Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de sions 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
May 23, 2017	2017_544527_0003	003274-17	Resident Quality Inspection

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH BRAMPTON ON L6Y 5A7

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

FAITH MANOR NURSING HOME
7900 MCLAUGHLIN ROAD SOUTH BRAMPTON ON L6Y 5A7

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

KATHLEEN MILLAR (527), CATHIE ROBITAILLE (536), THERESA MCMILLAN (526)

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): February 8, 9, 10, 13, 14, 15, 16 17, 21, 22, 23, 24, 27, 28 and March 1, 2, 3, 8, 9, 14, 2017.

The following critical incidents, complaints and follow-up to Orders were inspected concurrently with the Resident Quality Inspection (RQI). They included:

Critical Incidents:
Log #019581-16 related to a fall,

Log #027873-16 related to an injury of unknown origin;
Log #033960-16 related to alleged staff to resident neglect;
Log #034150-16 related to an injury of unknown cause;
Log #035456-16 related to a fall;
Log #002516-17 related to a fall; and
Log #005211-17 related to an injury of unknown cause.

Complaints:
Log #020042-16 related to continence and personal care;
Log #030132-16 related to personal care and alleged financial abuse;
Log #031504-16 related continence care; and
Log #000647-17 related to alleged sexual abuse.

FOLLOW-UP ORDERS:
Log #025390-16 - Order #001 related to care not being provided as specified in the plan;
Log #025391-16 - Order #002 related to the Licensee not protecting residents from abuse and neglect;
Log #025397-16 - Order #006 related to compliance with the home's policies and procedures;
Log #025400-16 - Order #008 related to safe transferring and positioning;
Log #025403-16 - Order #009 related to falls prevention and management;
Log #025404-16 - Order #010 related to skin and wound care;
Log #025405-16 - Order #011 related to related to continence care;
Log #025406-16 - Order #012 related to pain management; and
Log #025409-16 - Order #014 related to privacy when providing care and treatment to residents.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Administrator, the Director of Resident Care (DRC), Assistant Director of Resident Care (ARDC), Resident Assessment Inventory (RAI) Coordinator, Behavioural Support (BSO) Nurse, Health and Safety/Education Coordinator, Housekeeping Manager, Laundry Manager, Maintenance Manager, Dietary Manager, Activation Manager, Social Service Worker, Physiotherapist (PT), Physiotherapy Assistants (PTA's), Occupational Therapist (OT), Registered Nurses (RN's), Registered Practical Nurses (RPN's), Personal Support Workers (PSW's), Registered Dietitian (RD), dietary aides, housekeeping and maintenance staff, staffing clerk, residents, family members and visitors.

During the course of this inspection, inspectors toured the home; observed residents, staff, and dining service; reviewed health records, policies and procedures, training files, meeting minutes, evaluation files, complaints logs, maintenance and housekeeping logs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **2 VPC(s)**
- **3 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
LTCHA, 2007 s. 19. (1)	CO #002	2016_265526_0010	527
LTCHA, 2007 s. 3. (1)	CO #014	2016_265526_0010	526
O.Reg 79/10 s. 36.	CO #008	2016_265526_0010	527
O.Reg 79/10 s. 49. (2)	CO #009	2016_265526_0010	526
O.Reg 79/10 s. 51. (2)	CO #011	2016_265526_0010	527
O.Reg 79/10 s. 52. (2)	CO #012	2016_265526_0010	536
LTCHA, 2007 s. 6. (7)	CO #001	2016_265526_0010	527
O.Reg 79/10 s. 8. (1)	CO #006	2016_265526_0010	536

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).

Findings/Faits saillants :

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).

The home was issued orders related to training of direct care providers in the 2016 Resident Quality Inspection (RQI), Inspection number 2016_265526_0010 related to Continence Care, Falls Prevention, Pain Management and Skin and Wound Care.

The home's training records were reviewed and the following were the results of the home's training:

Continence Care - 70 percent (%) of direct care staff were trained in 2016;
Falls Preventions - 68% of direct care staff were trained in 2016;
Pain Management - 67% of direct care staff were trained in 2016; and
Skin and Wound Care - 59% of direct care staff were trained in 2016.

The Administrator, the DRC and the Human Resources Manager were interviewed and confirmed that they had not achieved 100% of the training of direct care providers for the above programs in 2016. The Administrator explained that they were hired full time at the end of November 2016 and the home had since developed and implemented a comprehensive educational plan to ensure the home was compliant with the training requirements of direct care staff upon hire and annually for the identified programs.

The home did not provide training to the staff who provide direct care to residents related to falls prevention and management, skin and wound care, continence care and bowel management, and pain management, including pain recognition of specific and non-specific signs of pain.

Additional Required Actions:

CO # - 002 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. 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A) On a specific date in March 2017, PSW #143 had conducted a PSW head to toe assessment at the time of resident #055's shower. The PSW identified the resident had altered skin integrity. PSW #143 notified RPN #144 who conducted a head to toe assessment, notified the physician and notified the resident's substitute decision maker (SDM). The physician ordered a diagnostic test, which revealed an injury. On a specific date in March 2017, and after the injury was diagnosed the physician ordered the treatment and monitoring for registered staff to perform.
When the resident was observed by the LTCH Inspector #527 on specific dates and

times in March, the resident did not have the treatment performed as ordered by the physician.
RPN #140 was interviewed and indicated that they had been off work for a month and were not as familiar with the residents. The RPN confirmed that they had not completed the resident's treatment and monitoring during their shift. RPN #140 confirmed that they did not know if the resident's care was provided as ordered by the physician during their shift as they did not monitor the injury.
Interview with the DOC confirmed that RPN #140 should have been monitoring the resident's injury throughout their shift and if they would have checked in the morning, then they would have known the treatment was not provided as ordered by the physician. The DOC confirmed that the resident could have been further harmed because their treatment and monitoring was not provided.
The home did not provide care as specified in the plan. (527)

B) Resident #041 was at risk for falls. They required extensive assistance from one staff for transferring and ambulation. The home’s Behaviour Support Ontario (BSO) RPN stated that the resident was non-compliant when using a wheelchair for ambulation, and had been able to ambulate independently but not safely.

According to the progress notes, resident #041 fell on specific dates in November 2016, after which time they began complaining that they had pain. They fell again several days later and they continued to complain of pain and were assessed by the home’s Nurse Practitioner (NP) on a specific date in November 2016. A diagnostic test was ordered and a physician ordered an increase in the resident's medication. The resident continued to fall and fell several more times on specific dates in November 2016. Progress notes indicated that they complained of pain on a number of occasions over an eight day period in November 2016, and received regularly scheduled medication with some effect. According to the progress notes and investigative notes, the resident was subsequently transferred to the hospital on a specific date in November 2016, based on the family request since the resident continued to have pain and the diagnostic test had not been completed. The resident was diagnosed with an injury. They returned to the home and had a prescription for medication for pain management.
During interview, the home’s RAI Coordinator, DRC and Administrator stated that the diagnostic test should have been completed within 48 hours of the NP's order or according to the resident’s needs to determine the underlying cause of the resident’s pain. They confirmed that resident #041’s plan of care had not been followed when they did not have the diagnostic test completed until later in November 2016, when the resident was sent to hospital on the family’s request.

2. The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) According to the progress notes, resident #041 fell on specific dates in November 2016, after which time they began complaining that they had pain. They fell again several days later and they continued to complain of pain and were assessed by the home's Nurse Practitioner (NP) on a specific date in November 2016. They were assessed by the home's NP on a specific date in November 2016, who prescribed an increase in medication and a diagnostic test. The resident was diagnosed with an injury.
During interview, RPN #103 and the home's NP stated that when resident #041 had new and unresolved pain after their fall on a specific date in November 2016, the resident should have been reassessed by the physician or NP sooner than three days later.

B) Resident #043 was identified on a specific date in December 2016, as having altered skin integrity and was experiencing pain.
RPN #108 was interviewed and indicated that they assessed the resident on the same day in December 2016, and were unsure whether it was an old injury or a new injury. RPN #108 stated "I couldn't figure it out, so I put it in the doctor's communication book to assess the resident the next day."
The clinical record was reviewed and there was no indication that any effort was made to contact the physician or NP on the specific date in December 2016. The physician attended the home the following day in December 2016, and assessed the resident. The resident was subsequently transferred to the hospital for a diagnostic test and further assessment, which identified the resident had an injury.
The DRC was interviewed and confirmed that RPN #108 should have contacted the on-call physician and/or the NP of the resident's change in condition on the specific date in December 2016, when they identified the altered skin integrity and the resident was experiencing pain to ensure the resident was assessed and treated in a timely fashion.

3. The licensee failed to ensure that different approaches had been considered in the revision of the plan of care, if a resident was reassessed and the plan of care was revised because care set out in the plan had not been effective.

A) Resident #041 was at risk for falls. They required extensive assistance from one staff for transferring and ambulation. The home's Behaviour Support Ontario (BSO) RPN stated that the resident was non-compliant when using a wheelchair for ambulation, and

could ambulate independently but not safely.
The written plan of care dated November 2016, was reviewed and included falls prevention strategies.
According to the progress notes, resident #041 fell a number of times in November and in December 2016. They began complaining of pain after a fall early in November 2016. The resident was assessed by the home's Nurse Practitioner on a specific date in November 2016, and a diagnostic test was ordered. The plan of care was updated several days later to include specific directions for the use of a front releasing lap belt. Progress notes indicated that the resident would release the lap belt and ambulate, or would stand up with the lap belt fastened.
The BSO RPN confirmed that the lap belt acted as a trigger to the resident's behaviours. The resident was diagnosed with an injury later in November 2016, after being assessed and an diagnostic test was performed at the hospital.
After the resident's fall in December 2016, their family member complained to the home that the resident was having multiple falls and the care provided was not effective or adequate. On a specific date in December 2016, the lap belt was to be fastened in a specified manner according to family request. In addition, the resident's pain and behaviour management plan of care was reviewed and updated.
The use of a specified device was initiated later in December 2016. The resident's care was reviewed in the first week of January 2017, and updated to include toileting prior to bedtime.
During interview the Resident Assessment Inventory (RAI) Coordinator who was also the home's Falls Prevention Program lead, stated that a specified device had not been tried prior to the use of a lap belt. They also stated that another specified device had not been utilized as a different strategy to prevent falls from bed, and that neither of these interventions were considered by staff. During interview the Director of Resident Care (DRC) stated that the specified devices were part of the home's falls prevention program and confirmed that these different approaches had not been considered in the revision of the plan of care to prevent resident #041's falls.

B) (i) Resident #042 had a history of falls. Prior to their fall on a specific date in January 2017, the resident exhibited responsive behaviours. The home's Behaviour Support Ontario (BSO) RPN stated, that the resident used a device for ambulation, and could ambulate independently with the device however, would often not use the device.
The written plan of care dated November 2016, included falls prevention strategies. Behaviour management strategies were also outlined.
According to the progress notes, resident #042 fell (multiple times) between July 2016, and January 2017. On a specific date in January 2017, resident #042 was transferred to

hospital after complaining of pain. Resident #042 was diagnosed with an injury.
During interview the Restorative Care Nurse #127, confirmed that a specified device had not been utilized as a different strategy to prevent falls, stating that prior to their fall that interventions had not been considered by staff. During interview, the Director of Resident Care (DRC) stated that the specified devices were part of the home's falls prevention program and confirmed that these different approaches had not been considered in the revision of the plan of care to prevent resident #042's falls.

(ii) Resident #050 was at high risk for falls. Prior to their fall on a specific date in June 2016, the resident would attempt to get out of bed unassisted. The care plan for resident #050 dated April 2016, stated the resident required assistance for transferring from one position to another, included fall prevention strategies and behaviour management strategies.
According to the progress notes, resident #050 fell a number of times between December 2014 and May 2016. Several of the falls occurred in the resident's room and one occurred while walking in their room. According to the progress notes on a specific date in June 2016, resident #050 was in bed and stated that they had pain. When examined the resident the resident had signs and symptoms of an injury. Resident #050 was sent to the hospital and was diagnosed with an injury. According to the investigation notes, on a specific date in June 2016, the resident was a full mechanical lift and would have been unable to transfer and get themselves back into bed had they fallen out of bed.
During interview, the Restorative Care Nurse #127, confirmed that a device had not been utilized as a different strategy to prevent falls from bed, stating that prior to their fall that interventions had not been considered by staff. During interview the Director of Resident Care (DRC) stated that identified devices were part of the home's falls prevention program and confirmed that these different approaches had not been considered in the revision of the plan of care to prevent resident #050's falls. (536)

Additional Required Actions:

CO # - 003 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) According to their health record, resident #031 was at risk for altered skin integrity. During the month of October 2016, the progress notes indicated that they had developed areas of altered skin integrity.
Review of the clinical records indicated that, when resident #031 developed areas of altered skin integrity, they had not received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.
During interview on a specific date in February 2017, Registered Nurse (RN) #103 stated that they would use a Weekly Assessment Summary for Skin/Wound instrument if they assessed a newly developed area of altered skin integrity. They confirmed that resident #031's areas of altered skin integrity had not been initially assessed using an instrument specifically designed for skin and wound assessment. During interview, the Director of Care (DOC) confirmed the home's expectation that both new and reoccurring wounds should be assessed initially using the home's Point Click Care (PCC) assessment documentation tab. They confirmed that resident #031's areas of altered skin integrity

had not been initially assessed using an instrument specifically designed for skin and wound assessment according to the home’s policy and legislative requirements.

B) According to their health records, resident #037 returned from hospital in January 2017.
The clinical record was reviewed and the progress notes indicated that they developed altered skin integrity after returning from the hospital. A progress note with a specific date in January 2017, indicated the condition of the altered skin integrity and it was assessed by a physician and treatment was prescribed.
According to the DOC, staff were expected to assess any new alteration of skin integrity using an instrument specifically designed for this purpose, and that was located in the home’s electronic documentation system (Point Click Care) in the assessment tab.
Review of the resident’s clinical record indicated that the resident’s altered skin integrity had not been assessed using an instrument specifically designed for skin and wound assessment according to the home’s expectations when it was first discovered on a specific date in January 2017. This was confirmed by RN #106 and the DOC during interview.

C) Resident #024 was at risk for altered skin integrity and had a history of responsive behaviours that were not easily altered. The resident required assistance from one staff person for dressing and hygiene.
Review of progress notes indicated that on a specific date in January 2017, Personal Support Worker (PSW) #116 notified Registered Practical Nurse (RPN) #135 that resident #024 had altered skin integrity. The RPN provided treatment and dressing to the area.
According to the DOC, staff were expected to assess any new alteration of skin integrity using an instrument specifically designed for this purpose, and that was located in the home’s electronic documentation system (Point Click Care) in the assessment tab.
Review of the home's clinical record indicated that resident #024's altered skin integrity in January 2017, had not been assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. During interview the Assistant Director of Resident Care (ADRC) confirmed this.

2. The licensee failed to ensure that the resident who exhibited 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.

A) According to their clinical record, resident #031 had developed areas of altered skin

integrity that required treatment between October 2016 and February 2017.
The home's Wound Care policy number NUR-01-102 that was in effect during this time required that registered staff conduct weekly skin assessments using the home's Point Click Care (PCC) assessment documentation system. The DOC confirmed this. During interview, RN #104 stated that staff would also enter assessments into the progress notes without using the assessment tab. Review of the clinical record indicated that weekly assessments using either the PCC assessment tab or progress notes had not been completed for the altered skin integrity.
During an interview on a specific date in February 2017, RN #103 confirmed that weekly reassessment of resident #031's altered skin integrity had not been completed weekly as noted above when they should have, according to the home's policy. During an interview, the DOC confirmed that staff had not reassessed resident #031's areas of altered skin integrity weekly according to the home's policy and legislative requirements.

B) Resident #036 was identified by PSW staff #107 and RN #104 as being at risk for injury due to their medical condition. On a specific date in January 2017, the resident was assessed as having areas of altered skin integrity.
Review of the clinical records indicated that the areas of altered skin integrity had not been reassessed weekly between a specific date in January and February 2017. During one of the resident's reassessments on a specific date in January 2017, the resident was found to have had an injury. The altered skin integrity to that area was not reassessed weekly between January and February 2017.
During interview, the DOC confirmed that resident #036's altered skin integrity had not been reassessed weekly when indicated.

C) According to their clinical records, resident #037 returned from hospital on a specific date in January 2017.

i) Review of their clinical record indicated that their new area of altered skin integrity had not been reassessed weekly between beginning of January to a specific date in February 2017. This was confirmed on interview with RN #106 and the DOC.

ii) Progress notes indicated that they developed another area of altered skin integrity when they returned from the hospital on a specific date in January 2017. The resident's altered skin integrity was assessed by a physician on a specific date in January 2017, and prescribed a treatment. Review of their clinical record indicated that weekly wound assessments had not been completed for this area of altered skin integrity between January and February 2017. This was confirmed on interview with RN #106 and the

DOC.

D) According to clinical records, on a specific date in January 2017, resident #024 had developed new altered skin integrity.
Review of the clinical records indicated that the new area had not been assessed weekly between January and February 2017. During interview, the Assistant Director of Resident Care (ADRC) stated that a weekly assessment of this wound was clinically indicated and should have been completed in the assessment tab of the home's electronic documentation system (Point Click Care) and that it had not been completed according to legislative requirements or the home's policy.

E) Resident #055 had altered skin integrity identified by RN #142 on specific dates in January and February 2017.
The head to toe skin assessments that were conducted in January and February 2017 did not have altered skin integrity documented.
RN # 104 was interviewed and was aware of the altered skin integrity.
The home's policy called "Overview of Skin Care ad Wound Management Program", number 30-08-0A, and revised November 2013, directed registered staff to conduct head to toe skin assessments for residents with altered skin integrity on a weekly basis.
A review of the clinical record from January to March 2017, revealed that there was no head to toe skin assessment conducted on specific dates in January and February 2017.

Interview with the DRC and the ADRC who was also the Skin and Wound lead for the home confirmed that the registered staff were expected to conduct weekly skin assessments for residents who had altered skin integrity.
The clinical record confirmed resident #055's altered skin integrity was not reassessed weekly, and there were areas that had worsened.
RN #104 confirmed the weekly skin assessments for resident #055 were not consistently completed.

Additional Required Actions:

CO # - 001 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #036's plan of care was based on an interdisciplinary assessment with respect to their resident's skin condition, altered skin integrity and foot conditions.

According to their Resident Assessment Protocol completed on a specific date in January 2017, it was noted that resident #036 would often ambulate without footwear and that staff should monitor their skin integrity daily. Assessments conducted by the Behavioural Supports Ontario (BSO) RPN on a specific date in February 2017, and then by the Physiotherapist (PT) several days later, they identified that resident #036 was at risk for injury due to their high risk for falls.
Observation of resident #036 on a specific date in February 2017, by LTCH Inspector #526 indicated that they had altered skin integrity. Their skin assessment in January 2017, identified multiple areas of altered skin integrity.
During interviews, RN #104, PSW #107, and the DOC confirmed that the resident was at risk for altered skin integrity due to injury. The resident's written plan of care, last reviewed in January 2017, did not include a care area related to the resident's risk for injury to their skin. Review of their plan of care in February 2016, revealed that it was not based on an interdisciplinary assessment with respect to resident #036's skin condition, and altered skin integrity. The DRC was interviewed and confirmed this.

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 plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 15. Skin condition, including altered skin integrity and foot conditions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, when restraining a resident by a physical device under section 31 or section 36 of the Act, the physical device was applied in accordance with manufacturer's instructions.

The home's "Restraint" policy number EMR-PP-00-01, last revised February 2017, directed staff to "ensure the restraint is applied correctly and safely according to manufacturer's specifications and as comfortable as possible". The manufacturer's instructions provided to the home by the vendor directed staff to "allow just enough space for two fingers to fit between the hip belt and the person's body, at any one point along the belt" and "care staff should observe and report any problems with hip belts".

A) On a specific date in February 2017, Long Term Care Homes (LTCH) Inspector #526 was touring the second floor home area and observed resident #046 sitting upright in their wheelchair with their lap belt noted to be positioned approximately four inches from their torso. The LTCH Inspector #526 asked RPN #103 to assess resident #046's lap belt

application and safety. The RPN reported that the lap belt was too loose and adjusted it to two finger widths from the resident's torso. They confirmed that resident #046's lap belt had not been applied according to manufacturer's instructions, which directed staff to allow just enough space for two fingers to fit between the hip belt and the person's body, at any one point along the belt .

B) On a specific date in February 2017, LTCH Inspector #526 was touring the second floor care area and observed resident #045 seated in a wheelchair that was equipped with a lap belt and that was positioned in front of the nursing station.
During observation, the resident began sliding toward the footrest to the point where the lap belt was positioned at the level of their axilla. RN #104 and PSW #110 saw the resident slipping, they approached the resident while saying, "we see her". The RN released the lap belt, and the RN and PSW lifted the resident so that they were seated in the chair. RN #104 refastened the lap belt.
The LTCH inspector observed that the lap belt was loose at approximately four inches from the resident's torso, and asked RN #104 if they were satisfied with the application of the lap belt.
During interview RN #104 confirmed that the lap belt was loose and should have been applied to two finger widths from the resident's torso. After several attempts, the RN was able to adjust the lap belt so that it was positioned to two finger widths from the resident's torso. The RN stated that the resident, was at risk for slipping down in their wheelchair and was therefore an intervention was implemented. PSW #110 reported to the LTCH Inspector that the resident's lap belt was checked regularly but was loosened, and so staff monitored them closely. Within five minutes of this incident, RN #104, RPN #103, and PSW #110 left the area to attend to other residents.
The Administrator and (Director of Resident Care) DRC were contacted immediately by the LTCH Inspector #526 in relation to the above incident. During interview, the DRC confirmed that staff failed to apply resident #045's lap belt according to manufacturer's instructions since it was positioned greater than two finger widths from the resident's torso. The DRC stated that staff did not ensure that the lap belt was applied correctly. This allowed regularly loosening of the belt and staff should have ensured that it was installed correctly during their regular checks.

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 following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #6: 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 failed to ensure that where the Act or this Regulation required the licensee of a long term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Regulation, s.114 (3) The written policies and protocols must be, (a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
On a specific date in February 2017, the LTCH Inspector #536 was in the second floor medication room reviewing B Wing binder for narcotic administration records. The A Wing narcotic administration binder was in use by an agency RPN #121. The LTCH Inspector #536 asked the agency nurse if they could have the narcotic administration binder when they were finished. While the LTCH Inspector was reviewing the B Wing narcotic administration binder when they observed the agency nurse writing in the narcotic book. The Inspector glanced over the agency nurse's shoulder and observed the nurse dating and signing for their 0800 hour narcotics, approximately three hours later than when they were administered to residents at their breakfast medication pass. When the LTCH Inspector asked the nurse if they were signing for their 0800 hour narcotics that had been given hours earlier, the nurse quickly denied it. When the LTCH Inspector advised the nurse that she had witnessed her dating and signing for the 0800 hour narcotics the agency nurse would not respond despite the questions being asked. During interview, the DRC confirmed that staff were expected to sign the home's "Resident's Individual Narcotic and Controlled Drug Count Sheet" when a controlled substance was administered.

WN #7: The Licensee has failed to comply with LTCHA, 2007, 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 failed to ensure that equipment was kept clean and sanitary.

On a specific date in February 2017, the LTCH Inspector #536 was approached by a family member about the condition of the coffee mugs in use in the residents' dining room. They stated the coffee mugs were stained, scratched and had a white residue inside them for some time.
Several days later in February 2017, the LTCH Inspector #536 went to the dining rooms to observe the green resin coffee mugs that would be used for the lunch meal. The LTCH Inspector observed twenty-four out of thirty mugs had various degrees of stains, had a white residue present and were scratched inside. When the LTCH Inspector scratched the inside of the mugs the white residue came off.
On another date in February 2017, the LTCH Inspector once again went to the dining rooms to observe the green resin coffee mugs that would be used for the breakfast meal. Twenty-five out of thirty-eight mugs had various degrees of stains, had a white residue and were scratched inside.
The Dietary Manager was interviewed and confirmed that they were aware of this problem and that they had been working with their chemical supply company for a long time on resolution of the issue.
On a specific date in February 2017, the Administrator was shown the condition of the coffee mugs and responded that they had just received an email on the condition of the coffee mugs.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must 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. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record relating to program evaluations as required under O. Reg. 30. (1) paragraph 3 for organized programs under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation, included a summary of the changes made and the date that those changes were implemented.

A) A review of the home's annual evaluation of the Nursing Rehabilitation/Restorative Care Program; the Pain Management Program; and the Prevention of Abuse and Neglect Program identified that there was no written record related to the summary of changes made and the date that those changes were implemented for these programs. The DRC and Administrator were interviewed and confirmed that the summary of changes made and dates they were implemented was not included in the written record. The Administrator confirmed that it was the expectation of the home to include the dates of the summary of changes made and implementation dates. (527)

B) Review of the home's 2016 Annual Falls Prevention and Management Program Review conducted in January 2016, indicated that the home's fall rate for 2015-2016 was 25.5% and that the goal of 17% had not been met. Interventions such as the purchase of hi-lo beds, and the designation of the Resident Assessment Inventory (RAI) Coordinator as the program lead were identified, without including a date that this was achieved. Deficiencies of the home's Falls Prevention Program were identified without recommendations or target dates for implementation. During interview with Long Term Care Homes (LTCH) Inspector #527, the Administrator confirmed that the home's program evaluations did not include a summary of changes made or the date that those changes were implemented.

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including interventions are documented.

A review was completed of resident #042's written plan of care, which indicated that resident #042 had a fall in January 2017, resulting in an injury. On a specific date in January 2017, a post fall meeting was held and interventions implemented.
The LTCH Inspector #536 observed the falls prevention strategies being implemented; however the written plan of care did not have the high low bed documented on the resident's care plan. The Resident Assessment Instrument (RAI) Coordinator #124 stated it was their role to update the written plan of care following the post fall meeting, and confirmed the high low bed had not been added.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to inform the Director no later than one business day after the occurrence of the incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

Resident #041 fell on a specific date in November 2016, and began to complain of pain. They fell several more times in November 2016.
Progress notes indicated that they complained of pain over an eight day period in November 2016, and received regularly scheduled medication. They required more supervision, and their ability to participate in activities of daily living was decreased so that they required more assistance. A diagnostic test had been ordered on a specific date in November 2016, and was not completed over five days in November 2016. Due to this, and the resident's pain, their family insisted that they be taken to hospital on a specific date in November 2016. Resident #041 returned to the home that same day with a prescription for medications. Progress notes indicated that a couple of days later, the Director of Resident Care (DRC) notified the resident's family that the resident had sustained an injury.
Review of the home's investigative notes indicated that the home did not have documentation that they had informed the Director that resident #041 had sustained an injury for which they were taken to hospital and that resulted in a significant change in condition.
During interview, the DRC confirmed that they had not complied with critical incident reporting legislative requirements when they failed to inform the Director of resident #041's incident(s) injury, hospitalization and accompanying significant change in condition.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs obtained for use in the home are obtained based on resident usage, and that no more than a three-month supply is in the home at any time.

During inspection of the home's government stock supply, LTCH Inspector #536 observed that there were 36 bottles of Alugel 425 millilitres (ml's) each, 33 bottles of Milk of Magnesia (MOM) 500 ml's each and 45 vials of B12 injectable solution 10 ml's each. During interview, the Assistant Director of Resident Care (ADRC) who was responsible for the ordering of the government supply stock confirmed that there was more than a three month supply of the medications.

Issued on this 22nd day of June, 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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN MILLAR (527), CATHIE ROBITAILLE (536), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2017_544527_0003
Log No. / Registre no:	003274-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 23, 2017
Licensee / Titulaire de permis :	HOLLAND CHRISTIAN HOMES INC 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	FAITH MANOR NURSING HOME 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracy Kamino

To HOLLAND CHRISTIAN HOMES 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)

Linked to Existing Order / Lien vers ordre existant: 2016_265526_0010, CO #010;

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 do the following:

1. A member of the registered nursing staff shall conduct skin assessments on residents who exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

2. A member of the registered nursing staff shall reassess residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, at least weekly, if clinically indicated and according to the home's policy.

Grounds / Motifs :

1. This Order is being issued based on the application of the factors of severity (2), scope (3) and Compliance history of (4) in keeping with r. 229 of the Regulation. This is in respect to the severity of actual and/or potential harm/risk that the identified residents experienced, the scope was widespread and the home's history of noncompliance included the following: Compliance Order issued on May 9, 2016, a VPC and WN on March 5, 2014.

2.The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) According to their health record, resident #031 was at risk for altered skin integrity. During the month of October 2016, the progress notes indicated that they had developed areas of altered skin integrity.
Review of the clinical records indicated that, when resident #031 developed areas of altered skin integrity, they had not received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.
During interview on a specific date in February 2017, Registered Nurse (RN) #103 stated that they would use a Weekly Assessment Summary for Skin/Wound instrument if they assessed a newly developed area of altered skin integrity. They confirmed that resident #031's areas of altered skin integrity had not been initially assessed using an instrument specifically designed for skin and wound assessment. During interview, the Director of Care (DOC) confirmed the

home's expectation that both new and reoccurring wounds should be assessed initially using the home's Point Click Care (PCC) assessment documentation tab. They confirmed that resident #031's areas of altered skin integrity had not been initially assessed using an instrument specifically designed for skin and wound assessment according to the home's policy and legislative requirements.

B) According to their health records, resident #037 returned from hospital in January 2017.
The clinical record was reviewed and the progress notes indicated that they developed altered skin integrity after returning from the hospital. A progress note with a specific date in January 2017, indicated the condition of the altered skin integrity and it was assessed by a physician and treatment was prescribed.
According to the DOC, staff were expected to assess any new alteration of skin integrity using an instrument specifically designed for this purpose, and that was located in the home's electronic documentation system (Point Click Care) in the assessment tab. Review of the resident's clinical record indicated that the resident's altered skin integrity had not been assessed using an instrument specifically designed for skin and wound assessment according to the home's expectations when it was first discovered on a specific date in January 2017. This was confirmed by RN #106 and the DOC during interview.

C) Resident #024 was at risk for altered skin integrity and had a history of responsive behaviours that were not easily altered. The resident required assistance from one staff person for dressing and hygiene.
Review of progress notes indicated that on a specific date in January 2017, Personal Support Worker (PSW) #116 notified Registered Practical Nurse (RPN) #135 that resident #024 had altered skin integrity. The RPN provided treatment and dressing to the area.
According to the DOC, staff were expected to assess any new alteration of skin integrity using an instrument specifically designed for this purpose, and that was located in the home's electronic documentation system (Point Click Care) in the assessment tab. Review of the home's clinical record indicated that resident #024's altered skin integrity in January 2017, had not been assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. During interview the Assistant Director of Resident Care (ADRC) confirmed this.

(526)

2. The licensee failed to ensure that the resident who exhibited 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.

A) According to their clinical record, resident #031 had developed areas of altered skin integrity that required treatment between October 2016 and February 2017.
The home's Wound Care policy number NUR-01-102 that was in effect during this time required that registered staff conduct weekly skin assessments using the home's Point Click Care (PCC) assessment documentation system. The DOC confirmed this. During interview, RN #104 stated that staff would also enter assessments into the progress notes without using the assessment tab. Review of the clinical record indicated that weekly assessments using either the PCC assessment tab or progress notes had not been completed for the altered skin integrity.
During an interview on a specific date in February 2017, RN #103 confirmed that weekly reassessment of resident #031's altered skin integrity had not been completed weekly as noted above when they should have, according to the home's policy. During an interview, the DOC confirmed that staff had not reassessed resident #031's areas of altered skin integrity weekly according to the home's policy and legislative requirements.

B) Resident #036 was identified by PSW staff #107 and RN #104 as being at risk for injury due to their medical condition. On a specific date in January 2017, the resident was assessed as having areas of altered skin integrity.
Review of the clinical records indicated that the areas of altered skin integrity had not been reassessed weekly between a specific date in January and February 2017. During one of the resident's reassessments on a specific date in January 2017, the resident was found to have had an injury. The altered skin integrity to that area was not reassessed weekly between January and February 2017.
During interview, the DOC confirmed that resident #036's altered skin integrity had not been reassessed weekly when indicated.

C) According to their clinical records, resident #037 returned from hospital on a specific date in January 2017.

i) Review of their clinical record indicated that their new area of altered skin

integrity had not been reassessed weekly between beginning of January to a specific date in February 2017. This was confirmed on interview with RN #106 and the DOC.

ii) Progress notes indicated that they developed another area of altered skin integrity when they returned from the hospital on a specific date in January 2017. The resident's altered skin integrity was assessed by a physician on a specific date in January 2017, and prescribed a treatment. Review of their clinical record indicated that weekly wound assessments had not been completed for this area of altered skin integrity between January and February 2017. This was confirmed on interview with RN #106 and the DOC.

D) According to clinical records, on a specific date in January 2017, resident #024 had developed new altered skin integrity.
Review of the clinical records indicated that the new area had not been assessed weekly between January and February 2017. During interview, the Assistant Director of Resident Care (ADRC) stated that a weekly assessment of this wound was clinically indicated and should have been completed in the assessment tab of the home's electronic documentation system (Point Click Care) and that it had not been completed according to legislative requirements or the home's policy.

E) Resident #055 had altered skin integrity identified by RN #142 on specific dates in January and February 2017.
The head to toe skin assessments that were conducted in January and February 2017 did not have altered skin integrity documented.
RN # 104 was interviewed and was aware of the altered skin integrity.
The home's policy called "Overview of Skin Care ad Wound Management Program", number 30-08-0A, and revised November 2013, directed registered staff to conduct head to toe skin assessments for residents with altered skin integrity on a weekly basis.
A review of the clinical record from January to March 2017, revealed that there was no head to toe skin assessment conducted on specific dates in January and February 2017.
Interview with the DRC and the ADRC who was also the Skin and Wound lead for the home confirmed that the registered staff were expected to conduct weekly skin assessments for residents who had altered skin integrity.
The clinical record confirmed resident #055's altered skin integrity was not reassessed weekly, and there were areas that had worsened.

RN #104 confirmed the weekly skin assessments for resident #055 were not consistently completed.

(526)

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

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. 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 :

1. The licensee shall train all direct care staff in the home's falls prevention and management program, skin and wound care program, continence care and bowel management program, and pain management program, including pain recognition of specific and non-specific signs of pain by the compliance date and annually.

2. The licensee will develop and implement an audit process to ensure that the training for the mandatory programs are effective and meeting the needs of residents.

Grounds / Motifs :

1. 1.This Order is being issued based on the application of the factors of severity (1), scope (3) and Compliance history of (4) in keeping with r. 229 of the Regulation. This is in respect to the severity of the noncompliance, the scope was widespread and the home's history of noncompliance that included the following: Compliance Order issued on May 9, 2016, a VPC on February 5, 2015, and a Compliance Order issued April 7, 2014.

2. 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).

The home was issued orders related to training of direct care providers in the 2016 Resident Quality Inspection (RQI), Inspection number 2016_265526_0010 related to Continence Care, Falls Prevention, Pain Management and Skin and Wound Care.

The home's training records were reviewed and the following were the results of the home's training:
Continence Care - 70 percent (%) of direct care staff were trained in 2016;
Falls Preventions - 68% of direct care staff were trained in 2016;
Pain Management - 67% of direct care staff were trained in 2016; and
Skin and Wound Care - 59% of direct care staff were trained in 2016.

The Administrator, the DRC and the Human Resources Manager were interviewed and confirmed that they had not achieved 100% of the training of direct care providers for the above programs in 2016. The Administrator explained that they were hired full time at the end of November 2016 and the home had since developed and implemented a comprehensive educational plan to ensure the home was compliant with the training requirements of direct care staff upon hire and annually for the identified programs.

The home did not provide training to the staff who provide direct care to residents related to falls prevention and management, skin and wound care, continence care and bowel management, and pain management, including pain

recognition of specific and non-specific signs of pain.
(527)

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

When a resident has fallen and the plan of care is updated by a Physician/Nurse Practitioner to include diagnostic tests such as x-ray, the licensee shall do the following:

1) Ensure that the updates to the plan of care, specifically a Physician/Nurse Practitioner's order for a diagnostic test, is carried out as specified in the plan, as soon as possible and according to expectations in the home; and

2) Contact the substitute decision maker (SDM) to inform them of an update to the plan of care that includes a diagnostic test; inform them when the test was conducted and the results of the test.

Grounds / Motifs :

1. This Order is being issued based on the application of the factors of severity (3), scope (1) and Compliance history of (4) in keeping with r. 229 of the Regulation. This is in respect to the severity of actual harm/risk that the identified resident experienced, the scope of the isolated incident and the home's history of noncompliance that included the following: Compliance Order issued on May 9, 2016, a VPC on February 5, 2015, a WN on January 7, 2015, and November 13, 2014.

2. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

Resident #041 was at risk for falls. They required extensive assistance from one staff for transferring and ambulation. The home's Behaviour Support Ontario (BSO) RPN stated that the resident was non-compliant when using a wheelchair for ambulation, and had been able to ambulate independently but not safely.

According to the progress notes, resident #041 fell on specific dates in November 2016, after which time they began complaining that they had pain. They fell again several days later and they continued to complain of pain and were assessed by the home's Nurse Practitioner (NP) on a specific date in November 2016. A diagnostic test was ordered and a physician ordered an increase in the resident's medication. The resident continued to fall and fell several more times on specific dates in November 2016. Progress notes indicated that they complained of pain on a number of occasions over an eight day period in November 2016, and received regularly scheduled medication with some effect. According to the progress notes and investigative notes, the resident was subsequently transferred to the hospital on a specific date in November 2016, based on the family request since the resident continued to have pain and the diagnostic test had not been completed. The resident was diagnosed with an injury. They returned to the home and had a prescription for medication for pain management.
During interview, the home's RAI Coordinator, DRC and Administrator stated that the diagnostic test should have been completed within 48 hours of the NP's order or according to the resident's needs to determine the underlying cause of the resident's pain. They confirmed that resident #041's plan of care had not been followed when they did not have the diagnostic test completed until later in November 2016, when the resident was sent to hospital on the family's request. (536)
(526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 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
TORONTO, 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
TORONTO, 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 23rd day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kathleen Millar

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