures were documented. When the inspector asked the Food Service Manager about the documented food temperatures, they reported that the morning of the incident, and when completing their investigation, the temperatures were not documented then. The Food Service Worker (FSW) working that day had reported to them during the investigation, that they had taken the temperatures, however had not documented them yet.

The homes' policy titled 'Temperatures of Food at Point of Service', policy number NC-07 -01-03, and last updated in March 2019, was reviewed. The policy stated that 'Dietary staff shall serve food and beverages to each resident at a temperature and in a manner that promotes comfort and safety'. The dietary staff procedure section of the policy outlined that they were to 'Insert the probe of the thermometer into the thickest part of the food. Make sure the probe does not touch bone or the pan. Record the temperature on the Food Temperature Record or another appropriate form provided in Synergy.'.

In an interview with FSW #104 they shared that food temperatures were to be checked at point of service and were to be recorded on the provided food temperature record right after.

In an interview with Personal Support Worker (PSW) #107, they shared that when feeding residents they were usually told from the food worker that the food was really hot and may need to sit for a couple minutes. They shared that if possible, they will add milk and stir the food to help cool it down. The PSW shared that they will scoop a small amount of food on a spoon and place it on the residents lips and see if they have any reaction. If they do not have a reaction they continue with feeding the resident, if there is a reaction, they will set it aside to cool some more and try again in a few minutes.

In an interview with the Food Service Manager (FSM) #101, they shared that at the time of the incident that the home did not have maximum temperatures outlined for hot foods, only a minimum temperature as outlined by the legislation. They shared that there have been new forms developed and implemented which include a new maximum temperature for hot foods, in an effort to prevent something like this from happening again. The FSM shared the homes' expectations, in that temperatures were to be taken at point of service, just prior to serving to the residents, and this had not been done.

The licensee had failed to ensure that food and fluids were served at a temperature that was both safe and palatable for resident #002. [s. 73. (1) 6.]

---

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

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

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee had failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Upon review of resident #006's clinical record, specifically eTAR and the physician's orders for a specific month, it was observed that there were two physician's orders that were not transcribed properly.

The first order on the eTAR directed staff to cleanse a specific area of the residents skin and apply a medication twice a day; this was ordered on a specific date. The order on the eTAR had only scheduled a once a day time slot for this order. Review of the written physician's order showed that this order was to be provided twice a day, not once a day as scheduled on the eTAR.

The second order on the eTAR directed staff to cleanse a specific area of the residents skin and apply a different medication daily, this was ordered on a specific date. Review of the written physician's order showed that this treatment was to be provided to the resident's skin under, and not directly to, the specific area identified.

In an interview with RPN #105, they clarified the orders and the treatments that were actually being provided. The RPN shared that they provided the care to resident #006's skin and had transcribed the orders on the eTAR. The actual care that has been provided was that the specified area was being cleansed once a day, with the medication applied, and the other medication was being applied to the appropriate area under the specific area. The RPN acknowledged their mistakes in transcribing the orders and corrected the orders in the computer system.

In an interview with DOC #102, they shared that RPN #105 takes care of all the skin care orders and treatments. They shared that the RPN had made an honest mistake when transcribing the orders, however the orders on the eTAR should be accurate to reflect the order.

The licensee had failed to ensure that drugs were administered to resident #006 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 sous *la Loi de 2007 sur les foyers de soins de longue durée***

**Issued on this 21st day of May, 2019**

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

**Original report signed by the inspector.**

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

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

# Order(s) of the Inspector

# Ordre(s) de l'inspecteur

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

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) :** | ALICIA MARLATT (590), AMBERLY COWPERTHWAITE (435), CHERYL MCFADDEN (745) |
| **Inspection No. / No de l'inspection :** | 2019_532590_0013 |
| **Log No. / No de registre :** | 005252-18, 006388-18, 008452-18, 008732-18, 021964-18, 033163-18 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | May 14, 2019 |
| **Licensee / Titulaire de permis :** | Blackadar Continuing Care Centre Inc.<br>101 Creighton Road, DUNDAS, ON, L9H-3B7 |
| **LTC Home / Foyer de SLD :** | Blackadar Continuing Care Centre<br>101 Creighton Road, DUNDAS, ON, L9H-3B7 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Shelly Desgagne |

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

**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

To Blackadar Continuing Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

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

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

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

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

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

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

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

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

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

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

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

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

**Order / Ordre :**

The licensee must be compliant with Ontario Regulation 79/10, r. 50. (2).

Specifically the licensee must:
a) Ensure that resident #002, #006, #007, and any other residents' 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.

**Grounds / Motifs :**

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

A) A CIS report was received by the MOHLTC on a specified date, and reported an incident of improper or incompetent treatment of a resident. The report explained that resident #002 sustained an injury while being fed breakfast.

Review of resident #002's clinical record showed that medical interventions were required to assist the resident to heal. The wound was documented as resolved on a specific date.

A review of resident #002's completed skin and wound assessment tools during the time frame of treatment, showed that two assessments of the wound had been completed. The first assessment was dated the day of the injury and the second assessment was dated when the staff had documented that the wound had resolved. The time frame of treatment provided was 28 days.

B) Review of resident #006's clinical record showed that this resident had a wound that required treatments and monitoring. The treatment was ordered by the physician on a specific date.

Review of resident #006's skin and wound assessment tools, showed that weekly assessments had been not been completed on four occasions of the 15 weeks treatment was provided.

C) Review of resident #007's clinical record showed that this resident had a

wound that required dressing changes and monitoring by the staff. The treatment was ordered by the physician on a specified date.

The inspector reviewed resident #007's completed skin and wound assessment tools for the identified wound. Assessments were reviewed for a 10 week time frame. Skin and wound assessments were not completed for three of those weeks.

A review of the homes' policy titled 'Skin and Wound Program: Wound Care Management', policy number RC-23-01-02 and last updated in February 2017, was completed. The policy stated that a resident exhibiting any form of altered skin integrity, which may include but is not limited to skin breakdown, unexplained bruises, pressure ulcers, skin tears and wounds, will: Be reassessed at least weekly by a Nurse, if clinically indicated. The procedure section of the policy contained a section called Assessment. The Assessment section stated that staff were to 'Monitor resident skin condition with each dressing change. Re-assess at minimum weekly. Re-evaluation and documentation of treatments with creams or other medicated preparations should occur at minimum weekly.'

In an interview with RPN #105, they shared that they were not aware of the requirement to complete weekly skin and wound assessments. The RPN shared that they had not been doing weekly wound assessments on minor wounds, however had been doing weekly assessments on other more complex wounds to monitor them more closely.

In an interview with DOC #102, they shared that the home expected registered staff members to complete weekly assessments on areas of impaired skin integrity until they were resolved.

The licensee had failed to ensure that skin impairments on residents' #002, #006 and #007 were reassessed at least weekly by a member of the registered nursing staff.

The severity of this issue was determined to be a level 2 as there was minimal harm or risk for harm for the residents. The scope of the issue was a level 3 as all 3 sampled residents with impaired skin integrity had not had weekly wound

assessments. The home had a level 3 compliance history as they had ongoing non-compliance with this subsection of the Ontario Regulations 79/10 that included:
- a Voluntary Plan of Correction issued February 13, 2018, for r. 50. (2) (b) (iv) in Resident Quality Inspection #2017_555506_0027. (590)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 21, 2019

**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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 must be compliant with LTCHA, 2007, s. 6 (7).

Specifically the licensee must:
A) Ensure that the care set out in the plan of care is provided to residents #002, #006, #007, and any other residents, as specified in their plans.

**Grounds / Motifs :**

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

A) A CIS report was submitted to the MOHLTC on a specific date. The long term care home reported that resident #002 had sustained a wound while being fed breakfast, and that physician's orders were to be followed for treatment until the wound healed.

Review of resident #002's clinical record showed that medical interventions were required to assist the resident to heal. The physician had ordered to apply a medicated ointment twice a day until it healed. Further, the physician ordered that three times a day the wound was to be cleansed and Vaseline was to be applied after each meal. These treatments were to continue until the wound healed.

Review of completed skin and wound assessments showed that an assessment was completed and documented the wound as resolved 28 days later.

Review of resident #002's electronic Treatment Administration Record (eTAR) for a specified month, showed that there were some missing documentation for

these treatments. On three specific days, the treatments due were not signed for. Review of the progress notes on these specific days, showed that no progress note documentation was completed about this residents' wound.

B) Review of resident #006's clinical record showed that medical interventions were required to assist the resident in healing their wound. The physician had ordered to clean the wound and apply a dressing daily and as needed. The wound was to be monitored daily.

Review of resident #006's eTAR for two specified months, showed that there was some missing documentation for these treatments. On six days, the treatments due on days shift were not signed for. Review of the progress notes on these dates, showed that no progress note documentation was completed about this residents' wound.

C) Review of resident #007's clinical record showed that this resident had a wound that required dressing changes and monitoring. The treatment ordered by the physician was due every four days. The wound and dressing was to be monitored daily. This treatment was scheduled to be completed on four identified days in a specific month.

Review of resident #007's eTAR for the specific month, showed that on three days, the number nine was documented along with a staff's initials for this treatment. Nine on the eTAR legend indicated 'Other/See Nurse Notes'. When the inspector reviewed resident #007's progress notes for information about the treatment/wound, there was no documentation about the wound/treatment on these dates.

In an interview with RPN #105 they shared that when a treatment was due the staff were required to provide the treatment and sign their initials on the eTAR, which indicated that the treatment had been provided. They shared that if a signature was missing, that either the treatment had not been provided, or the treatment had been provided and the staff forgot to sign the eTAR when they were finished.

The homes' policy titled 'Skin and Wound Program: Wound Care Management', policy number RC-23-01-01 and last updated in February 2017, was reviewed.

In the procedure section of the policy there is a section titled Documentation. The Documentation section provided direction: that treatments were to be recorded on the MAR/eMAR (Medication Administration Record/electronic Medication Administration Record) and/or TAR/eTAR.

In an interview with DOC #102, they reviewed the eTAR and saw that the documentation was incomplete. They shared that when a treatment was provided, that the staff who provided the treatment were expected to sign the appropriate records and to follow the plan of care.

The licensee had failed to ensure that the care set out in the plan of care was provided to resident #002, #006 and #007, as specified in the plan.

The severity of this issue was determined to be a level 2 as there was no harm to the residents', but a minimal risk of harm is present. The scope of this issue was a level 3 as all 3 sampled residents had not had their plan of care followed. The home had a level 3 compliance history as they had ongoing non-compliance with this subsection of the LTCHA, 2007, that included:
- a Voluntary Plan of Correction issued February 13, 2018 for s. 6 (7) in Resident Quality Inspection #2017_555506_0027. (590)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 21, 2019

## 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

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

**Issued on this 14th day of May, 2019**

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

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

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