Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 15, 2016	2016_483637_0014	028671-16, 029217-16	Complaint

Licensee/Titulaire de permis

VALLEY EAST LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

ELIZABETH CENTRE
2100 Main Street Val Caron ON P3N 1S7

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

MISHA BALCIUNAS (637)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 6, 7, and 11, 2016.

This Complaint inspection is related to two complaints regarding resident care.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Staff Educators, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and resident's family members.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, residents' plans of care, various policies/procedures/programs and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Pain
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Inspector #637 reviewed a complaint submitted to the Director in September 2016, related to concerns regarding the care of resident #001. Please refer to WN #2 for further details.

The Inspector reviewed specific progress notes, for resident #001 which revealed that on a given number of separate occasions, during a six month period, pain was identified by registered staff when a specific, resident care need had been completed. Review of the plan of care for resident #001 identified that no formal pain assessment using the electronic Pain Assessment tool had been completed regarding the given number of documented incidents of pain during the resident's specific care need.

Review of the health care record for resident #001 by the Inspector, revealed that a pain focus had not been identified in the care plan during a six month period.

In an interview, PSW #101 said that resident #001 was in constant pain and that they always reported the resident's pain to registered staff.

The Inspector interviewed Staff Educator #2 who stated that as the Pain Wound Lead they generally only saw a resident if pain was triggered in a Minimum Data Set (MDS) assessment or someone mentioned that a resident was having pain. Staff Educator #2 verified that they had not been involved in pain management for resident #001.

Inspector #637 interviewed the DOC who stated that resident #001's pain had not been managed, and that the home had not notified the Pain Wound Lead. The DOC verified that pain had not been identified as a focus for resident #001. [s. 6. (2)]

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. 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 all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

According to the LTCHA, 2007 O. Reg 79/10, s.5 neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #637 reviewed a complaint submitted to the Director during September 2016, related to concerns regarding the care of resident #001. According to the complaint, resident #001 returned from hospital on a certain date in 2016, with altered skin integrity. The complainant stated to the Inspector that resident #001 had poor pain control and questioned the treatment to the area of altered skin integrity, as the area was of a significant size. The resident passed away on a date in 2016.

Inspector #637 reviewed the health care record of resident #001 and identified the following:
a) The physician orders for resident #001 revealed that on a date in 2016, the physician had changed a specific order related to the area of altered skin integrity. The Inspector observed a handwritten addition at the side of the order that changed the order by a specific staff member.

On October 11, 2016, the Inspector interviewed the DOC who stated that the order was changed without the physician being notified. The DOC stated that it was the home's expectation that all orders were to be transcribed as written and not altered unless consultation and approval was given by the home's physician.

Review of the home's policy Resident Rights, Care and Services - Medication Management - Physician Orders - Written, Verbal & Telephone Revised 2013-10-07 stated that to ensure the safety of all residents and that prescribing of medications and

treatments is in accordance with legislated and regulatory standards all physician orders for care and treatments shall be written and signed by the prescribing physician. According to the home's policy Resident Rights, Care and Services - Medication Management - Physician Orders - Transcription (Routine and Stat Orders) 2013-10-07, it stated that transcription of the order must be exactly as written by the prescriber onto the Medication Administration Record or the Treatment Administration Record.

b) Review of the specific progress notes, revealed that on a given number of separate occasions, during a six month period, pain was identified by registered staff when a specific, resident care need had been completed. Review of the plan of care for resident #001 identified that no formal pain assessment using the electronic Pain Assessment tool had been completed regarding the given number of documented incidents of pain during the specific, resident care need. According to O.Reg. 79/10, s.52(2), the licensee shall ensure that when the resident's pain is not relieved by initial interventions, that the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. Please refer to WN #4 for additional details.

c) Review of the health care record revealed that a pain focus had not been identified in the care plan from during a six month period. According to the LTCHA, 2007, s.6(2), every licensee of a long-term care home shall ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences. Please refer to WN #1 for additional details.

d) Review of progress notes revealed that on certain date in 2016, the resident returned from hospital with an area of altered skin integrity. Progress notes in Point Click Care revealed that no, specific assessment progress notes, had been completed in their entirety on a number of separate occasions. According to O.Reg. 79/10, s. 50. 2(b). iv, The licensee shall ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. Please refer to WN #3, finding one for further details

e) Review of the health care record revealed that during a six month period, there was no turning and repositioning in place for this resident who required assistance. According to O.Reg. 79/10, s. 50 (2), d, every licensee of a long term care home shall ensure that the resident who is dependent on staff for repositioning has been repositioned every two hours as required depending on the resident's condition and tolerance. Please refer to WN #3 finding two for further details.

f) Review of the staff training documentation regarding pain management for 2015, revealed that one staff member, had not completed the required training. According to O.Reg. 79/10, s.221(1), 4, the licensee shall ensure that direct care staff were provided training in pain management, including recognition of specific and non-specific signs of pain. Please refer to WN #5 finding one for further details.

g) Review of the 2015 training documentation for skin and wound care revealed that five registered staff and seven PSWs had not completed the required training. In total, 12 front line staff had not completed the required skin and wound training for 2015. According to O.Reg. 79/10, s.221(2), the licensee shall ensure that for the purpose of paragraph 6 of subsection 76(7) of the Act, skin and wound care shall be provided to all staff who provide direct care to residents. Please refer to WN #5 finding two for further details. [s. 19. (1)]

Additional Required Actions:

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

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

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

Findings/Faits saillants :

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

Inspector #637 reviewed a complaint submitted to the Director in September 2016, related to the concerns regarding the care of resident #001. Please refer to WN #2 for further details.

The inspector reviewed resident #001's progress notes which revealed that on a certain date in 2016, the resident returned from hospital with an area of altered skin integrity.

Review of specific assessment notes in Point Click Care, revealed that specific assessment notes had not been completed in their entirety during specific dates in a three month period.

Review of the home's policy Resident Rights, Care and Services - Required Programs - Skin and Wound Care - Program Revised 2016-09-09, stated that Registered Staff will ensure that a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin wounds has a completed wound assessment and treatment record, which will serve as a referral to the skin and wound care lead. As well, as has a completed wound progress note, weekly and that the Lead for Skin and Wound Care Program will assess each resident with a pressure ulcer Stage II or greater at least every two weeks

The ADOC provided written confirmation on October 10, 2016, that a completed wound assessment note could not be found between the specific dates. The ADOC confirmed that the home's expectation had been that a weekly specific note be completed.

Inspector #637 interviewed the DOC on October 11, 2016, who confirmed that it was the home's expectation that the weekly specifc note be completed weekly and in their entirety. [s. 50. (2) (b) (iv)]

2. The licensee has failed to ensure that a resident who was dependent on staff for repositioning had been repositioned every two hours as required depending on the resident's condition and tolerance.

Inspector #637 reviewed a complaint submitted to the Director in September 2016, related to the concerns regarding the care of resident #001. Please refer to WN #2 for further details.

A review of resident #001's health care record revealed that between a six month period, there was no turning and repositioning in place for this resident.

The Inspector interviewed PSW #101 who recalled resident #001 having been on a turning and repositioning schedule at the end of a certain month or the beginning of the next month; five months after returning from hospital with an area of altered skin integrity.

Review of the home's policy Resident Rights, Care and Services - Required Programs - Skin and Wound Care - Program Revised 2016-09-09, stated that for a resident with potential for altered skin integrity including skin breakdown, pressure ulcers or wounds, registered staff will ensure that a resident who is unable to reposition themselves, has a turning schedule as part of their plan of care and receives assistance to reposition at

least every 2 hours or more as required. The registered staff has the turning schedule added to Point of Care (POC) for PSW documentation. PSWs will ensure that the resident who is unable to reposition themselves receives assistance and prompt documentation related to turning schedules occurs.

Inspector #637 interviewed the DOC who stated no, when asked if resident #001 was able to turn and reposition themselves. The DOC confirmed that no turning and repositioning occurred between a five month period, for resident #001 as no documentation existed. The DOC stated that the home's expectation had been resident #001 was to have been turned and repositioned between the five month period and that it would have been documented. [s. 50. (2) (d)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, that the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Inspector #637 reviewed a complaint submitted to the Director in September 2016, related to the concerns regarding the care of resident #001. Please refer to WN #2 for further details.

The Inspector reviewed specific progress notes, for resident #001 which revealed that on a given number of separate occasions, during a six month period, pain was identified by registered staff when a specific, resident care need had been completed. Review of the plan of care for resident #001 identified that no formal pain assessment using the electronic Pain Assessment tool had been completed regarding the given number of documented incidents of pain during the specific, resident care need.

Review of the home's policy Resident Rights, Care and Services - Required Programs - Pain Management - Program revised date 2016-03-11 stated that registered staff will ensure a resident with worsening pain or unrelieved pain has a comprehensive pain assessment completed in Point Click Care, is assessed for pain using the appropriate screening tool described above.

In an interview with PSW #101, they revealed that resident #001 had been in constant pain and that they had always reported this to registered staff.

In an interview with RPN #200, they stated that they had performed specific care on resident #001 and that when a resident identified pain there was a specific pain assessment tool that they were supposed to use; however, they had not completed it in regards to resident #001's identified pain, during specific care.

The Inspector interviewed the DOC who stated that resident #001 should have had a pain assessment completed for all of the times pain had been identified in the specific progress notes. The DOC confirmed that no pain assessments existed for the specific number of documented incidents of pain for resident #001. [s. 52. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were provided training in pain management, including recognition of specific and non-specific signs of pain.

Inspector #637 reviewed a complaint submitted to the Director in September 2016, related to the concerns regarding the care of resident #001. Please refer to WN #2 for further details.

Inspector #637 reviewed the staff training documentation regarding pain management for 2015, which revealed that one staff member had not completed the required training.

Review of the home's policy Resident Rights, Care and Services - Required Programs - Pain Management - Program revised date 2016-03-11 stated that the Lead for Training

and Orientation will ensure that education and/or retraining regarding pain management is provided to all direct care staff in orientation and annually.

The Inspector interviewed Staff Educator #1 who verified that one staff member had not completed the required pain training for 2015. Staff Educator #1 stated that the home expected everyone to have completed the training.

In an interview with the DOC, they verified that one person had not completed the 2015 pain training and that the home's expectation was that everyone should have completed that training for 2015. [s. 221. (1) 4.]

2. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76(7) of the Act, skin and wound care training shall be provided to all staff who provide direct care to residents.

Inspector #637 reviewed a complaint submitted to the Director in September 2016, related to the concerns regarding the care of resident #001. Please refer to WN #2 for further details.

The Inspector reviewed the 2015 training documentation for skin and wound care which revealed that five registered staff and seven PSWs had not completed the required training. In total 12 front line staff had not completed the required skin and wound training for 2015.

Review of the home's policy Resident Rights, Care and Services - Required Programs - Skin and Wound Care - Program Revised 2016-09-09, stated that the Lead for Training and Orientation will ensure that education and/or retraining regarding skin and wound care is provided to all direct care staff in orientation and annually.

In an interview with the DOC, they confirmed that five registered staff and seven PSWs had not completed the 2015 skin and wound training. [s. 221. (2)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 one staff member who had not yet received training in pain management receives such training, including recognition of specific and non-specific signs of pain, to be implemented voluntarily.

Issued on this 4th day of January, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MISHA BALCIUNAS (637)
Inspection No. / No de l'inspection :	2016_483637_0014
Log No. / Registre no:	028671-16, 029217-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 15, 2016
Licensee / Titulaire de permis :	VALLEY EAST LONG TERM CARE CENTRE INC. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	ELIZABETH CENTRE 2100 Main Street, Val Caron, ON, P3N-1S7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SHELLY MURPHY

To VALLEY EAST LONG TERM CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee shall:

a) Conduct an audit of the residents in the home who are experiencing pain, to ensure that the care set out in the plan of care is based on the assessment of the resident and the needs and preferences of that resident.

b) Ensure that the plan of care, including the written and electronic care plans relating to pain, for all residents in the home are reviewed and revised to identify goals and interventions that reflect the needs and preferences of that resident.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Inspector #637 reviewed a complaint submitted to the Director in September 2016, related to concerns regarding the care of resident #001. Please refer to WN #2 for further details.

The Inspector reviewed specific progress notes, for resident #001 which revealed that on a given number of separate occasions, during a six month period, pain was identified by registered staff when a specific, resident care need had been completed. Review of the plan of care for resident #001 identified that no formal pain assessment using the electronic Pain Assessment tool had been completed regarding the given number of documented incidents of pain during the specific resident care need.

Review of the health care record for resident #001 by the Inspector, revealed that a pain focus had not been identified in the care plan during a six month period.

In an interview, PSW #101 said that resident #001 was in constant pain and that they always reported the resident's pain to registered staff.

The Inspector interviewed Staff Educator #2 who stated that as the Pain Wound Lead they generally only saw a resident if pain was triggered in a Minimum Data Set (MDS) assessment or someone mentioned that a resident was having pain. Staff Educator #2 verified that they had not been involved in pain management for resident #001.

Inspector #637 interviewed the DOC who stated that resident #001's pain had not been managed, and that the home had not notified the Pain Wound Lead. The DOC verified that pain had not been identified as a focus for resident #001

The decision to issue this compliance order was based on previous non-compliance in unrelated areas and although the scope of the issue was isolated, the severity resulted in actual harm occurring. (637)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2017

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

Order / Ordre :

The licensee shall ensure:

1. Residents of the home are protected from neglect by the staff.

2. That no physician order is altered unless consultation and approval is given by the prescriber.

Grounds / Motifs :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

According to the LTCHA, 2007 O. Reg 79/10, s.5 neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #637 reviewed a complaint submitted to the Director during September 2016, related to concerns regarding the care of resident #001. According to the complaint, resident #001 returned from hospital on a certain date in 2016, with altered skin integrity. The complainant stated to the Inspector that resident #001 had poor pain control and questioned the treatment to the area of altered skin integrity, as the area was of a significant size. The resident passed away on a date in 2016.

Inspector #637 reviewed the health care record of resident #001 and identified the following:
a) The physician orders for resident #001 revealed that on a date in 2016, the

physician had changed a specific order related to the area of altered skin integrity. The Inspector observed a handwritten addition at the side of the order that changed the order by a specific staff member.

On October 11, 2016, the Inspector interviewed the DOC who stated that the order was changed without the physician being notified. The DOC stated that it was the home's expectation that all orders were to be transcribed as written and not altered unless consultation and approval was given by the home's physician.

Review of the home's policy Resident Rights, Care and Services - Medication Management - Physician Orders - Written, Verbal & Telephone Revised 2013-10 -07 stated that to ensure the safety of all residents and that prescribing of medications and treatments is in accordance with legislated and regulatory standards all physician orders for care and treatments shall be written and signed by the prescribing physician. According to the home's policy Resident Rights, Care and Services - Medication Management - Physician Orders - Transcription (Routine and Stat Orders) 2013-10-07, it stated that transcription of the order must be exactly as written by the prescriber onto the Medication Administration Record or the Treatment Administration Record.

b) Review of the specific progress notes, revealed that on a given number of separate occasions, during a six month period, pain was identified by registered staff when a specific, resident care need had been completed. Review of the plan of care for resident #001 identified that no formal pain assessment using the electronic Pain Assessment tool had been completed regarding the given number of documented incidents of pain during the specific, resident care need. According to O.Reg. 79/10, s.52(2), the licensee shall ensure that when the resident's pain is not relieved by initial interventions, that the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. Please refer to WN #4 for additional details.

c) Review of the health care record revealed that a pain focus had not been identified in the care plan from during a six month period. According to the LTCHA, 2007, s.6(2), every licensee of a long-term care home shall ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences. Please refer to WN #1 for additional details.

d) Review of progress notes revealed that on certain date in 2016, the resident returned from hospital with an area of altered skin integrity. Progress notes in

Point Click Care, revealed that no specific assessment progress notes had been completed in their entirety on a number of separate occasions. According to O.Reg. 79/10, s. 50. 2(b). iv, The licensee shall ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. Please refer to WN #3, finding one for further details

e) Review of the health care record revealed that during a six month period, there was no turning and repositioning in place for this resident who required assistance. According to O.Reg. 79/10, s. 50 (2), d, every licensee of a long term care home shall ensure that the resident who is dependent on staff for repositioning has been repositioned every two hours as required depending on the resident's condition and tolerance. Please refer to WN #3 finding two for further details.

f) Review of the staff training documentation regarding pain management for 2015, revealed that one staff member, had not completed the required training. According to O.Reg. 79/10, s.221(1), 4, the licensee shall ensure that direct care staff were provided training in pain management, including recognition of specific and non-specific signs of pain. Please refer to WN #5 finding one for further details.

g) Review of the 2015 training documentation for skin and wound care revealed that five registered staff and seven PSWs had not completed the required training. In total, 12 front line staff had not completed the required skin and wound training for 2015. According to O.Reg. 79/10, s.221(2), the licensee shall ensure that for the purpose of paragraph 6 of subsection 76(7) of the Act, skin and wound care shall be provided to all staff who provide direct care to residents. Please refer to WN #5 finding two for further details.

The decision to issue this compliance order was based on the scope of this issue, which was isolated; the severity which identified that actual harm occurred; and the compliance history, which despite previous non-compliance has continued in this area of legislation. (637)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee shall:

a) Conduct an audit of the resident's in the home who are exhibiting altered skin integrity, including skin breakdown, pressure ulcers, to ensure that the resident is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

b) Develop a process for ensuring that the weekly skin and wound assessments are completed.

c) Ensure that any resident who is dependent on staff for positioning is repositioned at least every two hours, depending on resident's condition and tolerance of tissue load.

d) Ensure that documentation is kept when a resident is dependent on staff for turning and repositioning.

Grounds / Motifs :

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

Inspector #637 reviewed a complaint submitted to the Director in September 2016, related to the concerns regarding the care of resident #001. Please refer to WN #2 for further details.

The inspector reviewed resident #001's progress notes which revealed that on a certain date in 2016, the resident returned from hospital with an area of altered skin integrity.

Review of specific assessment notes in Point Click Care, revealed that specific assessment notes had not been completed in their entirety during specific dates in a three month period.

Review of the home's policy Resident Rights, Care and Services - Required Programs - Skin and Wound Care - Program Revised 2016-09-09, stated that Registered Staff will ensure that a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin wounds has a completed wound

assessment and treatment record, which will serve as a referral to the skin and wound care lead. As well, as has a completed wound progress note, weekly and that the Lead for Skin and Wound Care Program will assess each resident with a pressure ulcer Stage II or greater at least every two weeks

The ADOC provided written confirmation on October 10, 2016, that a completed specific assessment note could not be found between the specific dates. The ADOC confirmed that the home's expectation had been that a weekly specific note be completed.

Inspector #637 interviewed the DOC on October 11, 2016, who confirmed that it was the home's expectation that the weekly specific note be completed weekly and in their entirety. (637)

2. The licensee has failed to ensure that a resident who was dependent on staff for repositioning had been repositioned every two hours as required depending on the resident's condition and tolerance.

Inspector #637 reviewed a complaint submitted to the Director in September 2016, related to the concerns regarding the care of resident #001. Please refer to WN #2 for further details.

A review of resident #001's health care record revealed that between a six month period, there was no turning and repositioning in place for this resident.

The Inspector interviewed PSW #101 who recalled resident #001 having been on a turning and repositioning schedule at the end of a certain month or the beginning of the next month; five months after returning from hospital with an area of altered skin integrity.

Review of the home's policy Resident Rights, Care and Services - Required Programs - Skin and Wound Care - Program Revised 2016-09-09, stated that for a resident with potential for altered skin integrity including skin breakdown, pressure ulcers or wounds, registered staff will ensure that a resident who is unable to reposition themselves, has a turning schedule as part of their plan of care and receives assistance to reposition at least every 2 hours or more as required. The registered staff has the turning schedule added to Point of Care (POC) for PSW documentation. PSWs will ensure that the resident who is unable to reposition themselves receives assistance and prompt documentation

related to turning schedules occurs.

Inspector #637 interviewed the DOC who stated no, when asked if resident #001 was able to turn and reposition themselves. The DOC confirmed that no turning and repositioning occurred between a five month period, for resident #001 as no documentation existed. The DOC stated that the home's expectation had been resident #001 was to have been turned and repositioned between the five month period and that it would have been documented.

The decision to issue this compliance order was based on previous non-compliance in unrelated areas and although the scope of the issue was isolated, the severity resulted in actual harm occurring. (637)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee shall ensure that when a resident is identified as having pain and when initial interventions are not successful, they are assessed using a clinically appropriate instrument designed for this purpose.

Grounds / Motifs :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, that the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Inspector #637 reviewed a complaint submitted to the Director in September 2016, related to the concerns regarding the care of resident #001. Please refer to WN #2 for further details.

The Inspector reviewed specific progress notes, for resident #001 which revealed that on a given number of separate occasions, during a six month period, pain was identified by registered staff when a specific, resident care need had been completed. Review of the plan of care for resident #001 identified that no formal pain assessment using the electronic Pain Assessment tool had been completed regarding the given number of documented incidents of pain during the specific, resident care need.

Review of the home's policy Resident Rights, Care and Services - Required Programs - Pain Management - Program revised date 2016-03-11 stated that registered staff will ensure a resident with worsening pain or unrelieved pain has a comprehensive pain assessment completed in Point Click Care, is assessed for pain using the appropriate screening tool described above.

In an interview with PSW #101, they revealed that resident #001 had been in constant pain and that they had always reported this to registered staff.

In an interview with RPN #200, they stated that they had performed specific care on resident #001 and that when a resident identified pain there was a specific pain assessment tool that they were supposed to use; however, they had not completed it in regards to resident #001's identified pain, during specific care.

The Inspector interviewed the DOC who stated that resident #001 should have had a pain assessment completed for all of the times pain had been identified in the specific progress notes. The DOC confirmed that no pain assessments existed for the specific number of documented incidents of pain for resident #001.

The decision to issue this compliance order was based on previous non-compliance in unrelated areas and although the scope of the issue was isolated, the severity resulted in actual harm occurring. (637)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2016

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 : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Order / Ordre :

The licensee shall:

a) Ensure that all staff who provide direct care to residents, receives re-training related to skin and wound care.

b) Maintain a record of who attended the training, when the training occurred, and what training materials were utilized as a result of this order.

Grounds / Motifs :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76(7) of the Act, skin and wound care training shall be provided to all staff who provide direct care to residents.

Inspector #637 reviewed a complaint submitted to the Director in September 2016, related to the concerns regarding the care of resident #001. Please refer to WN #2 for further details.

The Inspector reviewed the 2015 training documentation for skin and wound care which revealed that five registered staff and seven PSWs had not completed the required training. In total 12 front line staff had not completed the required skin and wound training for 2015.

Review of the home's policy Resident Rights, Care and Services - Required Programs - Skin and Wound Care - Program Revised 2016-09-09, stated that the Lead for Training and Orientation will ensure that education and/or retraining regarding skin and wound care is provided to all direct care staff in orientation and annually.

In an interview with the DOC, they confirmed that five registered staff and seven PSWs had not completed the 2015 skin and wound training.

The decision to issue this compliance order was based on previous non-compliance in unrelated areas and although the scope of the issue was isolated, the severity resulted in actual harm occurring. (637)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 04, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 15th day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Misha Balciunas

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