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) :	LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2012_104196_0033
Log No. / Registre no:	S-000901-12,S-001003-12
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 25, 2013
Licensee / Titulaire de permis :	F. J. DAVEY HOME 733 Third Line East, Box 9600, Sault Ste Marie, ON, P6A-7C1
LTC Home / Foyer de SLD :	F. J. DAVEY HOME 733 Third Line East, Sault Ste Marie, ON, P6A-7C1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER J. MACLEAN

To F. J. DAVEY HOME, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 001

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

Linked to Existing Order /
Lien vers ordre existant: 2012_099188_0027, CO #007;
2012_099188_0015, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to resident #002 as specified in the plan.

Grounds / Motifs :

1. Resident #002 's care plan was reviewed by the inspector and included the intervention of "Trunk Restraint on wheelchair: Rear fastened table top for safety. Off at mealtimes and with supervised activity". Inspector observed resident #002, sitting in the dining room on a particular day, having the lunch meal in a wheelchair with a table top in place with rear closing seat belt. The restraint was not removed during the mealtime as specified in the care plan. (196)

2. Resident #002 had a physician's order for topical treatment cream to be applied twice daily and to "Elevate feet at bedtime". The treatment administration record (TAR) was reviewed and in the month of September 2012, the topical treatment cream was not documented as applied twenty-five out of sixty times, and the resident's feet were not documented as elevated at bedtime, ten out of thirty times. The TAR was reviewed from the month of October 2012, and there were no staff initials in that month to indicate that the topical treatment cream had been applied and the resident's feet were not documented as elevated at bedtime twenty-seven out of thirty-one days. Resident #002 has not been receiving the care as included in their plan of care, specifically the twice daily application of topical treatment cream and the elevation of their feet at bedtime.

Eleven previous written notifications of non-compliance under LTCHA s.6 have been issued. Including one voluntary plan of correction (VPC) issued in October 2011 during inspection #2011_099188_0023 and three compliance orders (CO) issued in December 2011 during inspection #2011_099188_0034, in February 2012 during inspection #2012_099188_0005 and in April 2012 during inspection #2012_099188_0015. A compliance order (CO) was issued in July 2012 during inspection #2012_099188_0027. A Director's Referral (DR) followed.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007,S.O.2007, **c.** 8, s. 6 (7).] (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 17, 2013

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 : 002

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 ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, specifically resident #001.

Grounds / Motifs :

1. In May 2012, resident #001 was admitted to the home and according to the twenty-four hour plan of care, had a medical condition that resulted in paralysis of one side of the body. In addition, the plan of care identified the resident as having total dependence on others for the activities of daily living. The day after admission, a "head to toe skin assessment" was completed and did not identify any areas of skin breakdown on the resident's coccyx/buttock or on the heels. The "Waterlow score assessment" completed thirteen days post admission, identified the resident as high risk for altered skin integrity. The health care record for resident #001 was reviewed and it identified that within two weeks of admission to the home, the resident had developed a stage 2 ulcer on the coccyx/buttock area and a care plan was initiated. Within seven weeks of admission, another care plan was initiated for a second stage 2 pressure ulcer, located on the right heel. The twenty-four hour plan of care did not include interventions to prevent the development of skin breakdown despite resident #001 being identified as high risk for altered skin integrity.

A written notification (WN) and voluntary plan of correction (VPC) under r. 50 was issued during inspection #2012_099188_0027 in July 2012.

The licensee failed to ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, [O.Reg.79/10,s.50.(2)(B)(ii).] (196)

2. During the inspection, resident #001 was observed sitting in a wheelchair in the common TV room, reclined at approximately 45 degrees. Observations were made at various times throughout an afternoon and the resident's position in the wheelchair had remained unchanged. The resident's care plan identified that the resident's medical condition required staff to reposition them every two hours, when in bed and when in the wheelchair. Resident #001 was dependent on staff for repositioning and on a particular day, was not repositioned every

two hours, as observed by the inspector.

The licensee failed to 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)(d).] (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 17, 2013

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant: 2012_099188_0027, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee shall ensure that all requirements are met with respect to the restraining of a resident by a physical device under section 31 of the Act.

Specifically the licensee shall,

- Ensure that when any resident, specifically resident #002, is restrained by a physical device, staff shall apply the device in accordance with any instructions specified by the physician or registered nursing in the extended class.

- Ensure that when any resident, specifically resident #002, is restrained by a physical device, the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Grounds / Motifs :

1. The health care record for resident # 002 contained a physician's order for a "reverse seatbelt: off at mealtimes and supervised activities". The care plan was reviewed and included the intervention of "Trunk Restraint on wheelchair: Rear fastened table top for safety. Off at mealtimes and with supervised activity". The inspector observed the resident during the inspection, sitting in the dining room having the lunch meal in their wheelchair with a table top in place with rear closing seat belt. The restraint was not removed during the mealtime as specified in the physician's orders.

Two previous written notifications (WN) of non-compliance under O.Reg. s.110 have been issued. Compliance order (CO) was issued in February 2012 during inspection #2012_099188_0005 and a compliance order (CO) was issued in July 2012 during inspection #2012_099188_0027.

The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. [O.Reg.79.10,s.110 (2)2.] (196)

2. Resident #002 was observed during the course of inspection, to have a table top with rear closing seat belt in place while up in their wheelchair. Inspector reviewed the "Physical Restraint Monitoring Record" for the month of October 2012 and noted the section for the registered nursing staff initials to identify assessment of the resident was blank, on twenty-three out of thirty days. The registered nursing staff had not reassessed the resident's condition and the effectiveness of the restraining as is required every eight hours.

The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 1. 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. [O. Reg. 79/10, s. 110 (2)(6).] (196)

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 : May 17, 2013

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 : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that drugs are administered to resident #002, #005, #006 and all other residents that this may apply, in accordance with directions for use specified by the prescriber.

The licensee shall prepare, submit and implement a plan for achieving compliance with the requirement that ensures that drugs are administered to resident #002, #005, #006 and all other residents that this may apply, in accordance with directions for use specified by the prescriber.

This plan is to be submitted in writing by May 10, 2013 to LTC Homes Inspector Lauren Tenhunen, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 402, Sudbury, Ontario P3E 6A5 or by fax to 1-705-564-3133. This plan shall be fully implemented and complied with by May 17, 2013.

Grounds / Motifs :

1. Resident #002 had a physician's order for topical treatment cream to be applied twice daily and to "Elevate feet at bedtime". The treatment administration record (TAR) was reviewed and in the month of September 2012, and the topical treatment cream was not documented as applied twenty-five out of sixty times, and the resident's feet were not documented as elevated at bedtime, ten out of thirty times. The TAR was reviewed from the month of October 2012, and there were no staff initials in that month to indicate that the topical treatment cream had been applied and the resident's feet were not documented as elevated at bedtime twenty-seven out of thirty-one days.

2. Resident #005 had a physician's order for a topical treatment cream to be applied twice daily. The treatment administration record (TAR) for the month of October 2012 was reviewed and it was recorded as applied once out of sixty-two times.

3. Resident #006 had a physician's order for a topical treatment cream to be applied twice daily. The TAR sheets for the month of October 2012 was reviewed and the topical treatment cream is included, but was not recorded as having been applied during the month.

4. An interview was conducted with staff member #101 on Nov. 1, 2012 and it was reported that they would apply topical treatment creams as on the TAR sheet in the flowsheet binder and if they are in the cream bucket and stated "I don't always sign for the cream I apply".

A written notification (WN) and a voluntary plan of correction (VPC) were issued for r. 131 during inspection #2012_099188_0005 in February 2012.

The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [O. Reg. 79/10, s. 131 (2).] (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 17, 2013

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 25th day of April, 2013

Signature of Inspector /
Signature de l'inspecteur : Lauren Tenhunen #196.

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 25, 2013	2012_104196_0033	S-000901-12,S-001003-12	Complaint

Licensee/Titulaire de permis

F. J. DAVEY HOME
733 Third Line East, Box 9600, Sault Ste Marie, ON, P6A-7C1

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

F. J. DAVEY HOME
733 Third Line East, Sault Ste Marie, ON, P6A-7C1

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

LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): October 31, November 1, 2, 3, 2012

Ministry of Health and Long-Term Care (MOHLTC) Log #'s

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Unit Managers, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and family members

During the course of the inspection, the inspector(s) conducted a tour of all resident care areas, observed the provision of care and services to residents by staff members, reviewed the health care records of several residents, reviewed various home policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Reporting and Complaints

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. Resident #002 had a physician's order for topical treatment cream to be applied twice daily and to "Elevate feet at bedtime". The treatment administration record (TAR) was reviewed and during the month of September 2012, the topical treatment cream was not documented as applied twenty-five out of sixty times, and the resident's feet were not documented as elevated at bedtime, ten out of thirty times. The TAR was reviewed for the month of October 2012, and there were no staff initials in that month to indicate that the topical treatment cream had been applied and the resident's feet were not documented as elevated at bedtime, twenty-seven out of thirty -one days. Resident #002 has not been receiving the care as specified in their plan of care, specifically the twice daily application of the topical treatment cream and the elevation of their feet at bedtime.

Resident #002's care plan was reviewed by the inspector and included the intervention of "Trunk Restraint on wheelchair: Rear fastened table top for safety. Off at mealtimes and with supervised activity". Resident #002 was observed on a particular day, sitting in the dining room having the lunch meal in a wheelchair with a table top in place with a rear closing seat belt. The restraint, a rear closing seat belt with table top, was not removed during the mealtime, as specified in the plan of care.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

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 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. In May 2012, resident #001 was admitted to the home and according to the twenty-four hour plan of care, had a medical condition that resulted in paralysis of one side of the body. In addition, the plan of care identified the resident as having total dependence on others for the activities of daily living. The day after admission, a "head to toe skin assessment" was completed and did not identify any areas of skin breakdown on the resident's coccyx/buttock or on the heels. The "Waterlow score assessment" completed thirteen days post admission, identified the resident as high risk for altered skin integrity. The health care record for resident #001 was reviewed and it identified that within two weeks of admission to the home, the resident had developed a stage 2 ulcer on the coccyx/buttock area and a care plan was initiated. Within seven weeks of admission, another care plan was initiated for a second stage 2 pressure ulcer, located on the right heel. The twenty-four hour plan of care did not include interventions to prevent the development of skin breakdown despite resident #001 being identified as high risk for altered skin integrity.

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

2. During the inspection, resident #001 was observed sitting in a wheelchair in the common TV room, reclined at approximately 45 degrees. Observations were made at various times throughout an afternoon and the resident's position in the wheelchair had remained unchanged. The resident's care plan identified that the resident's medical condition required staff to reposition them every two hours, when in bed and when in the wheelchair. Resident #001 was dependent on staff for repositioning and on a particular day was not repositioned every two hours, as observed by the inspector.

The licensee failed to 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. [s. 50. (2) (d)]

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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. Resident #002 had a physician's order for a "reverse seatbelt: off at mealtimes and supervised activities". The care plan was reviewed and included the intervention of "Trunk Restraint on wheelchair: Rear fastened table top for safety. Off at mealtimes and with supervised activity". The inspector observed resident #002 on a particular day during the inspection, sitting in the dining room having the lunch meal in their wheelchair with a table top in place with rear closing seat belt. The restraint, rear closing seat belt with table top, was not removed during the mealtime as specified in the physician's orders.

The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. [s. 110. (2) 2.]

2. Resident #002 was observed during the course of inspection, to have a table top with rear closing seat belt in place while up in their wheelchair. Inspector reviewed the "Physical Restraint Monitoring Record" for the month of October 2012 and noted the section for the registered nursing staff to initial, identifying assessment of resident #002, was missing on twenty-three out of thirty days. The registered nursing staff had not reassessed the resident's condition and the effectiveness of the restraining as is required every eight hours.

The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 1. 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. [s. 110. (2) 6.]

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. 131. Administration of drugs

Specifically failed to comply with the following:

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

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. Resident #002 had a physician's order for topical treatment cream to be applied twice daily and to "Elevate feet at bedtime". The treatment administration record (TAR) was reviewed and in the month of September 2012, the topical treatment cream was not documented as applied twenty-five out of sixty times, and the resident's feet were not documented as elevated at bedtime, ten out of thirty times. The TAR was reviewed from the month of October 2012, and there were no staff initials in that month to indicate that the topical treatment cream had been applied and the resident's feet were not documented as elevated at bedtime twenty-seven out of thirty-one days.

Resident #005 had a physician's order for a topical treatment cream to be applied twice daily. The treatment administration record (TAR) for the month of October 2012 was reviewed and it was recorded as applied once out of sixty-two times.

Resident #006 had a physician's order for a topical treatment cream to be applied twice daily. The TAR sheets for the month of October 2012 was reviewed and the topical treatment cream is included, but was not documented as having been applied during the month.

An interview was conducted with PSW #101 on Nov. 1, 2012, and it was reported that they would apply topical treatment creams as noted on the TAR sheets in the flow sheet binder and if they are in the cream bucket and stated "I don't always sign for the cream I apply".

Resident #002, #005 and #006 had drugs ordered for application and they were not administered as specified by the physician.

The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

2. Resident #002, #005 and #006 had physician's orders for the application of topical treatment creams, as listed in the previous finding.

The treatment creams for resident #002, #005, #006 were identified on the TAR sheets as treatment that was to be provided by the PSW's. Upon review by the inspector, there were numerous times the topical treatment creams were scheduled to be administered, but were not documented as administered.

An interview was conducted with PSW #101 on Nov. 1, 2012 and it was reported that they would apply topical treatment creams as noted on the TAR sheet in the flow sheet binder and if they are in the cream bucket and stated "I don't always sign for the cream I apply".

An interview was conducted with registered staff member #100 on Nov. 1, 2012 and it was reported that the PSW's don't often sign that they have applied the topical medication for the resident although they have a copy of the TAR sheet with the treatment cream listed and it is noted for the PSW to apply.

Registered nursing staff have not supervised the administration of topical medication by the PSW staff members.

The licensee failed to ensure that a member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if, (c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. [s. 131. (4) (c)]

Additional Required Actions:

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

Issued on this 2nd day of May, 2013

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

Lauren Lenhuren #96.