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

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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
Jun 21, 2018	2018_548592_0008	008974-18	Resident Quality Inspection

Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

Centre d'Accueil Champlain
275 Perrier Street VANIER ON K1L 5C6

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

MELANIE SARRAZIN (592), JOANNE HENRIE (550), LINDA HARKINS (126), LISA KLUKE (547)

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): May 07, 08, 09, 10, 11, 14, 15, 16, 17, 18, 22, 23, 24 and 25, 2018.

During the course of the Resident Quality Inspection, the inspector(s) also conducted 17 concurrent inspections which included:
- One follow-up to a compliance order with a compliance date of March 23, 2018, related to responsive behaviours log: #002882-18

- One follow-up to a compliance order with a compliance date of January 11, 2018, related to minimizing of restraining log: #026158-17
- Three critical incident inspections related to resident falls resulting in injuries: logs #002711-18, 027483-17, #027312-17
- One critical incident inspection related to medications: log #000974-18
- One critical incident inspection related to alleged abuse: log #000214-18
- Five complaints inspections related to alleged abuse: logs #001133-18, #028261-17, #001275-18, #008986-18 and #009280-18
- Two complaints inspections related to skin management: logs #003836-18 and #029277-17
- One complaint inspection related to plan of care: Log# 005351-18
- One complaint inspection related to admission of a resident: Log #007184-18 and
- One complaint inspection related to personal care: Log #009101-18

During the course of the inspection, the inspector(s) spoke with with the home's Administrator, the Program Manager for Personal Care (PMPC), the Program Manager for Resident Care (PMRC), the Activity Director, the Registered Dietician (RD), one Physician, the Recreational Therapist, one Wound Care Specialist, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSWs), the president of the Family Council, the president of the Resident Council, several family members and several residents.

During the course of the inspection, the inspector(s) conducted a tour of the resident care areas, reviewed residents' health care records, relevant policies and procedures, staff work routines, observed resident rooms, resident common areas, the Admission process and Quality Improvement system, Residents' Council minutes, a medication administration pass, the delivery of resident care and services and staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
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.
- **16 WN(s)**
- **7 VPC(s)**
- **3 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 53. (4)	CO #001	2017_621547_0019	547

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. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with the following compliance order CO#001 from inspection #2017_619550_0018 served on September 22, 2017, with a compliance date of January 11, 2018:

The Licensee shall ensure that the written policy to minimize the restraining of residents is complied with. Specifically, the license shall:

1. Provide education to direct care staff on the licensee's "Least restraint" policy. This education shall include a review of the documentation requirements under O. Reg. 79/10, s.110. (7). This education shall be documented.
2. Review the plan of care of residents #003, #006, #046 and #047 and all other residents who are being restrained by a physical device to ensure that any restraining is done in accordance with the Act, the regulations and the licensee's "Least restraint" policy.
3. Develop and implement a monitoring process to ensure that the licensee's ''Least Restraint'' policy is complied with.

The licensee completed step 1 in CO #001, however, the licensee did not complete step 2 and 3 of that same Compliance Order.

As demonstrated below, the licensee failed to complete step 2 and 3, regarding ensuring that any restraining of residents by a physical device is done in accordance with the Act, the regulations and the licensee's "Least restraint" policy.

The inspector reviewed the home's policy ''Least Restraint'', No. 335.10, last reviewed in December 2017. Under procedure, initiation of restraint on page 4 of 7 it was documented:
1. Complete an assessment to determine rationale for considering a restraint. Potential for injury to self or others.
5. Obtain and document consent or refusal on consent form.
8. Document in the progress notes circumstances precipitating the application of the restraint; alternatives considered and why inappropriate; person who made the order, what device was ordered; consent; person who applied the device and the time of application.
9. Initiate the Restraint Monitoring form. Ensure completion using the appropriate key and response.
13. Every release of the device and all repositioning will be recorded on the restraint/Personal Assistance Service Device (PASD) flow sheet.

14. Document all assessments, reassessment and monitoring including the resident's response, as well as the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining.
17. The resident's condition is reassessed and the effectiveness of the restraining is evaluated every 8 hours by a member of the registered staff and documented on the Medication Administration Records (MAR).

The Program Manager of Resident Care (PMRC) indicated to inspector #550 that the application, the release, the repositioning, the removal or discontinuance of the device and the resident's response to the restraining is documented on the restraint monitoring form #335.10B by PSWs using the appropriate key and response code indicated on the top of the form. The legend for the codes is identified as:
Code:
A – Appliqué (Applied)
EP – En place (In place)
RP – Repositionné (Repositioned)
RT – Retiré (Removed)
R – Refusé (Refused)

Reaction:
0 – Aucune reaction/calme (No response/calm)
1 – Agité (Agitated/restless)
2 – Essaye de l'enlever (Attempting to remove)

According to the policy, the reassessment of the resident's condition and the evaluation of the effectiveness of the restraining every eight hours by registered nursing staff is to be documented on each shift in the MAR.

On May 14, 2018, inspector #550 observed resident #004 seated in a tilted wheelchair with a specific safety device in place. During an interview, PSW #123 told the inspector that resident #004 requires a specific safety device to prevent the resident from getting up from the wheelchair on their own. The PSW indicated they have to verify the resident every thirty minutes and reposition the resident every two hours when the restraint is in place. They have to document this on the restraint monitoring form # 335.10B including the time for the application and removal of the restraint.

The inspector #550 reviewed resident #004's health care records and noted a document titled "Restraint/PASD consent form" signed by the resident's substitute decision maker

on a specified date in 2017. On this document, the recommended restraint type was left blank and the type of restraint was not indicated anywhere else on the consent form.

During a review of the documentation on the restraint monitoring form #335.10B for resident #004, the inspector noted the following:
-the repositioning of the resident every two hours was not documented for each day.
-on a specified day, there was no documentation of the removal of the restraint at the end of the day.
-on another specified day, from 0800 hours (hrs) to 1500hrs it was documented code AP which is not a code as per the restraint from. There was no documentation in the resident's reaction to the restraining column.

The inspector reviewed the documentation for the reassessment of resident #004's condition and the evaluation of the effectiveness of the restraining every eight hours in the MAR. The inspector noted that there was no staff initials for three specified shifts.

On May 14, 2018, inspector #550 observed resident #029 sleeping in a wheelchair in front of the television in the main sitting area. The wheelchair was reclined and the resident had a specific safety device in place. During an interview PSW #123 told the inspector that that the resident requires a specific safety device while seated in the wheelchair to prevent the resident from getting up. PSW #123 indicated that the safety device is verified every thirty minutes and the resident is repositioned every 2 hours. The application, removal, and repositioning was to be documented on the restraint monitoring form # 335.10B.

During a review of the documentation on the restraint monitoring form #335.10B for resident #029, the inspector noted the following:
-there was no documentation of the repositioning every two hours for that period.
-on a specified day, the last entry at 2300hrs indicated that the restraint was in place (EP), there was no documentation indicating when the restraint was removed. The next documentation was on the following day at 0700hrs where it was documented that the restraint was applied.
-On another specified day, there was no documentation from 2400hrs to 1400hrs to indicate when the restraint was applied. At 1500hrs, it was documented that the restraint was in place (EP).
-On another specified day, from 0700hrs to 2000hrs, it was documented code AP which is not a code on the restraint monitoring form # 335.10B.
-On another specified day, from 1600hrs to 1900hrs it was documented code AP which is

not a code on the restraint monitoring form # 335.10B.
-On another specified day, there was no documentation of the application of the restraint. The first documentation was at 1200hrs which indicated that the restraint was in place (EP). At 2000hrs it was documented that the restraint was applied (A). From 2100hrs to 2300hrs, there was no documentation.
-There was no documentation found for another specified date.

The inspector reviewed the documentation for the reassessment of resident #029's condition and the evaluation of the effectiveness of the restraining every eight hours in the MAR and observed the following:
-there was no documentation on two days.
-there was no documentation on three specified days.
-For a period of eight days, it was documented code 7 which indicated that the resident was sleeping as per the legend of the codes on the MAR.

On May 14, 2018, inspector #550 observed resident #029 self-propelling in a wheelchair. There was a specific safety device applied. The resident was not able to remove the device when asked by the inspector. RPN #122 indicated to the inspector that this resident requires this specific safety device while seated in the wheelchair to prevent the resident from getting up on their own. RN #121 indicated that this resident required as well that device since the resident returned from the hospital on a specified date, following an injury. Before the injury, the resident was mobilizing on their own.

Inspector #550 reviewed resident #029's health care records. The "Initial evaluation of the restraint application" form #335.10C was not completed except for a note indicating that a referral was sent to physiotherapist and rehab assistant by RN #121 upon resident's # 029 return form the hospital. There was no documentation in the progress notes indicating the circumstances precipitating the application of the restraint; alternatives considered and why inappropriate; the person who made the order, what device was ordered; consent; person who applied the device and the time of application.

During a review of the documentation on the restraint monitoring form #335.10B for resident #029, the inspector noted the following:
-There was no documentation regarding the repositioning of the resident every two hours for 13 consecutive days.
-On a specified day, there was no documentation until 1500hrs where it was indicated that the restraint was in place (EP). The time the restraint was applied was not documented.

-On four consecutive days, there was no documentation until 1500hrs where it was indicated that the restraint was in place (EP). The time the restraint was applied was not documented.
-On another specified day, there was no documentation until 1500hrs.
-On two consecutive days, there was no documentation until 1700hrs where it was indicated that the restraint was in place (EP). The time the restraint was applied was not documented.

The inspector reviewed the documentation for the reassessment of the resident's condition and the evaluation of the effectiveness of the restraining every eight hours in the MAR and observed the following:
-There was no documentation for the day shift for four days.
-There was no documentation for the evening on two days.
-There was no documentation for the night shift for five days. A total of 19 days were noted to be documented code 7, which indicated that the resident was sleeping as per the legend of the codes on the MAR.

During an interview RN #121 indicated to the inspector that the registered nurses are to reassess the resident's condition and evaluate the effectiveness of the restraining every eight hours and document on the MAR. PSWs are responsible to document on the restraint monitoring flow sheet form #335.10B. After reviewing resident #029's progress notes and the "Initial evaluation of restraint application" form with the inspector, RN #121 indicated that the documentation was not completed.

The PMRC indicated that the registered nursing staff have to document their initials on the MAR on every shift to indicate that the resident's condition was reassessed and the effectiveness of the restraining was evaluated at least every eight hours, even if the resident was sleeping.

The PMRC indicated to the inspector that their monitoring process to ensure that the licensee's "Least Restraint" policy is complied with, is a list on each unit that identifies all the residents on the unit who have a restraint and/or a PASD. This list titled the "liste des contentions et AAP" is to be reviewed by a registered nurse on a monthly basis to ensure that all the residents who have a restraint/PASD are identified on this list with the type of restraint and/or PASD used. The registered nurse has to indicate for each resident:
- the date the order was made
- if the decision tree for physical and alternative treatments to restraints form #335.10A and if the consent/initial evaluation form #335.10C are in the resident's chart

- if the restraint is included in the resident's care plan in ADLs and in the kardex, and
-if the restraint is documented in the resident's MAR with instructions and that it has to be verified every eight hours.
The last column requires the signature of the registered nurse who completed the review and date the review was completed.

The inspector reviewed the "liste des contentions et AAP for a specified month with RN #121. The RN told the inspector that they reviewed this list for that month , including resident #004, #029 and #030 to make sure the restraining was done as per their policy. Under "consentement\evaluation initiale #335.10C" (initial evaluation of restraint application), it was indicated "oui" (yes) for resident #004, under "feuille de route contention/AAP #335.10B" (restraint monitoring form), it was indicated "oui" (yes) for resident #004, #029 and #030. Under "inscrit au MAR's et verifier q8h" (registered in the MAR and verified every eight hours), it was indicated "oui" (yes) for resident #004, #029 and #030. RN #121 told the inspector that they documented yes to indicate that the forms #335.10B and #335.C were in the residents' chart and the restraint was identified in the residents' MAR for the registered nursing staff to initial every eight hours.

The process did not include a review of the documentation to ensure that all required forms were completed or completed properly.

The PMRC confirmed to inspector #550 that this monitoring process to ensure that their "Least restraint" policy is complied with does not include ensuring that the documentation is completed on the required forms, although this is a requirement in their policy. [s. 29. (1) (b)]

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. a) The licensee has failed to ensure that the staff and others who are involved in the different aspect of care of the resident collaborate with each other,
a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

This finding is related to Intake log #029277-17.

Intake log # 029277-17, indicated that resident #012's family member had contacted the PMRC , on a specified date regarding some concerns about the resident care after the resident had been taken to the hospital four days earlier, for the treatment of an infection.

A review of the resident's health care records was done by Inspector #592.

Resident #012 was admitted to the home on a specified date with several diagnosis and was known to have altered skin integrity. Treatments were in place for the resident who was seen on a monthly basis by the wound care specialist.

In a review of the follow-up assessment done two months prior the resident's hospitalization, by the wound care specialist #143, the assessment indicated that all wounds were closed and to continue with current treatment. The current treatment which was prescribed several weeks prior to the assessment was to continue with a specific treatment on a specific body part twice a week and to apply another specified treatment to the other body part.

In a review of the last follow-up assessment done, nine days prior to the resident's

hospitalization by the wound care specialist, the assessment indicated that old wounds had reopened and to provide resident #012 with a new treatment. The follow-up assessment also indicated to request MD (physician) to consider a specified medication.

In a review of the physician's orders, it was indicated that seven days, following the recommendation from the wound care specialist the specified medication was prescribed.

During the review of the resident health care records, the Inspector was not able to find any documentation within a two months time frame period of the state of the wound ulcers prior to the hospitalization.

A review of the MAR was done by the Inspector prior to the resident's hospitalization which indicated to provide the resident with the same treatment recommended by the wound care specialist two months before.

On May 17, 2018, in an interview with the wound care specialist #143, the nurse indicated being scheduled once a month for four hours and that it was the home who was deciding which resident to see depending of the state of the wounds or if advice were required. The wound care specialist also indicated that a round was done with the PMRC and one registered nurse in order to know which resident to assess and also for them to do the specific follow-ups. The wound care specialist also indicated that if there was a significant evidence that the wound was not doing well, the wound care specialist would turn over to the physician. When Inspector #592 inquired about resident #012, the wound care specialist indicated that resident #012's wound were closed at a certain point and the goal was for resident #012 to receive a specific treatment for two weeks on a specific body part, in order to have the body part measured to have the appropriate treatment and compression in place. The wound care specialist indicated not being made aware of the changed in resident #012's wounds status until nine days before the resident's hospitalization. The wound care specialist further indicated not being made aware that resident #012 was not cooperative with the specific treatment as per the orders from the physician.

During the review of the progress notes and the 24 hour report, there was several documentation which indicated that resident # 012 was refusing to be provided with the specific treatment as per the orders from the physician.

On May 17, 2018, in an interview with resident #012, the resident indicated that the

registered nursing staff was trying on a daily basis to provide a specific treatment which the resident did not like as it was displacing the dressings that the nurse had just completed.

On May 18, 2018, in an interview with the physician assigned to resident #012, the physician indicated to Inspector #592 that the registered nursing staff will provide a list of the concerns for each residents and if the nursing staff have any concerns in the meantime, they would contact the physician. The physician indicated that once the wound care specialist has done the resident's assessment, the nurse from the home would contact the physician to share the wound care specialist recommendations which usually will be accepted by the physician. When Inspector inquired about resident #012 and the recommendation of a specified medication from the wound care specialist nine days prior to the resident's hospitalization, the physician indicated not remembering being contacted on that day.

On May 18, 2018, in an interview with RPN #128, the RPN indicated that the tool " Outil d'evaluation des plaies" (Skin Assessment Tool) was used to assess any altered skin integrity, and measurements of the wounds would be done at the same time. RPN #128 indicated that if the staff observed that the skin integrity was deteriorating, the wound care nurse would be notified as well as the PMRC. RPN #128 indicated that once the wound care specialist has made recommendations, the nurse would transcribe the information on the MAR and on the " Outil d'evaluation des plaies" (Skin Assessment Tool). The RPN further indicated that if a specific treatment or specific medications is recommended by the wound care specialist, that the physician will be contacted by the nursing staff and that usually the physician will follow the recommendations. When inquired about the wound status of resident #012 prior to the hospitalization, the RPN was unable to recall when the wounds had re-opened as there was no specific documentation and no " Outil d'evaluation des plaies" (Skin Assessment Tool) found. When asked which treatment was provided to resident #012 few days before being admitted to the hospital, the RPN indicated that as per the MAR, application of a specific treatment ordered two months prior was provided. When Inspector showed the wound care follow-up consultation and the new recommendations dated from the last assessment, the RPN indicated not knowing that a new treatment regimen had been recommended by the wound care specialist, therefore was providing the other treatment prescribed two months earlier.

On May 18, 2018, in an interview with RPN #136, the RPN indicated that following the recommendations from the wound care specialist, the nurse was responsible to

transcribe the recommendations on the MAR and on the “ Outil d’evaluation des plaies” (Skin Assessment Tool). The RPN further indicated that if there is a recommendation for a specific treatment or medication, the nurse was expected to contact the physician. When Inspector #592 inquired about resident #012, the RPN indicated being the one who had received the wound care consultation nine days prior to the resident's admission to the hospital. RPN # 136 indicated that the follow-up recommendations done by the wound care specialist had not been communicated to other members of the health care team.

On May 22, 2018, in an interview with the PMRC who is the resource person for the skin care program, the PMRC indicated that the home process for the wound care specialist was that a week prior to the wound care visit, a list was provided to the registered nursing staff to add any residents with complex skin care who would benefit of the wound care consult. The PMRC further indicated that if the service of the wound care specialist was needed earlier before the scheduled visit, an email with pictures of the wounds would be sent out and new recommendations would be received for the nursing staff to follow. The PMRC indicated that resident #012 was added on the list to be seen for the visit scheduled nine days prior to the resident's admission to the hospital. The PMRC indicated being present with the wound care specialist to assess each resident on the list to be seen. The PMRC indicated not being made aware that resident #012 was not cooperative with the treatment as recommended by the wound care specialist and as ordered by the physician until the day of the visit. The PMRC further indicated not being aware of the deterioration of the resident’s wounds until that day.

As such, the Nursing staff, the wound care specialist, the physician and the PMRC did not collaborate with each other in the assessment of resident #012's wound care needs, so that their assessments were integrated ,consistent and complemented each other.

b) The licensee has failed to ensure that the wound care treatment for resident #038 was communicated to all the staff involved in the care of the resident, resulting in a treatment not being provided for 15 days.

This finding is related to log #003836-18 which indicated that resident #038‘s family member sent a written complaint to the PMRC #125 on a specified date. The complaint was about some concerns regarding the home’s policy on skin care after discovering a dressing on a specified date on resident #038’s specific body part.

A review of the resident’s health care records was done by Inspector #592.

Resident #038 was admitted with several diagnosis and was identified on the last Resident Assessment Protocols (RAI) of being at risk for altered skin integrity with no presence of pressure ulcers/skin tear for the period covered by the assessment.

In a review of resident #038's progress notes, there was documentation found on a specific day indicating that the family member of resident #038 inquired with RN #139 what had happened to resident #038's specific body part as the resident had a dressing in place with dated two weeks before. The notes further indicated that RN #139 had verified the resident health records, the software system, the MAR and the 24 hour nursing report and was unable to find any documentation regarding the dressing and care provided for resident #038. The notes described that the dressing was removed by the RN, the wound site was cleaned and a dry dressing was applied to be changed on a specified day or as needed.

In a review of the licensee's internal investigation documents provided by the PMRC , the documentation indicated that following the written concerns received by the family member of resident #038, follow ups were done, including an interview conducted with RN #140. The documentation also revealed in a written response email sent to the family member of resident #038 by the PMRC that RN #140 was the registered staff who had discovered the resident's wound 15 days before, by observing the presence of a tape on resident #038's specific body part. The documentation of the email further indicated that the RN noted that the tape was covering a skin abrasion and was told by the resident that the resident had applied the tape without notifying the nurse. The documentation further indicated that RN #140 observed that the wound was not recent and a small amount of discharge was present.
The documentation further indicated that the RN indicated that a dressing was done to resident #038, however that no documentation was done about the wound and the wound care provided.

A review of the licensee's written response letter following the completion of the internal investigation to the family member was done by Inspector #592. The written response letter indicated that RN #140 had documented in the 24 hours nursing report that resident #038 had a wound on a specific body part from unknown cause and that the wound was clean and a dry dressing was put in place. The written response further indicated that RN #140 had forgotten to document the observation of the altered skin integrity and the required treatment in the progress notes and that no tool had been initiated for the assessment of altered skin integrity (form #355.29B). The letter also indicated that the Medication Administration Records with the specific treatments and the

resident's #038 plan of care, were as well not completed by RN #140.

As such, the PSWs and the registered nursing staff did not communicate and collaborate with each other in the assessment of resident #038's wound care needs, so that their assessments were integrated ,consistent and complemented each other. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the staff and others who are involved in the different aspect of care of the resident collaborate with each other,
a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Resident #022 was admitted to the home on a specified date with several medical diagnoses. On a specified date, family member of resident #022 indicated concerns related to medication administration.

On May 22, 2018 the PMPC indicated to inspector #547 based on the documented notes taken during a meeting held on a specified date, with the resident's family member, they planned to discontinue some medications that were not necessary to decrease resistive behaviours with the resident and that RN #134 was to leave a note to that effect for the physician. The PMPC also indicated that the nursing staff were evaluating the resident's dietary intake during this period on every shifts, and offered the resident several choices of food and fluids that were usually refused. The Registered Dietician reviewed the residents' nutritional requirements related to weight loss and made specific recommendations. The PMPC indicated that the resident's family member was not informed of these dietary assessments and the change in fluid texture requirement.

On May 22, 2018, inspector #547 reviewed the resident's health care records three days after the meeting had been held which indicated in the physician's orders "telephone order a meeting was held on a specified date and medications were to be discontinued" by RN #134. The resident's MAR's indicated that five medications were discontinued following the telephone order.

The physician's telephone order was co-signed by the physician five days later. The physician wrote a progress note five days later, that indicated to discontinue one specific medication as per the Substitute Decision Maker (SDM) request and noted that the specific medication was available as required (PRN).

On May 23, 2018, RN #134 indicated to Inspector #547 that the resident's medications

were discontinued based on the meeting held on a specified date with the PMPC and the resident's family member. RN #134 indicated that the family member requested that all medications be discontinued. RN #134 indicated not reviewing the resident's MAR for each individual medication that was discontinued with the resident's family member.

As such, the nursing staff, dietary staff and the attending physician failed to collaborate with each other when planning with the SDM interventions for the management of responsive behaviours exhibited by resident #022. [s. 6. (4) (a)]

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 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 resident #038 was protected from neglect.

According to Ontario Regulation 79/10 "neglect" means: the failure to provide a resident with a treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

This inspection is related to Log # 003836-18.
On a specified date, resident #038's family member sent a written complaint to the PMRC #125. The complaint was about some concerns regarding the home's policy related to skin care after discovering a dressing on a specified date on resident #038's specific body part.

In a review of resident #038's progress notes, there was documentation found indicating

that on a specific day, the family member of resident #038 inquired with RN #139 what had happened to resident #038's specific body part as the resident had a dressing in place dated from two weeks before. The notes further indicated that RN #139 had verified the resident health records, the software system, the MAR and the 24 hour nursing report and was unable to find any documentation regarding the dressing for resident #038. The notes described that the dressing was removed by the RN , the wound site was cleaned, dry dressing was applied and scheduled to be changed on a specific date or as needed.

Inspector #592 reviewed the documentation in the licensee's internal investigation file. It was documented that their investigation determined that their skin and wound care program had not been followed by registered nursing staff and PSWs for a 17 day period. The documentation also indicated that 17 days prior, RN #140 did not document the observation of the altered skin integrity and the required treatment in the progress notes of resident #038. RN #140 did not complete the specific tool required for the assessment of new altered skin integrity. Furthermore, RN #140 did not document on the Medication Administration Records, the specific treatments to provide to resident #038, as well as not documenting any instructions and interventions in the resident plan of care. The documentation also indicated that no subsequent follow-up or any treatments was done by the registered nursing staff. The PSWs did not report the dressing to the registered staff.

A review of the licensee's written response letter following the completion of the internal investigation to the family member was done by Inspector #592. The written response letter indicated that on the day that the wound was discovered, RN #140 had documented in the 24 hours nursing report that resident #038 had a wound on a specific body part from unknown cause and that the wound was clean and a dry dressing was applied. No follow-up had been done from registered nursing staff member, resulting in resident #038 to have a dressing in place with no wound care treatment for 15 days.

As such, the licensee failed to protect resident #038 from neglect by staff when the wound care treatment required to meet this resident skin care needs was not provided for 15 days.

In addition, the licensee failed to protect resident #038 from neglect when:

A. The licensee's skin and wound care policies #355.29 and # 315.12, were not complied

with as indicated in WN #11.

B. The PMRC #125 failed to immediately report the incident of neglect to the Director, as indicated in WN #13.

C. Nursing staff did not communicated to all staff involved, the wound care treatment required to meet the skin care needs of resident #038, as indicated in WN 2. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to immediately forward to the Director, a written complaint by resident #023's Substitute Decision Maker (SDM) received on a specified day concerning the care provided to resident #023.

The PMPC forwarded the written complaint and the response to the Director 33 days letter via email. [s. 22. (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 when the licensee receives a written complaint concerning the care of a resident or the operation of the home immediately forward it to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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, if clinically indicated.

Resident #021 was admitted on a specified day with several diagnosis.

A review of resident #021's health care record was completed by Inspector #592 which indicated that resident #021 was identified with a chronic pressure ulcer located on a

specific body part. The health care record also indicated that a second pressure ulcer had started on a specific day also located on the same specific body part.

Upon a review of the documentation titled "outil d'evaluation des plaies" (Skin Assessment Tool), one of the current pressure ulcer was described to be at a specified stage with the presence of drainage and oedema. The treatment orders on the documentation form directed the nursing staff to provide a specific treatment which required to be changed twice a week.

A review was also completed by Inspector #592 of the documentation titled "outil d'evaluation des plaies" (Skin Assessment Tool) for the second pressure ulcer. The pressure ulcer was described to be at a specified stage with the presence of drainage. The treatment orders on the form directed the nursing staff to provide a specific treatment twice a week.

On May 14, 2018, during an interview with RPN #108, the RPN indicated that when pressure ulcers occur, the nurse wound consultant will be made aware and an assessment would be completed. The RPN further indicated that following the assessment, the wound treatment would be written on the form "outil d'evaluation des plaies" (Skin Assessment Tool) and that every wound regardless of the stage will be measured and assess every second day and documented on the "outil d'evaluation des plaies" (Skin Assessment Tool) as well. The RPN further indicated that once the treatment is provided to the resident, they will document on the "outil d'evaluation des plaies" (Skin Assessment Tool) and the MAR. When Inspector inquired about resident #021, the RPN indicated that resident #012 was currently receiving treatment for two pressure ulcers. The RPN further indicated that one of the pressure ulcer was a chronic wound as it was related to the resident's diagnosis and was followed closely by the wound care specialist. RPN #108 also indicated that the second pressure ulcer was healing well and that both ulcers had to be measured every two days.

Upon a review of the "outil d'evaluation des plaies" (Skin Assessment Tool) for resident #021 with the presence of the RPN, Inspector #592 was not able to find any weekly skin assessment performed on the first pressure ulcer for a period of four specific weeks. Furthermore, Inspector #592 was not able to find any weekly skin assessment performed for the second pressure ulcer for a period of two specific weeks.

On May 15, 2018, during an interview with the PMRC who is assigned to the skin care program, the PMRC was unable to find any weekly skin assessment for the time period

noted above and indicated that every residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, should be reassess weekly by a member of the registered nursing staff as per the home's wound care program. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents 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, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the physical device was applied in accordance with the manufacturer's instructions (if any).

On May 14, 2018, inspector #550 inspector observed resident #029 sleeping in a wheelchair in front of the television in the main sitting area. The resident's chair was reclined and the resident had a specific safety device in place. The inspector noted that there was a 3-4 inches gab between the resident's body and the safety device. The inspector informed RPN #122 of the gap in the safety device who informed the inspector that a call the rehabilitation assistant would be done in order for the rehabilitation assistant to come and tighten it.

The PMRC indicated to the inspector that the safety device is to be tighten so it is snug with the resident's body to prevent injury.

The PMRC provided inspector #550 with the manufacturer's instructions for the specific safety device. The document number BP1005-en2016.8 from Bodypoint was reviewed by the inspector. On page 1, the fourth paragraph indicated "Warning! The " specific safety device" must be worn tightly fitted across the lower pelvis or thighs at all times. A loose device can allow the user to slip down and create a risk of strangulation". At the bottom of page 2, under "adjustment" it was indicated "When properly adjusted and the device tightened, it should fit snug so that the user's pelvis is secure".

On May 14, 2018, the safety device was not in accordance with the manufacturer's instructions. [s. 110. (1) 1.]

2. On May 14, 2018, inspector #550 observed resident #004 seated in a tilted wheelchair and a specific safety device in place. The inspector noted there was a gap of approximately 2.5 inches between the resident's body and the device.

During an interview, PSW #123 indicated to the inspector being aware that the device had a gap, that it could be a security issue if the resident slid down in the chair and that the nurse was informed so someone could be called to adjust the device. The PSW attempted to tighten the device but was unable to. At that time, the fire alarm sounded and the PSW had to leave to respond to a fire alarm on another floor. The PSW did not inform anyone of the gap in the device before leaving the unit and inspector #550 informed RN #121 of the gap in the device. The RN informed the inspector that the rehabilitation assistant would be called to come and tighten the device.

The PMRC indicated to the inspector that the safety device is to be tighten so they are snug with the resident's body to prevent injury. The PMRC provided inspector #550 with the manufacturer's instructions for the specific device. The document number BP1005-en2016.8 from Bodypoint was reviewed by the inspector. On page 1, the fourth paragraph indicated "Warning! The safety device must be worn tightly fitted across the lower pelvis or thighs at all times. A loose device can allow the user to slip down and create a risk of strangulation". At the bottom of page 2, under "adjustment" it was indicated "When properly adjusted and thedevice tightened, it should fit snug so that the user's pelvis is secure".

On May 14, 2018, the safety device was not in accordance with the manufacturer's instructions. [s. 110. (1) 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 the physical device is applied in accordance with the manufacturer's instructions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the specific Personal Assistive Services Device (PASD) used for resident #014 under section 33 of the Act was applied by nursing staff in accordance with the manufacturer's instructions.

Inspector #547 reviewed resident #014's health care records that indicated the resident was admitted to the home on a specified date with several medical diagnoses. Resident #014's plan of care indicated the resident cannot mobilize independently and required a PASD (safety device) while in a wheelchair for positioning.

On May 8, 14, 16, and 18, 2018 Inspector #547 observed resident #014 seated in a manual wheelchair with a specific safety device applied to the resident. Inspector #547 observed resident #014 moving arms and legs at all times, with feet folded onto the resident's seat hugging right knee next to the resident's head.

On May 18, 2018 at 1145 hours, PSW #135 indicated to Inspector #547 that the resident's PASD was properly applied to resident #014 as verified earlier that morning. PSW #135 and Inspector #547 observed resident #014's safety device to be loose, and PSW #135 indicated that it was fine earlier. Upon closer assessment of the resident's device, it was noted that the device was worn to the point that the device could no longer be tightened. PSW #135 indicated that re-adjustments would be done on the device, once the resident is transferred out of the wheelchair after lunch to see if it is still possible to readjust this device and report this to the registered nursing staff.

The Manufacturer's instructions document number BP1005-en2016.8 from Bodypoint was reviewed by the inspector. On page 1, the fourth paragraph indicated "Warning! The safety device must be worn tightly fitted across the lower pelvis or thighs at all times. A loose device can allow the user to slip down and create a risk of strangulation". At the bottom of page 2, under "adjustment" it was indicated "When properly adjusted and the device tightened, it should fit snug so that the user's pelvis is secure".

As such, resident #014's PASD was not applied by nursing staff in accordance with the manufacturer's instructions. [s. 111. (2) (b)]

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 PASD used under section 33 of the Act is applied by staff in accordance with the manufacturer's instructions, to be implemented voluntarily.

WN #8: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 has failed to ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident.

On May 15, 2018 inspector #547 reviewed the home's medication incident reports for the last quarter whereby an incident which occurred on a specified date, indicated resident #032 was administered 10 medications in error as the medications were not prescribed for the resident.

The medications were prescribed for resident #021 however administered to resident #032 in error by RN #101. The PMRC indicated that RN #101 did not follow the home's medication administration process as drugs were administered to resident #032 that were not prescribed for that resident, which placed the resident at risk of harm. [s. 131. (1)]

2. On a specified date, resident #028 was provided with a medication without a prescription from the physician. RN #101 reported that the resident received this medication in error without prescription as the MAR were not updated as per the directions for use specified by the prescriber.

3. On a specified date, resident #031 was provided with a lower dose of a specific medication at a specific time during the day. The administration of a low dose of the specific medication was discovered on the next day and changes were done for the appropriate dosage as prescribed for the resident. In addition, four days later, resident #031 was discovered to not have received the appropriate dosage of medication which was changed as prescribed for every 72 hours the day before at a specified time. The specific medication dosage was changed on a specific date once discovered over 96 hours after the medication was administered, that was not in accordance with the directions required for resident #031 specified by the prescriber. [s. 131. (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 no drug is administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #9: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's Substitute Decision Maker (SDM), the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

On a specified date, resident #028 received an extra dose of a medication at a specified time without the authorization from the physician due to an order transcription error. The incident report was completed on the same day by Registered Nurse (RN) #101 however the resident or the resident's SDM and pharmacy service provider were not documented as being reported about this medication incident.

On a specified date, resident #031 was administered with the wrong dosage of medication. The medication incident was discovered on the next day and the medication was changed for the appropriate dosage as prescribed for the resident.

The Pharmacist was not informed of this medication incident as required.

On a specified date, resident #031 was discovered to not have had a specific medication dosage changed as prescribed for every 72 hours the day before at a specific time. The appropriate dosage was changed on the next day, once discovered.

The Pharmacist and Physician were not informed of this medication incident as required.

On a specified date, resident #032 was provided with 10 medications that were not prescribed for the resident by RN #101 that were to be provided to resident #021. RN #101 prepared medications for residents #021 and #032 at the same time and gave the wrong medication to resident.

The resident's SDM or the Pharmacist were not informed of the medication incident as required.

On May 15, 2018 at 1200 hours, the PMRC indicated that the resident, resident's SDM, the Physician and the Pharmacist are required to be informed about medication incidents. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's Substitute Decision Maker (SDM), the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control Program.

On May 7 and 9, 2018, Inspector #592 observed several roll-on deodorants not labeled and open as well as nail clippers and several soiled facecloth located in several spa and shower rooms as follows:

The Spa room located on the second floor east area had four roll-on deodorants located in a plastic bin and several soiled facecloth were also observed left on the counter beside the sink. One used nail clipper was also observed with nails not labelled.

The Spa room located on the third floor east area had three roll-on deodorants located in a plastic bin and several soiled facecloth were also observed on a black furniture tablet.

The male Shower room located on the fourth floor east area had one nail clipper not labeled and several soiled face cloth were also observed on the counter beside the sink.

The women Shower room located on the fourth floor east area had one roll-on deodorant open, not labeled.

The Spa room located on the fifth floor east area had one nail file worn, not labeled.

On May 9, 2018, in an interview with PSW #103 who was assigned to the second floor unit, the PSW indicated that every roll-on deodorants must be labelled with the resident name for hygienic purposes and that they were kept in each resident's room. PSW #103 indicated to the Inspector that some extra roll-on deodorants were kept in the Spa room to use whenever the staff were running out of them.

On May 9, 2018, in an interview with PSW #104 who was assigned to the second floor unit, the PSW indicated to the Inspector when the Inspector showed the roll-on deodorants in the Shower male and female rooms that all the deodorants should not be left unlabeled due to hygienic purposes and the risk that the roll-on could be shared in between residents.

On May 9, 2018, in an interview with PSW #105 who was assigned to the fourth floor unit, the PSW indicated when the Inspector showed the roll-on deodorant in the male Shower room, that all the roll-on deodorant should be discarded specifically the one with no lids. PSW #105 indicated that without knowing which resident used the roll-on deodorants that for hygienic purposes the roll-on deodorants should be discarded. A soiled face cloth was also observed by Inspector #592 and PSW #105 left on the counter beside the sink which was removed by the PSW.

On May 10, 2018, in an interview with the PMPC who is the person assigned to the infection control, the PMPC indicated to the Inspector that to avoid cross contamination between residents and to ensure good hygienic practice, the staff were to label all the resident's personal items as it was part of their infection prevention and control program including roll-on deodorants and nail clippers. [s. 229. (4)]

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 all staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 8 (1) (b) in that the licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

As per 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:

2. 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.

Policy # 355.29 titled "Skin and Wound Care: Skin Integrity reviewed in February 2017 indicated under procedure:

5. Use Altered skin integrity Assessment Tool (form 355.29B) where a resident has any skin breakdown, rashes, pressure ulcers/injury, skin tears or wounds.

6. Use altered Skin integrity Assessment Tool to document dressing changes, assessments and weekly documentation.

Policy #315.12 titled "Assessment: Skin: New Admission & Residents at Risk for Altered Skin Integrity" reviewed in December 2017 indicated under Procedure:

4. Registered nursing staff will refer all residents with altered skin integrity to the registered dietitian for assessed.

7. Registered staff will conduct an assessment to establish root cause of altered skin integrity.

8. Assessments and interventions shall be documented in the plan of care.

This finding is related to log #003836-18 which indicated that resident #038's family member sent a written complaint to the PMRC #125 on a specified date. The complaint was about some concerns regarding the home's policy on skin care after discovering a dressing on resident #038's specific body part.

A review of the resident's health care records was done by Inspector #592.

Resident #038 was admitted with several diagnosis. Resident #038 was identified on the last Resident Assessment Protocols (RAI) of being at risk for altered skin integrity with no presence of pressure ulcers/skin tear for the period covered by the assessment.

In a review of resident #038's progress notes, there was documentation found on a specific date indicating that the family member of resident #038 inquired with RN #139 what had happened to resident #038's specific body part as the resident had a dressing in place dated for more than 14 days ago. The notes further indicated that RN #139 had verified the resident health records, the software system, the MAR and the 24 hour nursing report and was unable to find any documentation regarding the dressing and care provided for resident #038. The notes described that the dressing was removed by the RN and that the wound site was cleaned and a dry dressing was applied to be changed on a specific date or as needed.

In a review of the licensee's internal investigation documents provided by the PMRC , the documentation indicated that following the written concerns received by the family

member of resident #038, follow ups were done, including an interview conducted with RN #140. The documentation also revealed in a written response email sent to the family member of resident #038 by the PMRC that RN #140 was the registered staff who had discovered the resident's wound 15 days earlier by observing the presence of a tape on resident #038's specific body part. The documentation of the email further indicated that the RN noted that the tape was covering a skin abrasion and was told by the resident that the resident had applied the tape without notifying the nurse. The documentation further indicated that the RN indicated that a dressing was done to resident #038, however that no documentation was done about the wound and the wound care provided.

A review of the licensee's written response letter following the completion of the internal investigation to the family member was done by Inspector #592. The written response letter indicated that RN #140 had documented in the 24 hours nursing report that resident #038 had a wound on a specified body part from unknown cause and that the wound was clean and a dry dressing was put in place. The written response further indicated that RN #140 had forgotten to document the observation of the altered skin integrity and the required treatment in the progress notes and that no tool had been initiated for the assessment of altered skin integrity (form #355.29B). The letter also indicated that the Medication Administration Records with the specific treatments and the resident's #038 plan of care, were as well not completed by RN # 140. The written response letter also indicated that all these interventions were part of the skin and wound care programs which were not followed at that time.

As a result, the skin policy program had not been implemented for resident #038. [s. 8. (1) (a),s. 8. (1) (b)]

2. Resident #021 was admitted with several diagnosis.

A review of resident #021's health care record was completed by Inspector #592 which indicated that resident #021 was identified with a chronic pressure ulcer located on a specific body part. The health care record also indicated that a second pressure ulcer which had started on a specific date was also located on the same body part.

Upon a review of the documentation titled "outil d'evaluation des plaies" (Skin Assessment Tool) done on specified date, the first pressure ulcer was described to be at specified stage with the presence of drainage and oedema. The treatment orders on the documentation form directed the nursing staff to do a specific treatment which required to

be changed twice a week.

A review was also completed by Inspector #592 of the documentation titled "outil d'evaluation des plaies" (Skin Assessment Tool) for the second pressure ulcer. The pressure ulcer was described to be at another specified stage with the presence of drainage. The treatment orders on the form directed the nursing staff to do a specific treatment twice a week.

On May 14, 2018, during an interview with RPN #108, the RPN indicated that when pressure ulcers occur, the nurse wound consultant will be made aware and an assessment would be completed. Following the assessment, the treatment will be documented on the MAR and on the "outil d'evaluation des plaies" (Skin Assessment Tool). A copy of the assessment will be left for the physician in order for the physician to be aware of the treatment and to co-sign the actual treatment. RPN #108 further indicated that once the treatment was provided to the resident, the registered nursing staff will document on the "outil d'evaluation des plaies" (Skin Assessment Tool) and the MAR.

When Inspector #592 reviewed the MAR and the "outil d'evaluation des plaies" (Skin Assessment Tool) with the presence of RPN #108 for resident #021 for two specific months, the Inspector noted that there was no documentation in those records to indicate that the treatment was being provided as follow:

The plan of care for the treatment of the first pressure ulcer was to be provided on two specific dates, however no documentation was found that the treatment was being provided to resident #021 on these dates.

The plan of care for the treatment of the second pressure ulcer was to be provided on seven specific dates, however no documentation was found.

RPN #108 reviewed the MAR and the "outil d'evaluation des plaies" (Skin Assessment Tool) with the Inspector and was unable to find any documentation for the dates noted above.

On May 15, 2018, during an interview with the PMRC assigned to the skin care program, the PMRC was unable to find any documentation that the treatment was provided to resident #021 for the dates noted above.

As such, no evidence was found to support that the care was not provided to resident #021 in accordance with the plan of care, however the skin policy program had not been followed and implemented for resident #021. [s. 8. (1) (a),s. 8. (1) (b)]

3. As per O. Reg 79/10, s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

The policy # 345.04 titled "Medication: Counting Guidelines for Narcotic/Controlled Substances" reviewed January 2017 indicated:
Practice:
Narcotic and controlled substances shall be counted at change of shift.
There must always be two (2) RN/RPN's present to count the narcotics/controlled substances at the change of each shift."

The finding is related to log # 000974-18 (missing narcotic).

On a specified date, at a specific time, the narcotic count revealed that only 28 tablets of a controlled drug were available while the narcotic sheet count indicated 30 tablets. The PMPC investigated the missing narcotic. It was noted that on the previous day, the RPN #142 who was starting a specific shift, counted the narcotic alone and that RPN #141 did not assist with the narcotic count.

Both RPN did not comply with the Medication: Counting Guidelines for Narcotic/Controlled Substances as the narcotic count was not completed by the RN \RPN. [s. 8. (1) (b)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's furnishings and equipment were kept cleaned.

During resident observations conducted during Stage 1 of the Resident Quality Inspection (RQI), Long Term Care Homes (LTCH) Inspectors#547 and #592 observed several soiled residents' equipment.

On May 7, 2018, resident #003's wheelchair's seated cushion was observed by Inspector #592 with brown dry matter as well as the seated lap belt.

On May 8, 2018, resident #018's walker was observed by Inspector #547 with dust matter, and dried food and stains to the cushion.

As a result, Inspector #592 further inspected the ambulation equipment for the two residents on May 10, 2018:

• Resident #003's wheelchair's seated cushion was observed with brown dry matter as well as the seated lap belt. Inspector #592 also observed white matter on the left side of the seated cushion and on the seated lap belt.
• Resident #018's walker was observed with dust matter, and dried food and stains to the cushion.

During an interview with PSW #104 who was assign to resident #003, the PSW indicated that the home as a process in place for the cleaning of ambulating equipment. The PSW indicated that it was the responsibility of the night PSW to do the cleaning of the equipment as per a schedule located at the nursing desk. PSW #104 further indicated

that if the PSW observed that the ambulating equipment is soiled for a specific resident, they will add the resident on the cleaning schedule for the night shift and in the meantime they will do a quick cleaning. When the Inspector showed to the PSW the wheelchair of resident #003, the PSW indicated that the wheelchair was cleaned previously during the day but somehow a deeper cleaning was required. When Inspector inquired if resident #003 was on the list for the night shift cleaning, PSW #104 indicated that the resident was not put on the list but should have been.

Upon a review of the schedule for the ambulating equipment, Inspector #592 noted that resident #003's wheelchair was scheduled to be cleaned not until the third week of May on on a specific day.

During an interview with PSW #117 who was assign to resident #018, the PSW indicated that the PSW on the night shift were responsible for the cleaning of the ambulating equipment. The PSW also added that if in the meantime, an ambulating equipment was noted to be soiled, the PSW could do a quick cleaning and add the resident on the list in order to have the ambulating equipment cleaned on that night. PSW #117 told the Inspector that the ambulating equipment of resident #018 was soiled and that the staff were not able on days to do a cleaning of resident #018's walker as the resident was very active and the staff were not able to remove the walker. PSW #117 indicated not adding the resident's walker on the list to be cleaned up for the night shift.

Upon a review of the schedule for the ambulating equipment, Inspector #592 noted that resident #0018's walker was scheduled to be cleaned not until the third week of May on a specific day.

During an interview with the PMPC, the PMPC indicated that the resident's ambulating equipment were being cleaned on a rotation by the PSWs on night shift. The PMPC further indicated that there was a schedule in place and that if in the meantime, if any ambulating equipment needed to be cleaned, the staff were to do some cleaning and add the resident's on the schedule at the bottom of the list to have a deeper cleaning at night. The PMPC further indicated that it was everyone responsibility and added that the registered nursing staff were also doing monthly audits of the equipment in order to have a good follow-up. Once the equipment had been cleaned the staff were to sign their initials on the schedule.
Inspector #592 inquired about the April schedule, as the ambulating equipment for resident #003 and #018 were soiled. In a review of the schedule with the presence of the Inspector, the PMPC noted that resident #018's ambulating equipment was to be cleaned

on the third week of April and was not signed as being done. The PMPC also noted that resident #018's ambulating equipment was to be cleaned on the third week of April and was not signed as being done.

As such, the licensee did not ensure that the ambulating equipment for resident #003 and #018 were kept cleaned. [s. 15. (2) (a)]

WN #13: 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 has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm shall immediately report the suspicion and the information upon which it was based to the Director.

On a specific date, the licensee received a written complaint by resident #023's Substitute Decision Maker (SDM), indicating that on a specific time, the SDM visited resident #023, and found the resident crying because a PSW "forced" the resident to put a specific clothing when the resident was refusing to do so.

Resident #023 health care record was reviewed by Inspector #126. It was noted in the progress notes that 13 days before, RPN #102 was informed by resident #023's SDM that PSW #127 forced the resident to put on a specific clothing when the resident was refusing to do so. The SDM found resident #023 crying and complaining of pain to a specific body part because there were two PSWs trying to put on a specific clothing and resident #023 was resisting to put the clothing on. RPN # 102 notified RN #124 of the incident.

Incident investigation notes were reviewed. It was noted that the PMPC interviewed PSW #127 who indicated that resident #023 was forced to put on the specific clothing on, even if the resident was resistive to care. The PMCP indicated that the incident was not reported to the Director.

Discussion held with RN #124 who indicated not remembering specifically the incident but the way it was reported was about a resident that was resistive to care, not abuse. RN #124 indicated that the incident was reported on that specific day by RPN #102. RN #124 visited resident #023 who did not appear in any distress or did not complained of any pain at that time.

On a specific day, PSW #127 forced resident #023 to put on a specific clothing when the resident was refusing. Resident # 023 was found crying and complaining of pain to a specific body part. There was reasonable grounds to suspect that abuse of resident #023 by PSW #127 that resulted in harm or risk of harm was not immediately reported to the Director. [s. 24. (1)]

2. This finding is related to log #003836-18 which indicated that resident #038's family member sent a written complaint to the PMRC #125 on a specified date. The complaint was about some concerns regarding the home's policy on skin care after discovering a dressing on a specified date on resident #038's specific body part.

A review of the resident's health care records was done by Inspector #592.

Resident #038 was admitted with several diagnosis.

In a review of resident #038's progress notes, there was documentation found five days prior of the home receiving the complaint indicating that the family member of resident #038 inquired with RN #139 what had happened to resident #038's specific body part as the resident had a dressing in place dated from more than 14 days ago. The notes

further indicated that RN #139 had verified the resident health records, the software system, the MAR and the 24 hour nursing report and was unable to find any documentation regarding the dressing for resident #038. The notes described that the dressing was removed by the RN and that the wound site was cleaned, dry dressing was applied and scheduled to be changed on a specified day or as needed.

A review of the licensee's written response letter following the completion of the internal investigation to the family member was done by Inspector #592. The written response letter indicated that RN #140 was the registered staff who had discovered the resident's wound 15 days earlier and had documented in the 24 hours nursing report that resident #038 had a wound on a specified body part from unknown cause and that the wound was clean and a dry dressing was applied. No follow-up had been done from registered nursing staff member, resulting in resident #038 to have a dressing in place with no wound care treatment for 15 days.

Interview done with RN #139, who indicated to the Inspector that on a specified date, a family member of resident #038 inquired about resident #038's specific body part which had a dressing in place for more than 14 days ago. The RN indicated that no documentation was found for any skin care being provided to resident #038. RN #139 further indicated that the dressing was removed in order to assess the resident's skin and that some maceration was noted to the site as the dressing had been left on the skin for several days. The RN further indicated having reported the incident and the concern brought forward by the family member of resident #038 to PMRC # 125 on that day. RN #139 indicated bringing forward that incident to the PMRC as the RN considered that incident to be an incident of neglect by not following the skin procedures.

Interview done with PMRC #125, who indicated being reported by RN #139 about the dressing found on resident # 038's specific body part by the family member. The PMRC #125 indicated being unsure if the RN reported the concerns brought forward by the family of the resident on that same day or three days later. The PMRC indicated to the Inspector that they did not considered that it was an incident of neglect at that time.

This incident of neglect was never reported by the licensee to the Director of MOHTLC, even after the incident was described by PMRC #125 in a letter to the family member of resident #038 as neglect by nursing staff. [s. 24. (1)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee specifically failed to ensure that if the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care;
(c) an explanation of how the supporting facts justify the decision to withhold approval; and
(d) contact information for the Director.

As per O.Reg. 79/10, s. 44. (10), the persons referred to in subsection (9) are the following:
1. The applicant.
2. The Director.
3. The appropriate placement coordinator.

This inspection is related to Log #007184-18, a complaint regarding a bed refusal for a resident.

On January 22, 2018, the licensee received an application for the admission of resident #040. After reviewing the resident's application and information provided by the Community Care at the Champlain LHIN, the licensee decided to withhold this resident's application indicating that the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements.

The inspector reviewed the refusal letter dated April 9, 2018, which was sent to the resident's Substitute Decision Maker (SDM) with copies sent to the Director and the Home and Community Care at the Champlain LHIN. The inspector noted that the letter did not provide a detailed explanation of the supporting facts, an explanation of how the supporting facts justify the decision to withhold approval and the contact information for the Director.

During an interview, the Administrator indicated they were not aware of these requirements therefore it was not included in their letter. [s. 44. (9)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint made to the licensee concerning the care of resident #023 was responded within 10 business days of receipt

of the complaint.

A written complaint dated on a specified date was made to the licensee by resident #023's Substitute Decision Maker (SDM).

The response letter was dated 31 days later and was sent via email to the SDM on the following day by the PMCP.

The licensee did not respond to the SDM within 10 business days of receipts of the complaint. [s. 101. (1) 1.]

2. The licensee had failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response was made to the person who made the complaint, indicating:
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief?

This inspection is related to log #009101-18, a written complaint submitted to the Director on a specified date by the licensee regarding the care of resident #042.

On a specified date, resident #042's family member submitted a written complaint to the licensee regarding the care of the resident.

The inspector reviewed complaint form dated on a specified date. It was noted documented under bullet 7, that a voice message was left to the complainant six days later after the written complaint was received by the licensee but the complainant did not return the call.

During an interview, the PMPC indicated to inspector #550 they did not speak to the complainant to inform them of what the licensee did to resolve the complaint. [s. 101. (1) 3.]

3. The licensee failed to ensure that a documented record is kept in the home that included specifically:
(d) the final resolution, if any, and,
(e) every date on which any response was provided to the complainant and a description of the response.

This inspection is related to log # 009101-18, a written complaint submitted to the Director on a specified date by the licensee regarding the care of resident #042.

On a specified date, resident #042's family member submitted a written complaint to the licensee regarding the care of the resident.

The inspector reviewed the complaint form and noted that under bullet 5, Results of the investigation, the results of the investigation or the final resolution were not documented. Under bullet 7, date and time a response will be given to the complainant, there was no documentation of the response provided to the complainant with a description of the response.

During an interview, the PMPC indicated to the inspector that the final resolution should have been documented on the complaint form under bullet 5, and the response provided to the complainant with a description of the response should have been documented under bullet 7, but they did not document this. The PMPC had left a voice message to the complainant but the complainant never returned the call therefore they did not speak to them or send them a response. [s. 101. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 162. Approval by licensee

Specifically failed to comply with the following:

s. 162. (3) Subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following:
1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act. O. Reg. 79/10, s. 162 (3).
2. If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act. O. Reg. 79/10, s. 162 (3).

Findings/Faits saillants :

1. The Licensee has failed to respond within five business days after receiving applicant #040's request for authorization for admission to the Long-Term Care home. The Licensee is required to determine whether to give or withhold approval for the applicant's admission to the home. The Licensee is then required to provide a written notice of their decision under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act, being the applicant, the Director and the appropriate placement coordinator.

On January 22, 2018, the licensee received an application request for authorization for admission of resident #040 to the home from the Home and Community Care at the Champlain LHIN (placement coordinator). As per the documentation provided by the representative from the Home and Community Care at the Champlain LHIN, it was documented that they were informed of the withholding of this application by the licensee on March 16, 2018. The letter of refusal by the licensee was sent to the applicant, the Director and the Home and Community Care at the Champlain LHIN (placement coordinator) on April 9, 2018; fifty four business days after the application request was received by the licensee.

The PMPC and the Administrator confirmed that they had not responded within five business days as they were busy with many issues in the home.

As such, the licensee did not respond within five business days after receiving applicant #040's request for authorization for admission to the home. [s. 162. (3) 2.]

Issued on this 16th day of July, 2018

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) :	MELANIE SARRAZIN (592), JOANNE HENRIE (550), LINDA HARKINS (126), LISA KLUKE (547)
Inspection No. / No de l'inspection :	2018_548592_0008
Log No. / No de registre :	008974-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 21, 2018
Licensee / Titulaire de permis :	City of Ottawa Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2
LTC Home / Foyer de SLD :	Centre d'Accueil Champlain 275 Perrier Street, VANIER, ON, K1L-5C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jacqueline Roy

To City of Ottawa, 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)

Linked to Existing Order / Lien vers ordre existant: 2017_619550_0018, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Order / Ordre :

The licensee must be compliant with s.29 (1) b of the LTCHA, 2007.

Specifically, upon being served with this Compliance Order and for 7 consecutive days, the licensee shall implement an enhanced monitoring process to be used by registered nursing staff responsible for the supervision of resident care to validate that all residents restrained by the use of a physical device, including residents 004, 029 and 030, receive care interventions in accordance with the LTCH Act 2007, Ontario Regulation 79/10 and the licensee's "Least Restraint" policy.

Evidence of that enhanced monitoring process and the actions taken by registered nursing staff to address findings of non-compliance must be documented and submitted to both Program Managers for Personal Care at the end of every nursing shift.

Grounds / Motifs :

1. 1. The licensee has failed to comply with the following compliance order CO#001 from inspection #2017_619550_0018 served on September 22, 2017, with a compliance date of January 11, 2018:

The Licensee shall ensure that the written policy to minimize the restraining of

residents is complied with. Specifically, the license shall:

1. Provide education to direct care staff on the licensee's "Least restraint" policy. This education shall include a review of the documentation requirements under O. Reg. 79/10, s.110. (7). This education shall be documented.
2. Review the plan of care of residents #003, #006, #046 and #047 and all other residents who are being restrained by a physical device to ensure that any restraining is done in accordance with the Act, the regulations and the licensee's "Least restraint" policy.
3. Develop and implement a monitoring process to ensure that the licensee's "Least Restraint" policy is complied with.

The licensee completed step 1 in CO #001, however, the licensee did not complete step 2 and 3 of that same Compliance Order.

As demonstrated below, the licensee failed to complete step 2 and 3, regarding ensuring that any restraining of residents by a physical device is done in accordance with the Act, the regulations and the licensee's "Least restraint" policy.

The inspector reviewed the home's policy "Least Restraint", No. 335.10, last reviewed in December 2017. Under procedure, initiation of restraint on page 4 of 7 it was documented:
1. Complete an assessment to determine rationale for considering a restraint. Potential for injury to self or others.
5. Obtain and document consent or refusal on consent form.
8. Document in the progress notes circumstances precipitating the application of the restraint; alternatives considered and why inappropriate; person who made the order, what device was ordered; consent; person who applied the device and the time of application.
9. Initiate the Restraint Monitoring form. Ensure completion using the appropriate key and response.
13. Every release of the device and all repositioning will be recorded on the restraint/Personal Assistance Service Device (PASD) flow sheet.
14. Document all assessments, reassessment and monitoring including the resident's response, as well as the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining.
17. The resident's condition is reassessed and the effectiveness of the restraining is evaluated every 8 hours by a member of the registered staff and

documented on the Medication Administration Records (MAR).

The Program Manager of Resident Care (PMRC) indicated to inspector #550 that the application, the release, the repositioning, the removal or discontinuance of the device and the resident's response to the restraining is documented on the restraint monitoring form #335.10B by PSWs using the appropriate key and response code indicated on the top of the form. The legend for the codes is identified as:
Code:
A – Appliqué (Applied)
EP – En place (In place)
RP – Repositionné (Repositioned)
RT – Retiré (Removed)
R – Refusé (Refused)

Reaction:
0 – Aucune reaction/calme (No response/calm)
1 – Agité (Agitated/restless)
2 – Essaye de l'enlever (Attempting to remove)

According to the policy, the reassessment of the resident's condition and the evaluation of the effectiveness of the restraining every eight hours by registered nursing staff is to be documented on each shift in the MAR.

On May 14, 2018, inspector #550 observed resident #004 seated in a tilted wheelchair with a specific safety device in place. During an interview, PSW #123 told the inspector that resident #004 requires a specific safety device to prevent the resident from getting up from the wheelchair on their own. The PSW indicated they have to verify the resident every thirty minutes and reposition the resident every two hours when the restraint is in place. They have to document this on the restraint monitoring form # 335.10B including the time for the application and removal of the restraint.

The inspector #550 reviewed resident #004's health care records and noted a document titled "Restraint/PASD consent form" signed by the resident's substitute decision maker on a specified date in 2017. On this document, the recommended restraint type was left blank and the type of restraint was not indicated anywhere else on the consent form.

During a review of the documentation on the restraint monitoring form #335.10B for resident #004, the inspector noted the following:
-the repositioning of the resident every two hours was not documented for each day.
-on a specified day, there was no documentation of the removal of the restraint at the end of the day.
-on another specified day, from 0800 hours (hrs) to 1500hrs it was documented code AP which is not a code as per the restraint from. There was no documentation in the resident's reaction to the restraining column.

The inspector reviewed the documentation for the reassessment of resident #004's condition and the evaluation of the effectiveness of the restraining every eight hours in the MAR. The inspector noted that there was no staff initials for three specified shifts.

On May 14, 2018, inspector #550 observed resident #029 sleeping in a wheelchair in front of the television in the main sitting area. The wheelchair was reclined and the resident had a specific safety device in place. During an interview PSW #123 told the inspector that that the resident requires a specific safety device while seated in the wheelchair to prevent the resident from getting up. PSW #123 indicated that the safety device is verified every thirty minutes and the resident is repositioned every 2 hours. The application, removal, and repositioning was to be documented on the restraint monitoring form # 335.10B.

During a review of the documentation on the restraint monitoring form #335.10B for resident #029, the inspector noted the following:
-there was no documentation of the repositioning every two hours for that period.

-on a specified day, the last entry at 2300hrs indicated that the restraint was in place (EP), there was no documentation indicating when the restraint was removed. The next documentation was on the following day at 0700hrs where it was documented that the restraint was applied.
-On another specified day, there was no documentation from 2400hrs to 1400hrs to indicate when the restraint was applied. At 1500hrs, it was documented that the restraint was in place (EP).
-On another specified day, from 0700hrs to 2000hrs, it was documented code AP which is not a code on the restraint monitoring form # 335.10B.
-On another specified day, from 1600hrs to 1900hrs it was documented code AP which is not a code on the restraint monitoring form # 335.10B.

-On another specified day, there was no documentation of the application of the restraint. The first documentation was at 1200hrs which indicated that the restraint was in place (EP). At 2000hrs it was documented that the restraint was applied (A). From 2100hrs to 2300hrs, there was no documentation.
-There was no documentation found for another specified date.

The inspector reviewed the documentation for the reassessment of resident #029's condition and the evaluation of the effectiveness of the restraining every eight hours in the MAR and observed the following:
-there was no documentation on two days.
-there was no documentation on three specified days.
-For a period of eight days, it was documented code 7 which indicated that the resident was sleeping as per the legend of the codes on the MAR.

On May 14, 2018, inspector #550 observed resident #029 self-propelling in a wheelchair. There was a specific safety device applied. The resident was not able to remove the device when asked by the inspector. RPN #122 indicated to the inspector that this resident requires this specific safety device while seated in the wheelchair to prevent the resident from getting up on their own. RN #121 indicated that this resident required as well that device since the resident returned from the hospital on a specified date, following an injury. Before the injury, the resident was mobilizing on their own.

Inspector #550 reviewed resident #029's health care records. The "Initial evaluation of the restraint application" form #335.10C was not completed except for a note indicating that a referral was sent to physiotherapist and rehab assistant by RN #121 upon resident's # 029 return form the hospital. There was no documentation in the progress notes indicating the circumstances precipitating the application of the restraint; alternatives considered and why inappropriate; the person who made the order, what device was ordered; consent; person who applied the device and the time of application.

During a review of the documentation on the restraint monitoring form #335.10B for resident #029, the inspector noted the following:
-There was no documentation regarding the repositioning of the resident every two hours for 13 consecutive days.
-On a specified day, there was no documentation until 1500hrs where it was indicated that the restraint was in place (EP). The time the restraint was applied was not documented.

-On four consecutive days, there was no documentation until 1500hrs where it was indicated that the restraint was in place (EP). The time the restraint was applied was not documented.
-On another specified day, there was no documentation until 1500hrs.
-On two consecutive days, there was no documentation until 1700hrs where it was indicated that the restraint was in place (EP). The time the restraint was applied was not documented.

The inspector reviewed the documentation for the reassessment of the resident's condition and the evaluation of the effectiveness of the restraining every eight hours in the MAR and observed the following:
-There was no documentation for the day shift for four days.
-There was no documentation for the evening on two days.
-There was no documentation for the night shift for five days. A total of 19 days were noted to be documented code 7, which indicated that the resident was sleeping as per the legend of the codes on the MAR.

During an interview RN #121 indicated to the inspector that the registered nurses are to reassess the resident's condition and evaluate the effectiveness of the restraining every eight hours and document on the MAR. PSWs are responsible to document on the restraint monitoring flow sheet form #335.10B. After reviewing resident #029's progress notes and the "Initial evaluation of restraint application" form with the inspector, RN #121 indicated that the documentation was not completed.

The PMRC indicated that the registered nursing staff have to document their initials on the MAR on every shift to indicate that the resident's condition was reassessed and the effectiveness of the restraining was evaluated at least every eight hours, even if the resident was sleeping.

The PMRC indicated to the inspector that their monitoring process to ensure that the licensee's "Least Restraint" policy is complied with, is a list on each unit that identifies all the residents on the unit who have a restraint and/or a PASD. This list titled the "liste des contentions et AAP" is to be reviewed by a registered nurse on a monthly basis to ensure that all the residents who have a restraint/PASD are identified on this list with the type of restraint and/or PASD used. The registered nurse has to indicate for each resident:
- the date the order was made
- if the decision tree for physical and alternative treatments to restraints form

#335.10A and if the consent/initial evaluation form #335.10C are in the resident's chart
- if the restraint is included in the resident's care plan in ADLs and in the kardex, and
-if the restraint is documented in the resident's MAR with instructions and that it has to be verified every eight hours.
The last column requires the signature of the registered nurse who completed the review and date the review was completed.

The inspector reviewed the "liste des contentions et AAP for a specified month with RN #121. The RN told the inspector that they reviewed this list for that month , including resident #004, #029 and #030 to make sure the restraining was done as per their policy. Under "consentement\evaluation initiale #335.10C" (initial evaluation of restraint application), it was indicated "oui" (yes) for resident #004, under "feuille de route contention/AAP #335.10B" (restraint monitoring form), it was indicated "oui" (yes) for resident #004, #029 and #030. Under "inscrit au MAR's et verifier q8h" (registered in the MAR and verified every eight hours), it was indicated "oui" (yes) for resident #004, #029 and #030. RN #121 told the inspector that they documented yes to indicate that the forms #335.10B and #335.C were in the residents' chart and the restraint was identified in the residents' MAR for the registered nursing staff to initial every eight hours.

The process did not include a review of the documentation to ensure that all required forms were completed or completed properly.

The PMRC confirmed to inspector #550 that this monitoring process to ensure that their "Least restraint" policy is complied with does not include ensuring that the documentation is completed on the required forms, although this is a requirement in their policy. [s. 29. (1) (b)]

The severity of these issues was a level 3 as there was Actual risk to the residents. The home has a level 4 history as they had previous order for noncompliance with this section with the Long-Term Care Homes Act, 2007, that included:

Voluntary Plan of Correction (VPC) s.29 (1) Minimizing of Restraining February 24, 2017 (2017_620126_0003)
Compliance Order (CO) s.29. (1) Minimizing of Restraining issued September 22, 2017, 2016_219211_0021) (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 06, 2018

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee must be compliant with s. 6 (4) of the LTCHA, 2007.

Specifically, upon being served with this Compliance Order and for 30 consecutive days, the licensee shall implement an enhanced monitoring process to be used by both Program Managers for Personal Care to assess the effectiveness of the communication protocols supporting the interdisciplinary assessment of the skin and wound care needs of residents at risk of altered skin integrity and changes to the drug administration regimen of residents with responsive behaviors.

Evidence of that enhanced monitoring process and the actions taken by the Program Managers for Personal Care to address identified deficiencies must be documented and submitted to the Administrator and the Licensee at the end of every 24 hour period.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others who are involved in the different aspect of care of the resident collaborate with each other,
a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

This finding is related to Intake log #029277-17.

Intake log # 029277-17, indicated that resident #012's family member had contacted the PMRC , on a specified date regarding some concerns about the resident care after the resident had been taken to the hospital four days earlier, for the treatment of an infection.

A review of the resident's health care records was done by Inspector #592.

Resident #012 was admitted to the home on a specified date with several diagnosis. Resident #012 was known to have altered skin integrity and treatments were in place for the resident who was seen on a monthly basis by the wound care specialist.

In a review of the follow-up assessment done two months prior the resident's hospitalization, by the wound care specialist #143, the assessment indicated that all wounds were closed and to continue with current treatment. The current treatment which was prescribed several weeks prior to the assessment was to continue with a specific treatment on a specific body part twice a week and to apply another specified treatment to the other body part.

In a review of the last follow-up assessment done, nine days prior to the resident's hospitalization by the wound care specialist, the assessment indicated that old wounds had reopened and to provide resident #012 with a new treatment. The follow-up assessment also indicated to request MD (physician) to consider a specified medication.

In a review of the physician's orders, it was indicated that seven days, following the recommendation from the wound care specialist, the specified medication was prescribed.

During the review of the resident health care records, the Inspector was not able to find any documentation within a two months time frame period of the state of the wound ulcers prior to the hospitalization.

A review of the MAR was done by the Inspector prior to the resident's hospitalization which indicated to provide the resident with the same treatment recommended by the wound care specialist two months before.

On May 17, 2018, in an interview with the wound care specialist #143, the nurse

indicated being scheduled once a month for four hours and that it was the home who was deciding which resident to see depending of the state of the wounds or if advice were required. The wound care specialist also indicated that a round was done with the PMRC and one registered nurse in order to know which resident to assess and also for them to do the specific follow-ups. The wound care specialist also indicated that if there was a significant evidence that the wound was not doing well, the wound care specialist would turn over to the physician. When Inspector #592 inquired about resident #012, the wound care specialist indicated that resident #012's wound were closed at a certain point and the goal was for resident #012 to receive a specific treatment for two weeks on a specific body part, in order to have the body part measured to have the appropriate treatment and compression in place. The wound care specialist indicated not being made aware of the changed in resident #012's wounds status until nine days before the resident's hospitalization. The wound care specialist further indicated not being made aware that resident #012 was not cooperative with the specific treatment as per the orders from the physician.

During the review of the progress notes and the 24 hour report, there was several documentation which indicated that resident # 012 was refusing to be provided with the specific treatment as per the orders from the physician.

On May 17, 2018, in an interview with resident #012, the resident indicated that the registered nursing staff was trying on a daily basis to provide a specific treatment which the resident did not like as it was displacing the dressings that the nurse had just completed.

On May 18, 2018, in an interview with the physician assigned to resident #012, the physician indicated to Inspector #592 that the registered nursing staff will provide a list of the concerns for each residents and if the nursing staff have any concerns in the meantime, they would contact the physician. The physician indicated that once the wound care specialist has done the resident's assessment, the nurse from the home would contact the physician to share the wound care specialist recommendations which usually will be accepted by the physician. When Inspector inquired about resident #012 and the recommendation of a specified medication from the wound care specialist nine days prior to the resident's hospitalization, the physician indicated not remembering being contacted on that day.

On May 18, 2018, in an interview with RPN #128, the RPN indicated that the

tool " Outil d'evaluation des plaies" (Skin Assessment Tool) was used to assess any altered skin integrity, and measurements of the wounds would be done at the same time. RPN #128 indicated that if the staff observed that the skin integrity was deteriorating, the wound care nurse would be notified as well as the PMRC. RPN #128 indicated that once the wound care specialist has made recommendations, the nurse would transcribe the information on the MAR and on the " Outil d'evaluation des plaies" (Skin Assessment Tool). The RPN further indicated that if a specific treatment or specific medications is recommended by the wound care specialist, that the physician will be contacted by the nursing staff and that usually the physician will follow the recommendations. When inquired about the wound status of resident #012 prior to the hospitalization, the RPN was unable to recall when the wounds had re-opened as there was no specific documentation and no " Outil d'evaluation des plaies" (Skin Assessment Tool) found. When asked which treatment was provided to resident #012 few days before being admitted to the hospital, the RPN indicated that as per the MAR, application of a specific treatment ordered two months prior was provided. When Inspector showed the wound care follow-up consultation and the new recommendations dated from the last assessment, the RPN indicated not knowing that a new treatment regimen had been recommended by the wound care specialist, therefore was providing the other treatment prescribed two months earlier.

On May 18, 2018, in an interview with RPN #136, the RPN indicated that following the recommendations from the wound care specialist, the nurse was responsible to transcribe the recommendations on the MAR and on the " Outil d'evaluation des plaies" (Skin Assessment Tool). The RPN further indicated that if there is a recommendation for a specific treatment or medication, the nurse was expected to contact the physician. When Inspector #592 inquired about resident #012, the RPN indicated being the one who had received the wound care consultation nine days prior to the resident's admission to the hospital. RPN # 136 indicated that the follow-up recommendations done by the wound care specialist had not been communicated to other members of the health care team.

On May 22, 2018, in an interview with the PMRC who is the resource person for the skin care program, the PMRC indicated that the home process for the wound care specialist was that a week prior to the wound care visit, a list was provided to the registered nursing staff to add any residents with complex skin care who would benefit of the wound care consult. The PMRC further indicated that if the

service of the wound care specialist was needed earlier before the scheduled visit, an email with pictures of the wounds would be sent out and new recommendations would be received for the nursing staff to follow. The PMRC indicated that resident #012 was added on the list to be seen for the visit scheduled nine days prior to the resident's admission to the hospital. The PMRC indicated being present with the wound care specialist to assess each resident on the list to be seen. The PMRC indicated not being made aware that resident #012 was not cooperative with the treatment as recommended by the wound care specialist and as ordered by the physician until the day of the visit. The PMRC further indicated not being aware of the deterioration of the resident's wounds until that day.

As such, the Nursing staff, the wound care specialist, the physician and the PMRC did not collaborate with each other in the assessment of resident #012's wound care needs, so that their assessments were integrated ,consistent and complemented each other. (592)

2. The licensee has failed to ensure that the wound care treatment for resident #038 was communicated to all the staff involved in the care of the resident, resulting in a treatment not being provided for 15 days.

This finding is related to log #003836-18 which indicated that resident #038's family member sent a written complaint to the PMRC #125 on a specified date. The complaint was about some concerns regarding the home's policy on skin care after discovering a dressing on a specified date on resident #038's specific body part.

A review of the resident's health care records was done by Inspector #592.

Resident #038 was admitted with several diagnosis and was identified on the last Resident Assessment Protocols (RAI) of being at risk for altered skin integrity with no presence of pressure ulcers/skin tear for the period covered by the assessment.

In a review of resident #038's progress notes, there was documentation found on a specific day indicating that the family member of resident #038 inquired with RN #139 what had happened to resident #038's specific body part as the resident had a dressing in place with dated two weeks before. The notes further indicated that RN #139 had verified the resident health records, the software

system, the MAR and the 24 hour nursing report and was unable to find any documentation regarding the dressing and care provided for resident #038. The notes described that the dressing was removed by the RN and that the wound site was cleaned and a dry dressing was applied to be changed on a specified day or as needed.

In a review of the licensee's internal investigation documents provided by the PMRC , the documentation indicated that following the written concerns received by the family member of resident #038, follow ups were done, including an interview conducted with RN #140. The documentation also revealed in a written response email sent to the family member of resident #038 by the PMRC that RN #140 was the registered staff who had discovered the resident's wound 15 days before, by observing the presence of a tape on resident #038's specific body part. The documentation of the email further indicated that the RN noted that the tape was covering a skin abrasion and was told by the resident that the resident had applied the tape without notifying the nurse. The documentation further indicated that RN #140 observed that the wound was not recent and a small amount of discharge was present.

The documentation further indicated that the RN indicated that a dressing was done to resident #038, however that no documentation was done about the wound and the wound care provided.

A review of the licensee's written response letter following the completion of the internal investigation to the family member was done by Inspector #592. The written response letter indicated that RN #140 had documented in the 24 hours nursing report that resident #038 had a wound on a specific body part from unknown cause and that the wound was clean and a dry dressing was put in place. The written response further indicated that RN #140 had forgotten to document the observation of the altered skin integrity and the required treatment in the progress notes and that no tool had been initiated for the assessment of altered skin integrity (form #355.29B). The letter also indicated that the Medication Administration Records with the specific treatments and the resident's #038 plan of care, were as well not completed by RN #140.

As such, the PSWs and the registered nursing staff did not communicate and collaborate with each other in the assessment of resident #038's wound care needs, so that their assessments were integrated ,consistent and complemented each other. (592)

3. The licensee has failed to ensure that the staff and others who are involved in the different aspect of care of the resident collaborate with each other,
a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Resident #022 was admitted to the home on a specified date with several medical diagnoses. On a specified date, family member of resident #022 indicated concerns related to medication administration.

On May 22, 2018 the PMPC indicated to inspector #547 based on the documented notes taken during a meeting held on a specified date, with the resident's family member, they planned to discontinue some medications that were not necessary to decrease resistive behaviours with the resident and that RN #134 was to leave a note to that effect for the physician. The PMPC also indicated that the nursing staff were evaluating the resident's dietary intake during this period on every shifts, and offered the resident several choices of food and fluids that were usually refused. The Registered Dietician reviewed the residents' nutritional requirements related to weight loss and made specific recommendations. The PMPC indicated that the resident's family member was not informed of these dietary assessments and the change in fluid texture requirement.

On May 22, 2018, inspector #547 reviewed the resident's health care records three days after the meeting had been held which indicated in the physician's orders "telephone order a meeting was held on a specified date and medications were to be discontinued" by RN #134. The resident's MAR's indicated that five medications were discontinued following the telephone order.

The physician's telephone order was co-signed by the physician five days later. The physician wrote a progress note five days later, that indicated to discontinue one specific medication as per the Substitute Decision Maker (SDM) request and noted that the specific medication was available as required (PRN).

On May 23, 2018, RN #134 indicated to Inspector #547 that the resident's medications were discontinued based on the meeting held on a specified date with the PMPC and the resident's family member. RN #134 indicated that the family member requested that all medications be discontinued. RN #134 indicated not reviewing the resident's MAR for each individual medication that

was discontinued with the resident's family member.

As such, the nursing staff, dietary staff and the attending physician failed to collaborate with each other when planning with the SDM interventions for the management of responsive behaviours exhibited by resident #022.

The severity of these issues was a level 3 as there was Actual risk to the residents. The home has a level 4 history as they had previous non-compliance with this section with the Long-Term Care Homes Act, 2007, that included:

Voluntary Plan of Correction (VPC) s. 6. (4) Plan of care October 5, 2017 (2017_621547_0016)
(547)

2. (592)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 10, 2018

Order # / Ordre no : 003

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 must be compliant with s. 19 (1) of the LTCHA, 2007.

Specifically, the licensee shall:

1. Provide additional training to all managers working at Centre d'Acceuil Champlain in relation to their role and responsibilities related to the mandatory reporting of suspicions of neglect of a resident that resulted in harm or risk of harm to a resident;
2. Ensure that the planned interventions to meet the skin care needs of residents at risk for altered skin integrity are provided to residents by registered nursing staff as specified in the written plan of care and the applicable licensee's policies;
3. Implement enhanced monitoring processes to assess the effectiveness of the nursing care delivery on all units to ensure that all residents are provided with the treatment, care and assistance required to maintain their health, safety and overall well-being; and
4. Document the results of this monitoring process and the actions taken by the Long-Term Care home Senior Leadership Team of the City of Ottawa to address identified problems.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #038 was protected from neglect.

According to Ontario Regulation 79/10 "neglect" means: the failure to provide a resident with a treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the

health, safety or well-being of one or more residents.

This inspection is related to Log # 003836-18.
On a specified date, resident #038's family member sent a written complaint to the PMRC #125. The complaint was about some concerns regarding the home's policy related to skin care after discovering a dressing on a specified date on resident #038's specific body part.

In a review of resident #038's progress notes, there was documentation found indicating that on a specific day, the family member of resident #038 inquired with RN #139 what had happened to resident #038's specific body part as the resident had a dressing in place dated from two weeks before. The notes further indicated that RN #139 had verified the resident health records, the software system, the MAR and the 24 hour nursing report and was unable to find any documentation regarding the dressing for resident #038. The notes described that the dressing was removed by the RN and that the wound site was cleaned, dry dressing was applied and scheduled to be changed on a specific date or as needed.

Inspector #592 reviewed the documentation in the licensee's internal investigation file.
It was documented that their investigation determined that their skin and wound care program had not been followed by registered nursing staff and PSWs for a 17 day period. The documentation also indicated that 17 days prior, RN #140 did not document the observation of the altered skin integrity and the required treatment in the progress notes of resident #038. RN #140 did not complete the specific tool required for the assessment of new altered skin integrity. Furthermore, RN #140 did not document on the Medication Administration Records, the specific treatments to provide to resident #038, as well as not documenting any instructions and interventions in the resident plan of care. The documentation also indicated that no subsequent follow-up or any treatments was done by the registered nursing staff. The PSWs did not report the dressing to the registered staff.

A review of the licensee's written response letter following the completion of the internal investigation to the family member was done by Inspector #592. The written response letter indicated that on the day that the wound was discovered, RN #140 had documented in the 24 hours nursing report that resident #038 had

a wound on a specific body part from unknown cause and that the wound was clean and a dry dressing was applied. No follow-up had been done from registered nursing staff member, resulting in resident #038 to have a dressing in place with no wound care treatment for 15 days.

As such, the licensee failed to protect resident #038 from neglect by staff when the wound care treatment required to meet this resident skin care needs was not provided for 15 days.

In addition, the licensee failed to protect resident #038 from neglect when:

A. The licensee's skin and wound care policies #355.29 and # 315.12, were not complied with as indicated in WN #11.

B. The PMRC #125 failed to immediately report the incident of neglect to the Director, as indicated in WN #13.

C. Nursing staff did not communicated to all staff involved, the wound care treatment required to meet the skin care needs of resident #038, as indicated in WN 2.

The severity of these issues was a level 3 as there was Actual harm to resident #038. The home has a level 4 history as they had previous order for non-compliance with this section with the Long-Term Care Homes Act, 2007, that included:

Compliance Order (CO) s.19 duty to protect issued December 23, 2016 (2016_219211_0021)

Compliance Order (CO) s.19 duty to protect issued November 17, 2017 (2017_621547_0016) including a Director's Referral.

(592)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 28, 2018

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

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 21st day of June, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Melanie Sarrazin

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