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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 10, 2015	2015_303563_0014	L-002092-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE SOUTHWESTERN ONTARIO INC
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE PORT STANLEY
4551 EAST ROAD PORT STANLEY ON N5L 1J6

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

MELANIE NORTHEY (563), INA REYNOLDS (524), NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 31 - April 2, April 7 - 8, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Manager, the Resident Assessment Instrument (RAI) Coordinator, the Office Manager, the Dietary Manager, the Behavioural Supports Ontario (BSO) Personal Support Worker, the Resident Council President, the Family Council Representative, a Registered Nurse, a Registered Practical Nurse, three Personal Support Workers, three Family Members and 40 Residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **9 WN(s)**
- **7 VPC(s)**
- **1 CO(s)**
- **0 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. 17. (1)	CO #001	2014_260521_0026	524

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 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:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

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:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

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:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure 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:

- falls prevention and management,
- skin and wound care,
- continence care and bowel management,
- pain management, including pain recognition of specific and non-specific signs of pain,
- for staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices,

- for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs, as well as
- Mental health issues, including caring for persons with dementia and
- behaviour management

Record review of the "General Orientation" Agenda revealed it does not include education related to: skin and wound care, fall prevention and management, continence care and bowel management, pain management, application of physical devices and monitoring of residents restrained by physical devices / PASDs, dementia care, and behaviour management.

Record review of the "Skin Care Audit" education received September 11, 2014 revealed only some registered staff attended. Record review of the "Wound Care, How to Complete a Wound Assessment" education received on January 6, 2015 revealed only three registered nursing staff attended.

Record review of the "Worksheet for Tracking Staff Completion of Mandatory Training" on April 7, 2015 revealed some registered staff attended incontinence education on April 10, 2014, but no Personal Support Workers received this same training in continence care.

Record review of the "Worksheet for Tracking Staff Completion of Mandatory Training" on April 7, 2015 revealed all staff who provide direct care to residents did not receive training related to "Delirium, Dementia, Depression", "Pain", "Wound Care", or "Incontinence Care." The worksheet and orientation agenda was absent of any training for fall prevention and management, and application of physical devices and monitoring of residents restrained by physical devices / PASDs.

Staff interview with the Resident Assessment Instrument (RAI) Coordinator on April 8, 2015 confirmed there is no documented evidence that direct care staff received education in skin and wound care, fall prevention and management, continence care and bowel management, pain management, application of physical devices and monitoring of residents restrained by physical devices / PASDs, dementia care, and behaviour management. The RAI Coordinator confirmed the home did not meet the education requirements for 2014. [s. 221. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

Record review of the current care plan on April 7, 2015 for one resident revealed bed rails are used.

Record review of the Annual Minimum Data Set (MDS) Assessment revealed there was documentation in section P4b where by no bed rails were used for this resident.

Observation of this resident revealed two 1/4 bed rails in use.

Interview with the RAI Coordinator on April 7, 2015 confirmed that the resident has two 1/4 rails in the raised position, and that the Plan of Care does not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Observations of one resident's room revealed a sign posted above the resident's bed which indicating the use of side rails and a sticker which indicates the resident's mobility level. Observation of the resident's bed system revealed bilateral quarter bed rails in use.

Record review of the resident's current care plan revealed there were no interventions documented for the use of bed rails.

Record review of the resident's current care plan revealed there were no interventions documented for the use of bed rails. Record review of section "P4b- Other types of side rails used (e.g., half rail, 1 side)" in the MDS Assessments revealed side rails have been in use since 2014.

Staff interview with the Registered Nurse (RN) revealed this resident uses side rails at all times assistance for transfers and mobility. The RN confirmed the signs posted above the resident's bed were inaccurate and did not provide clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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 written plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 ensure that the "Continence Management Program" Policy # RESI-10-04-01 in place is complied with.

Record review of the "Continence Management Program" Policy # RESI-10-04-01 on April 2 2015 revealed, "Staff will complete a continence assessment using a clinically appropriate assessment tool that is specifically designed for assessing continence... An assessment is completed upon a resident's admission and with any deterioration in continence level" and the registered staff are to initiate a Three-Day Elimination Record as a component of the continence assessment.

Interview with a Registered Nurse(RN) revealed that a Continence Assessment was completed in 2013. There is no documented evidence of a Continence Assessment completed on admission for one resident. A Three day Elimination Monitoring Record and Continence Assessment were not initiated with a deterioration in continence level for this resident following the MDS quarterly review.

Interview with the RAI Coordinator confirmed that the home did not complete a Continence Assessment on admission or initiate the Three Day Elimination Monitoring Record and Continence Assessment. [s. 8. (1) (b)]

2. Record review of the MDS Assessment last completed in 2015 demonstrated a decline in bowel continence since the last MDS assessment where by one resident had a decline in bowel continence.

Staff interview with the RN confirmed a "Three Day Elimination Monitoring Record" is initiated when worsening incontinence is triggered from the MDS and the last "Three Day Elimination Monitoring Record" for this resident was completed in 2014.

Staff interview with the Registered Nurse confirmed a continence assessment would be completed in PointClickCare upon admission and when worsening incontinence is triggered from the MDS assessment and confirmed this was not done for this resident. [s. 8. (1) (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 the "Continence Management Program" Policy # RESI-10-04-01 in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Resident observations on March 31 and April 1, 2015 during stage 1 of the Resident Quality Inspection revealed 36 of 40 residents had one or more bed rails in use.

Record review of the residents clinical records revealed the absence of a documented resident assessment for the use of bed rails.

Record review of the "Bed Entrapment Worksheet" revealed it was completed December 4, 2014 by the Maintenance Supervisor and the RAI Coordinator. All bed systems were evaluated, however the RAI Coordinator confirmed the home has not completed a bed assessment for any resident using bed rails and confirmed there is no formal assessment in PointClickCare to assess a resident where bed rails are used. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #5: 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, furnishings and equipment are maintained in a good state of repair.

During the initial tour of the home on March 30, 2015 the following were observed:
- Multiple corner guards on hallway door frames were loose, cracked or missing
- Multiple door frames had missing paint bare to the metal with rust spots
- Baseboard heating units in hallways had chipped paint, or were rusty and damaged
- Dining room had wall damage by entry way; and, wall and plexiglass near kitchen door was soiled with food and liquid spills
- Wall in shower room was plastered but unpainted
- Activity room wall had damage and chipped paint

Observation of multiple resident rooms and bathrooms on March 31 and April 1, 2015 revealed one or more of the following:
- Bedroom and bathroom walls had missing and/or loose baseboards
- Multiple resident rooms had wall damage behind resident beds and/or scraped, damaged walls with peeling paint and gouges
- Wallpaper loose and/or bubbling above bedroom windows
- Multiple baseboard heaters were scraped and/or paint peeling
- Floor mats were observed to be soiled
- Multiple bathroom door frames were scraped
- Rust coloured stains noted around base of toilets, in sink and around drain holes
- Missing bolt cap covers on toilet base
- Six holes observed on a bedroom wall at side of bed

Record review of the Resident Council Meeting Minutes of November 25, 2014 revealed a concern related to touch up painting in the resident rooms. Follow up response to Resident Council revealed a schedule was to be developed and implemented in the New Year.

Interview with the Program Manager on April 7, 2015 confirmed that there are several areas of disrepair in resident rooms, bathrooms and hallways that need to be addressed. The Program Manager confirmed that no resident room audits for room repairs were being completed and confirmed it is the expectation that the home is maintained in a good state of repair. [s. 15. (2) (c)]

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 home, furnishings and equipment are maintained in a good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

Observation of two residents revealed the residents had a restraint in use.

Review of the residents' plan of care revealed the absence of documentation related to the use of a restraint. There was no physician order, monitoring or consent for the use of the restraint for these residents.

Staff interview with a Registered Nurse revealed that both residents do not use a restraint. [s. 30. (1) 3.]

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 resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that with the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident’s plan of care only if all of the following are satisfied: the use of the PASD has been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations and the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Record review of the "Personal Assistance Service Devices Policy # RESI-10-01-06" revealed, "Use of a PASD must be approved and this approval documented in the residents clinical record. Informed consent for the use of the PASD must be obtained from the resident or the POA/SDM."

Observation of one resident revealed the resident had a PASD in use.

Record review of current care plan for this resident revealed the use of a PASD.

Record review of the Physician's Orders in PointClickCare revealed the resident did not have an order/approval for the use of the PASD.

Record review of the resident's hard copy chart demonstrated that under the "Consents" section there was no written consent for the use of the PASD. [s. 33. (4)]

2. Observation of one resident revealed the use of a PASD.

Review of the current care plan for this resident revealed the the use of a PASD.

Review of the Physician Orders revealed no documented evidence of order/approval for the use of the PASD.

Interview with the RAI Coordinator confirmed that the home does not obtain order/approval for any resident that utilizes a PASD. [s. 33. (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 with the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: the use of the PASD has been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations and the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #8: 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who is a member of the staff of the home.

Record review of the "EO Weekly Wound Care Records" in PointClickCare revealed one resident had multiple areas of altered skin integrity.

Record review of the "EO Nutrition - Referral to Registered Dietitian v.4" revealed referrals were not completed for each incident of altered skin integrity. Staff interview with the RAI-C revealed the "Dietary and Nutritional Care Operational Review" completed February 5-6, 2015 outlined referrals were not routinely made to the dietitian for all skin issues including skin tears, worsening ulcers and healed ulcers.

The RAI Coordinator confirmed it is the responsibility of the registered nursing staff to complete a "EO Nutrition - Referral to Registered Dietitian v.4" for any resident exhibiting altered skin integrity. [s. 50. (2) (b) (iii)]

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

Record review of the "EO Weekly Wound Care Records" for one resident revealed missing weekly documentation for multiple areas of altered skin integrity.

Interview with the RAI Coordinator confirmed it is the home's expectation that any resident exhibiting altered skin integrity needs to be reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds be assessed by a registered dietitian who is a member of the staff of the home and to 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, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Interview on April 8, 2015 at 0930 hours with the Program Manager and Office Manager were unable to produce a written document of the annual evaluation of the staffing plan.

Interview on April 8, 2015 at 1100 hours with the Administrator confirmed that the home does not have an annual evaluation of the staffing plan. [s. 31. (3)]

Issued on this 20th day of April, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE NORTHEY (563), INA REYNOLDS (524), NANCY JOHNSON (538)
Inspection No. / No de l'inspection :	2015_303563_0014
Log No. / Registre no:	L-002092-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 10, 2015
Licensee / Titulaire de permis :	EXTENDICARE SOUTHWESTERN ONTARIO INC 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE PORT STANLEY 4551 EAST ROAD, PORT STANLEY, ON, N5L-1J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anne Wouters

To EXTENDICARE SOUTHWESTERN ONTARIO INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee must achieve compliance to ensure 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:

- falls prevention and management,
- skin and wound care,
- continence care and bowel management,
- pain management, including pain recognition of specific and non-specific signs of pain,
- for staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices,
- for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs, as well as
- Mental health issues, including caring for persons with dementia and
- behaviour management

Grounds / Motifs :

1. 1. The licensee failed to ensure 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:

- falls prevention and management,
- skin and wound care,
- continence care and bowel management,
- pain management, including pain recognition of specific and non-specific signs of pain,
- for staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices,
- for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs, as well as
- Mental health issues, including caring for persons with dementia and
- behaviour management

Record review of the "General Orientation" Agenda revealed it does not include education related to: skin and wound care, fall prevention and management, continence care and bowel management, pain management, application of physical devices and monitoring of residents restrained by physical devices / PASDs, dementia care, and behaviour management.

Record review of the "Skin Care Audit" education received September 11, 2014 revealed only some registered staff attended. Record review of the "Wound Care, How to Complete a Wound Assessment" education received on January 6, 2015 revealed only three registered nursing staff attended.

Record review of the "Worksheet for Tracking Staff Completion of Mandatory Training" on April 7, 2015 revealed some registered staff attended incontinence education on April 10, 2014, but no Personal Support Workers received this same training in continence care.

Record review of the "Worksheet for Tracking Staff Completion of Mandatory Training" on April 7, 2015 revealed all staff who provide direct care to residents did not receive training related to "Delirium, Dementia, Depression", "Pain", "Wound Care", or "Incontinence Care." The worksheet and orientation agenda

was absent of any training for fall prevention and management, and application of physical devices and monitoring of residents restrained by physical devices / PASDs.

Staff interview with the Resident Assessment Instrument (RAI) Coordinator on April 8, 2015 confirmed there is no documented evidence that direct care staff received education in skin and wound care, fall prevention and management, continence care and bowel management, pain management, application of physical devices and monitoring of residents restrained by physical devices / PASDs, dementia care, and behaviour management. The RAI Coordinator confirmed the home did not meet the education requirements for 2014. [s. 221. (1)] (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2015

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 10th day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

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

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