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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 30, 2019	2018_543561_0020	029425-17, 012406-18, 018450-18	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Wellington Park Care Centre
802 Hager Avenue BURLINGTON ON L7S 1X2

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

DARIA TRZOS (561), DIANNE BARSEVICH (581)

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): November 29, 30, 2018, December 3, 5, 6, 7, 11, 12 and 13, 2018.

A Follow Up inspection, log number 002739-18, was conducted concurrently with this Complaint Inspection.

Critical Incident System (CIS) Inspections were also conducted concurrently with this Inspection with the following log numbers:
003554-17, 1023-000007-17 - related to resident to resident abuse,
004647-18, 1023-000008-18 - related to resident to resident abuse,
013926-18, 1023-000016-18 - related to resident to resident abuse,
028391-18, 1023-000023-18 - related to a fall.

PLEASE NOTE: Non-compliance related to s. 6 (1) of the LTCHA, identified during CIS inspection number 2018_543561_0019, log numbers 003554-17, 004647-18, 013926-18, 028391-18, is included in this report and issued as a Voluntary Plan of Correction (VPC).

During the course of the inspection, the inspector(s) spoke with the Administrator, Clinical Director of Nursing (CDON), Social Services Worker (SSW), Environmental Services Manager (ESM), Registered Dietitian (RD), Behavioural Supports Ontario (BSO) Nurse, registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

During the course of the inspection, the inspectors toured the home, observed the provision of care, reviewed relevant documents including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Personal Support Services
Reporting and Complaints
Skin and Wound Care

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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 failed to ensure that the resident received a skin assessment by a member of the registered nursing staff within 24 hours of admission.

A Critical Incident System (CIS) report and a complaint were received by the Director for improper/incompetent treatment of resident #002 that resulted in harm.

Clinical record review identified that resident #002 was admitted to the home on an identified date in 2018.
The head to toe assessment did not provide a description of the full assessment related to the health condition.
Registered staff #105, who admitted the resident was interviewed and stated that the resident did not have the specified condition requiring treatment.

The LHIN admission assessments indicated that resident #002 had the condition. The Physical Examination Medical Assessment completed by the home's physician indicated that the resident required treatment.
The home's investigation notes indicated that the resident's specified condition was not assessed on admission. The interview with the CDON acknowledged the same.

The home failed to ensure that the resident received a skin assessment by registered staff within 24 hours of admission.

B) Clinical record review identified that resident #008 was admitted to the home on an identified date in 2018, with a health condition.
The head to toe assessment on admission indicated that the full description of the condition was not documented.
The progress note on an identified date in 2018, indicated that the resident reported an identified symptom. Upon assessment, registered staff discovered a change in the identified health condition.

The interview with the registered staff #106, indicated that registered staff were to complete a full assessment of the identified condition and document it on the head to toe assessment.

The CDON was interviewed and acknowledged that it was the expectation of the registered staff to complete the head to toe assessment.

The licensee failed to ensure that residents #002 and #008 received a skin assessment by a member of the registered nursing staff within 24 hours of admission. [s. 50. (2) (a) (i)]

2. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

A CIS report and a complaint were received by the Director for improper/incompetent treatment of resident #002 that resulted in harm.

Clinical record review identified that resident #002 was admitted to the home on an identified date in 2018, with a health condition.

The LHIN admission assessments indicated that resident #002 had the condition. The Physical Examination Medical Assessment completed by the home's physician on an identified date in 2018, indicated that the resident required treatment.

The clinical record review indicated that resident #002 went out for an appointment at a clinic after admission and there was a change in treatment. There was another appointment several weeks later it was identified that the treatment was not completed at the home during the time period between the two appointments. There was no skin assessments completed between the admission and the appointments. The Electronic Treatment Assessment Record (ETAR) was reviewed and the monitoring of the condition was not added to the ETAR.

The interview with resident #002's SDM, indicated that staff at the clinic reported that no treatment was done to the identified condition between the two appointments resident had at the clinic. Resident #002 was on several treatments for the deteriorated condition prior to their discharge from the home.

Registered staff #105 was interviewed and indicated that the resident did not provide any papers with orders when they returned from the clinic.
Registered staff #106 was interviewed and stated that the registered staff who admitted the resident should have added to monitor the condition on the ETAR.

Resident #002's condition was not monitored and it deteriorated requiring further treatment.

The CDON was interviewed and stated that the registered staff should have completed a full assessment of the condition. The home failed to ensure that the resident's identified condition was monitored to prevent deterioration.

The home failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection. [s. 50. (2) (b) (ii)]

3. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration were implemented.

A CIS and a complaint were received by the Director for improper/incompetent treatment of resident #002 that resulted in harm.

Clinical records review identified that resident #002 was admitted to the home on an identified date in 2018, with a health condition.
The LHIN admission assessments indicated that resident #002 had a treatment. The Physical Examination Medical Assessment completed by the home's physician on an identified date in 2018, indicated that the resident required treatment. Their condition had deteriorated and required further treatment.

The progress notes were reviewed and indicated that resident's food intake was poor. The Registered Dietitian (RD) made a progress note on an identified date in 2018, indicating that resident #002's meal intake was at an identified percentage and they would follow up with an order. The clinical record review indicated that there was no follow up. The clinical record review also indicated that there was no referral made to the RD anytime between the admission and the identified deterioration of the condition. The RD assessed the resident on an identified date in 2018 and ordered a new treatment after the condition was deteriorated.

The interview with the RD confirmed that they had made the progress note on the identified date in 2018, to follow up a new order; however, they did not and could not recall why. The RD indicated that they had not assessed the resident prior to the deterioration of the condition.

The licensee failed to ensure that the resident exhibiting altered skin integrity was assessed by the RD and any changes made to the plan of care related to nutrition and hydration were implemented. [s. 50. (2) (b) (iii)]

4. The licensee 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.

A) A CIS report and a complaint log #018450-18 were received by the Director for improper/incompetent treatment of resident #002 that resulted in harm.

Clinical records review identified that resident #002 was admitted to the home on an identified date in 2018, with a health condition.

The LHIN admission assessments indicated that resident #002 had a treatment. The Physical Examination Medical Assessment completed by the home's physician on an identified date in 2018, indicated that the resident required treatment. Their condition had deteriorated and required further treatment.

The clinical record review indicated that the weekly assessments were not completed for resident #002 since the admission or after the first appointment at the clinic until the condition had deteriorated. The Electronic Treatment Assessment Record (ETAR) was reviewed and the monitoring of the condition was not added to the ETAR.

Registered staff #105 was interviewed and stated that the home's expectation was to complete weekly skin assessments for residents exhibiting altered skin integrity.

The interview with the CDON indicated that the condition should have been monitored and the weekly skin assessments should have been completed.

B) Clinical record review identified that resident #008 was admitted to the home on an identified date in 2018, with a health condition. The progress note on an identified date indicated that the resident reported having a specified symptom related to the condition. Upon assessment the registered staff discovered a deterioration of the identified condition. Resident #008 received orders for treatment. The clinical record review indicated that between identified three month period only a specified number of skin assessments were completed for the condition. The resident was not assessed weekly.

Interview with the registered staff #106, indicated that the weekly skin assessments for resident #008 should have been completed on weekly basis.

The CDON acknowledged that the registered staffs' expectation was to complete the weekly skin assessments for resident #002 and #008 as per the home's policy.

The licensee failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out, (a) the planned care for the resident; (b) the goals the care was intended to achieve; and (c) clear directions to staff and others who provided direct care to the resident.

A CIS report was reviewed by LTCH Inspector #561 during a CIS Inspection conducted concurrently with this inspection for residents #011 and #013.
Clinical record review identified several incidents of abuse related to resident #011 and resident #013 in 2018. Clinical record review identified that there was a history of an identified behaviour towards resident #013 in 2017. The home had completed an assessment for the two residents in 2017. The clinical record review also identified that the resident #013's Substitute Decision Maker (SDM) was not in agreement with identified interactions.
The written plans of care for the time period between 2017 and 2018, were reviewed and did not identify the identified behaviour, the goals the care was to achieve, interventions to address the behaviour and clear directions to staff.

The interview with the BSO Nurse identified that they had implemented interventions related to the incidents an an identified date in 2018. The BSO indicated that they were not aware of the assessment that was completed in 2017.

The current written plans of care for resident #013 and #011 were reviewed by LTCH Inspector and did not identify the identified behaviour in both residents' written plans of care and did not include interventions implemented by the BSO Nurse in 2018.

The CDON acknowledged that the written plans of care did set out the planned care, goals and clear direction to staff for the two residents related to the identified behaviour.

The licensee failed to ensure that there was a written plan of care that set out the planned care for residents #011 and #013, the goals the care was intended to achieve and clear directions to staff. [s. 6. (1)]

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

A) A review of Complaint intake submitted on an identified date in 2017, identified multiple care concerns.

Review of resident #005's Minimum Data Set (MDS) assessment in an identified period of time in 2018, identified that the resident required a device. Review of the current written plan of care did not identify the resident had the device, goals and interventions. Interview with registered staff #109 stated that the resident did require the device and confirmed that there was no focus, goal or intervention documented in the written plan of care related to this.

B) On an identified date in 2018, resident #010 was observed using a device. Review of the resident's written plan of care did not identify that the resident required the device. During an interview with registered staff #112 stated that the resident did use the device and confirmed that use of the device was not documented as planned care in the written plan of care.

The licensee failed to ensure there was a written plan of care for each resident that set out the planned care for residents #005 and #010. [s. 6. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the 24 hour admission care plan included, at a minimum, the following with respect to the resident: 7. Skin condition, including interventions.

A) A CIS report and a complaint were received by the Director for improper/incompetent treatment of resident #002 that resulted in harm.

Clinical record review identified that resident #002 was admitted to the home on an identified date in 2018, with a health condition.
Registered staff #105, who admitted the resident was interviewed and stated that the resident did not have the specified condition requiring treatment.

The LHIN admission assessments indicated that resident #002 had the specified condition. The Physical Examination Medical Assessment completed by the home's physician indicated that the resident required treatment.

The written plan of care on admission was reviewed and did not include the identified condition and interventions related to this. The interventions related to the condition were added to the written plan of care on an identified date in 2018 several weeks after admission.

The interview with registered staff #106 indicated that care plans needed to be developed and interventions included for residents admitted with an identified condition.

B) Clinical record review identified that resident #008 was admitted to the home on an identified date in 2018, with a health condition.
The head to toe assessment did not have a full description of the identified condition. The progress note on an identified date in 2018, indicated that resident #008 reported a symptom associated with the identified condition. Upon assessment the registered staff discovered a deterioration of the condition.

The written plan of care at the time of the deterioration of the condition was reviewed and did not include the condition or interventions related to it. The interventions were added to the written plan of care several weeks after.

The home's policy titled "Admission of a Resident", Index I.D: RCS B-05, revised March 10, 2018, indicated that the 24-hour admission care plan must include at a minimum: skin condition including a head to toe assessment and interventions.

The CDON acknowledged that the 24 hour admission care plan did not include the identified condition and interventions for residents #002 and #008.

The licensee failed to ensure that the 24 hour admission care plan included the specified condition, including interventions. [s. 24. (2) 7.]

2. The licensee failed to ensure that the resident was reassessed and the care plan was reviewed and revised when the resident's care needs changed.

A CIS report and a complaint were received by the Director for improper/incompetent treatment of resident #002 that resulted in harm.

Clinical record review identified that resident #002 was admitted to the home on an identified date in 2018, with a health condition. The condition was not monitored and treated for several weeks in the home and the condition had deteriorated requiring further treatment.

The written plan of care in effect for the first 21 days of admission as required under the O. Reg 79/10 s. 25 (1) (b), was reviewed by LTCH Inspector and was not revised to include the changes in the resident's condition related to the deterioration of the specified condition and treatment of it.

The interview with the registered staff #106 indicated that care plans needed to be updated with any changes to the resident's condition.

The licensee failed to ensure that the resident was reassessed and the care plan was reviewed and revised when the resident's care needs changed. [s. 24. (9) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the 24 hour admission care plan includes, at a minimum, the following with respect to the resident: 7. Skin condition, including interventions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident had their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring.

A) A review of Complaint intake submitted on an identified date in 2017, identified multiple care concerns.
On an identified date in 2018, resident #005's device was observed unlabeled. Review of the MDS assessment completed in 2018, and interview with registered staff #109 identified the resident used the device. During an interview with the Administrator they confirmed that resident's device was not labeled.

B) On an identified date in 2018, resident #007 was observed using a device that was unlabeled. In an interview with registered staff #113 they confirmed that the resident's device was not labeled.

The licensee failed to ensure that the residents had their personal items labeled within 24 hours of admission. [s. 37. (1) (a)]

Issued on this 4th day of February, 2019

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

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

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) :	DARIA TRZOS (561), DIANNE BARSEVICH (581)
Inspection No. / No de l'inspection :	2018_543561_0020
Log No. / No de registre :	029425-17, 012406-18, 018450-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 30, 2019
Licensee / Titulaire de permis :	Rykka Care Centres LP 3760 14th Avenue, Suite 402, MARKHAM, ON, L3R-3T7
LTC Home / Foyer de SLD :	Wellington Park Care Centre 802 Hager Avenue, BURLINGTON, ON, L7S-1X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Charlotte Nevills

To Rykka Care Centres LP, 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) (b)

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 Long Term Care Homes Act, 2007, O. Reg. 50 (2).

The licensee shall prepare, submit and implement a plan to ensure that:
1. All residents who are admitted to the identified unit with altered skin integrity, receive a full assessment of the area of altered skin integrity and treatment to the area to reduce or relieve pain, promote healing, and prevent infection, as required.
2. All residents who are admitted to the identified unit with altered skin integrity are reassessed weekly by a member of the registered staff.
3. There is an auditing system to ensure that all residents being admitted to the identified unit post surgery are monitored and their areas of altered skin integrity are treated promptly to reduce or relieve pain, promote healing, and prevent infection, as required.
4. There is a system in place to ensure that after any resident leaves the facility to an external appointment there is a follow up done and any new orders are in place and implemented in the home for these residents.

Please submit the written plan, quoting log number 2018_543561_0020 and Inspector, Daria Trzos, by email to HamiltonSAO.moh@ontario.ca by February 18, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

A Critical Incident System (CIS) report and a complaint were received by the Director for improper/incompetent treatment of resident #002 that resulted in harm.

Clinical record review identified that resident #002 was admitted to the home on an identified date in 2018, with a health condition.
The LHIN admission assessments indicated that resident #002 had the

condition. The Physical Examination Medical Assessment completed by the home's physician on an identified date in 2018, indicated that the resident required treatment.

The clinical record review indicated that resident #002 went out for an appointment at a clinic after admission and there was a change in treatment. There was another appointment several weeks later it was identified that the treatment was not completed at the home during the time period between the two appointments. There was no skin assessments completed between the admission and the appointments. The Electronic Treatment Assessment Record (ETAR) was reviewed and the monitoring of the condition was not added to the ETAR.

The interview with resident #002's SDM, indicated that staff at the clinic reported that no treatment was done to the identified condition between the two appointments resident had at the clinic. Resident #002 was on several treatments for the deteriorated condition prior to their discharge from the home.

Registered staff #105 was interviewed and indicated that the resident did not provide any papers with orders when they returned from the clinic.
Registered staff #106 was interviewed and stated that the registered staff who admitted the resident should have added to monitor the condition on the ETAR.

Resident #002's condition was not monitored and it deteriorated requiring further treatment.

The CDON was interviewed and stated that the registered staff should have completed a full assessment of the condition. The home failed to ensure that the resident's identified condition was monitored to prevent deterioration.

The home failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection. (561)

2. The licensee 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.

A) A CIS report and a complaint log #018450-18 were received by the Director for improper/incompetent treatment of resident #002 that resulted in harm.

Clinical records review identified that resident #002 was admitted to the home on an identified date in 2018, with a health condition.
The LHIN admission assessments indicated that resident #002 had a treatment. The Physical Examination Medical Assessment completed by the home's physician on an identified date in 2018, indicated that the resident required treatment. Their condition had deteriorated and required further treatment.

The clinical record review indicated that the weekly assessments were not completed for resident #002 since the admission or after the first appointment at the clinic until the condition had deteriorated. The Electronic Treatment Assessment Record (ETAR) was reviewed and the monitoring of the condition was not added to the ETAR.

Registered staff #105 was interviewed and stated that the home's expectation was to complete weekly skin assessments for residents exhibiting altered skin integrity.

The interview with the CDON indicated that the condition should have been monitored and the weekly skin assessments should have been completed.

B) Clinical record review identified that resident #008 was admitted to the home on an identified date in 2018, with a health condition. The progress note on an identified date indicated that the resident reported having a specified symptom related to the condition. Upon assessment the registered staff discovered a deterioration of the identified condition. Resident #008 received orders for treatment. The clinical record review indicated that between identified three month period only a specified number of skin assessments were completed for the condition. The resident was not assessed weekly.

Interview with the registered staff #106, indicated that the weekly skin assessments for resident #008 should have been completed on weekly basis.

The CDON acknowledged that the registered staffs' expectation was to complete the weekly skin assessments for resident #002 and #008 as per the home's policy.

The licensee 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.

The severity of this issue was determined to be a level 3 as there was actual harm to residents. The scope of the issue was a level 2 (pattern), as it related to two residents out of three reviewed. The home had a level 3 history as they had one or more related non-compliance with the legislation in the last 36 months issued as a Voluntary Plan of Correction (VPC) on December 19, 2017 (2017_695156_0005). (561)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 30, 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 30th day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

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