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

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

Central West Service Area Office
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 03, 2019	2019_800532_0007 (A2)	026735-18, 032369-18, 001808-19, 002570-19, 002571-19, 002572-19, 002573-19, 002574-19, 002575-19, 002576-19, 002577-19, 003989-19, 005142-19, 005573-19, 012867-19	Follow up

Licensee/Titulaire de permis

LaPointe-Fisher Nursing Home, Limited
1934 Dufferin Avenue WALLACEBURG ON N8A 4M2

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

LaPointe-Fisher Nursing Home
271 Metcalfe Street GUELPH ON N1E 4Y8

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

Amended by NUZHAT UDDIN (532) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Extending the date for order #003 as requested by the home and approved by the SAO manager Tammy S.

Issued on this 3 rd day of September, 2019 (A2)

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

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

Ministère de la Santé et des Soins de longue durée

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

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Amended by NUZHAT UDDIN (532) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, and July 2, 3, 4, 5, 8, 9, 2019.

A Complaint inspection #2019_800532_0008 was conducted in conjunction with this inspection.

The following intakes were completed in this Follow-up (FU) inspection:

Log# 002572-19, FU to CO#001 from inspection #2018_610633_0022 related to plan of care;

Log #002573-19 FU to CO #002 from inspection #2018_610633_0022, related to 24/7 registered nurse (RN) on duty;

Log #002574-19 FU to CO #003 from inspection #2018_610633_0022, related to policy to promote zero tolerance of abuse;

Log #002570-19 FU to CO #004 from inspection #2018_610633_0022; related to falls prevention policy;

Log # 002576-19 FU to CO #005 from inspection #2018_610633_0022, related to skin and wound care training;

Log# 002571-19 FU to CO #006 from inspection #2018_610633_0022, related to documentation;

Log #002575-19 FU to CO #007 from inspection #2018_610633_0022, related to skin and wound care program;

Log #002577-19 FU CO #008 from inspection #2018_610633_0022, related to skin and wound care;

Log# 032369-18, CI #2358-000025-18, Log #003989-19, CI #2358-000005-19, related to falls prevention;

Log #026735-18, CI #2358-000016-18, Log #005142-19, CI #2358-000007-19, Log #001808-19, CI #2358-000001-19, related to abuse;

Log #005573-19, IL-64987-CW / IL-65701-CW, related to transferring and positioning;

Log #012867-19, IL-67972-CW, regarding skin and wound care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), assistant Director of Nursing (ADON), Resident Care Coordinator (RCC) and the Resident Assessment Instrument (RAI) Coordinator, Director of Quality Improvement (DQI), Recreation and Program Services Manager (RPSM), Resident Assessment Instrument (RAI) Coordinator, Behaviour Support Ontario Staff (BSO), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and family members.

The inspectors also toured resident home areas, observed resident care provision, resident staff interaction, dining services, reviewed relevant residents' clinical records, relevant policies and procedures pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Dining Observation
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
11 WN(s)
3 VPC(s)
5 CO(s)
3 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 221. (1)	CO #005	2018_610633_0022	532
O.Reg 79/10 s. 48. (1)	CO #007	2018_610633_0022	532
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_610633_0022	738
O.Reg 79/10 s. 8. (1)	CO #004	2018_610633_0022	532

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. This inspection was completed as a follow up to Compliance Order (CO) #002 that was issued on January 16, 2019, during inspection #2018_610633_0020, related to 24/7 RN on duty.

The registered staff schedules were reviewed for the period of March 1, 2019, to June 16, 2019. The schedules identified that there was no RN who was both an employee of the licensee and a member of the regular nursing staff present and working in the home on the six identified dates.

The DON said that there was no RN in the home on the identified dates, when the DON or the ADON were on call.

The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception for this requirement. [s. 8. (3)]

Additional Required Actions:

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

DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

This inspection was completed as a follow up to CO #003 from inspection 2018_610633_0022 related to the home's prevention of abuse policy.

The home's policy, titled "Abuse – Resident/Staff", stated:
Reporting an incident:
"All staff were required to immediately report to the appropriate supervisor in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect.
Management staff:
When a manager/ designate or other receives an investigation report (internal) from an employee on a suspected or alleged, or actual incident of abuse or neglect, they will immediately report to the Ministry of Long-Term Care (MLTC).
Management staff investigating the incident:
Staff must investigate immediately all reports of abuse or neglect, in accordance with the investigation procedures set out in this document".

A Critical Incident (CI) was submitted to MLTC on an identified date related to two incidents of alleged emotional abuse.

Investigation notes and the DOC acknowledged that an identified RN made them aware of the reported incident, but they did not immediately investigate the incident or report it to the MLTC.

Another incident of alleged emotional abuse was reported on a different date by the same identified resident to a staff member of the home.

The RN acknowledged that they did not report the incident to the on-call manager immediately but asked the resident to write their concerns down.

The licensee has failed to ensure that the written policy related to immediate investigation and reporting of abuse was complied with. [s. 20. (1)]

Additional Required Actions:

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

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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 :

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

This inspection was completed as a follow up to CO #006 from inspection 2018_610633_0022 related to documentation.

A) A review of the homes skin and wound care program, titled "Prevention of Pressure Injuries" stated that residents would be repositioned every two hours or more frequently during waking hours, depending on the resident's condition and the tolerance of tissue load. During the night residents would be repositioned at minimum twice if clinically indicated.

A review of the document titled "Care Repositioning Schedule" for an identified resident for a specified time frame showed that there was no documentation completed for the resident at specified times.

The ADON shared that the resident was on the turning and repositioning program and their documentation was incomplete. There was a gap in documentation for a specified time frame.

The licensee failed to ensure that the resident was turned and repositioned as part of their skin and wound care program, and that responses to the interventions were documented. (729)

B) A RN said that an identified resident had an area of altered skin integrity and that staff were to turn and reposition the resident every two hours to promote wound healing and prevent further skin breakdown. Staff were to document this intervention on a flow sheet called, Care Repositioning Schedule.

A review of the Care Repositioning Schedule flow sheets completed for the resident for a specified time frame showed that the staff failed to document that the resident had been turned and repositioned on identified dates.

The licensee failed to ensure that resident was turned and repositioned as part of their skin and wound care program, and that responses to the interventions were documented (738)

C) The following is further evidence to support CO #006 issued on January 16, 2019, during the follow up inspection from inspection #2018_610633_0022 with a compliance due date of April 19, 2019.

A CIS report was submitted to the MLTC which stated that an identified resident suffered an injury due to a fall, was taken to the hospital and the injury resulted in a significant change in their health status.

A review of the plan of care in PCC showed that there were resolved interventions related to personal assistance service device (PASD) that was to be in place for the resident.

An identified staff shared that they refer to the resident's plan of care to find fall interventions for the residents. The staff stated that the interventions that may have prevented the resident from falling, should not have been resolved.

The RPN shared that when care plan interventions were resolved from the plan of care, it meant the intervention was tried but did not work. The RPN could not find

documentation in the resident's plan of care that an assessment or reassessment of the resident was completed before the identified interventions were resolved. They shared that the resolved fall prevention interventions may have alerted the staff.

The Director of Quality Improvement (DQI) shared that the home was in a transition phase of updating all the fall prevention care plans for residents and the identified resident 's fall prevention interventions were resolved during the transition and there was no assessment or reassessment of the interventions by anyone.

The licensee failed to ensure that the resident assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (2)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 003

WN #4: 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 an identified resident 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 when an identified resident exhibited altered skin integrity.

This inspection was completed as a follow up to CO #008 from inspection 2018_610633_0022 related to skin and wound care assessments, immediate treatment and interventions.

An initial skin and wound assessment completed for a resident stated they had an area of altered skin integrity.

A PSW shared that they had reported to registered staff that the resident had an area of altered skin integrity approximately six weeks prior to the initial wound assessment that was completed. Two or three weeks after they initially reported the altered skin integrity, the PSW reported to the RN that the dressing required changing.

The ADON shared that there was no documentation of any areas of altered skin integrity in the resident’s clinical record.

The licensee failed to ensure that specified resident's 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 when the resident exhibited altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that an identified resident received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

This inspection was completed as a follow up to CO #008 from inspection 2018_610633_0022 related to following the skin and wound care program.

An initial skin and wound assessment completed on a specified dated stated that the resident had altered skin integrity that had been infected and the resident was experiencing pain during the treatment.

A PSW shared that they had reported to registered staff that the resident had altered skin integrity approximately six weeks prior to the initial wound assessment.

A review of the resident 's treatment record showed that there was no documentation of any treatment initiated or signed as completed for areas of altered skin integrity.

A pain assessment was completed for the resident but it indicated that the resident did not have pain, and their pain score was one out of ten.

A RN stated that when they were carrying out the treatment for the resident they were in a lot of pain and the RN called the physician to obtain an order for a routine analgesic.

The licensee failed to ensure that the resident received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection when an area of altered skin integrity was initially reported. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

This inspection was completed as a follow up to CO #008 from inspection 2018_610633_0022 related to following the skin and wound care.

A review of an identified resident's electronic Treatment Administration Record (eTAR) showed that they had an area of altered skin integrity.

A review of the weekly Skin Tear Assessments completed for the resident showed that the staff failed to examine the length and width of the altered skin integrity on a specified date.

The home's Skin and Wound Care Management policy, showed that staff were to examine the length and width of altered skin integrity when completing an assessment of the area.

The ADON said that the expectation was the same with every skin integrity issue. The registered staff were expected to assess it at least once weekly and they were required to measure the length and width of the area of altered skin integrity and whether it was improving or deteriorating.

The licensee failed to ensure that the resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that identified residents were protected from abuse by anyone and were not neglected by the licensee or staff.

This inspection was completed as a follow up to CO #003 from inspection 2018_610633_0022 related to abuse.

A) As per O.Reg 79/10 s.5 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The Minimum Data Set (MDS) assessment completed for a specified date stated that the identified resident did not have any altered skin integrity.

Record review for the specified date showed that the resident had an area of altered skin integrity that had been infected. Record review showed that there was an order for an antibiotic for the infection and an analgesic for pain.

Documentation in the progress notes stated that the resident was complaining of pain and they were given an analgesic but there was no assessment of the area to determine the source of pain.

An identified staff shared that they had reported to registered staff that the resident had altered skin integrity. Although they were unsure of when the treatment for the altered skin integrity was started, they remembered reporting the concern approximately six weeks prior to the initial skin and wound assessment that was completed.

The staff member shared that two or three weeks after they initially reported the altered skin integrity, they were providing care for the resident and noted that the dressing was black and had an odour. Staff reported the state of the dressing to

the RN and the RN was not able to find any documentation related to altered skin integrity.

A RN shared that approximately one month prior, a staff member asked that the treatment be changed for the resident.The RN stated that when they did their assessment, they noted that the resident had a treatment on area but did they were not aware that the resident had altered skin integrity in another area.

The home's wound care lead shared that they did the initial wound assessment when they were notified of the altered skin integrity.

The ADON said there was no documentation in the resident's clinical record for any areas of altered skin integrity. (729)

The licensee failed to protect identified resident from neglect, when an area of altered skin integrity was not assessed and left untreated for four weeks. The identified resident developed an infection, the area of skin integrity deteriorated, and the resident suffered pain requiring a new order for analgesic.

B) As per O.Reg 79/10 s. 2.(1) emotional abuse is defined as any threatening, insulting intimidating or humiliating gestures, actions behaviour or remarks including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are preformed by anyone other than a resident.

A Critical Incident (CI) was submitted to MLTC on an identified date related to two incidents of alleged emotional abuse between staff and a resident.

The identified resident verified the incidents and stated that they felt emotionally upset by them.

The identified staff involved in the alleged emotional abuse acknowledged the situation that the resident had described.

The licensee failed to ensure that identified resident was protected from emotional abuse.

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 005

WN #6: 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).

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).

Findings/Faits saillants :

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

The following is further evidence to support compliance order #001 issued on April 16, 2019, during inspection #2018_610633_0022 to be complied March 1, 2019.

The home submitted a CI report to the MLTC, related to the resident falling.

Risk Management report showed that the resident sustained an injury from the fall.

The resident’s plan of care indicated specified interventions to prevent falls.

A PSW said that they left the room to get assistance from another staff member and when they returned to the room, the resident was on the floor.

A post fall assessment showed that the resident was found on the floor of their room and fall prevention interventions were not in place at the time of the incident.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the 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.

This inspection was completed as a follow up to CO #004 from inspection 2018_610633_0022 related to falls prevention.

A) Review of an identified resident’s plan of care for falls prevention stated that the resident was at high risk for falls characterized by a history of falls and injury, as well as multiple other risk factors.

B) Review of another identified resident's plan of care stated that the resident was at high risk for falls characterized by a history of falls and injury, multiple risk factors related to cognitive impairment, impaired balance.

Review of the plans of care for each resident stated a specified intervention to identify that the residents were at risk of fall.
Room observation for both residents showed that the interventions were not in place.

Director of Nursing and Assistant Director of Care both acknowledged that the interventions were no longer being applied and stated that the plans of care for each resident had not been revised to reflect the change.

C) Review of the plan of care stated that an identified resident was not to have a specific intervention related to fall prevention.

Observation showed that the resident had the interventions in place.

A RN said that the plan of care was not up to date as the resident was able to have a different intervention in place as part of their fall prevention strategy as their care needs had changed.

The licensee failed to ensure that residents were 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. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #7: 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 Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the procedure was complied with.

The following is further evidence to support compliance order #004 issued on April 16, 2019, during inspection #2018_610633_0022 to be complied May 24, 2019, related to Head Injury Routine (HIR).

In accordance with O. Reg. 79/10, s. 30, the licensee was required to have a written description of each of the interdisciplinary programs, including falls prevention and management, required under section 48 of this Regulation that included relevant procedures that provided for methods to reduce risk and monitor outcomes.

Specifically, staff did not comply with the home's “Head Injury Routine” procedure (effective January 2008), which was part of their falls prevention and management program.

The home submitted a CI stating that an identified resident had an unwitnessed fall. The resident sustained injuries.

Progress notes showed that the resident had a second unwitnessed fall on an identified date. The resident did not sustain any injuries because of this fall.

The RPN said that when there was an unwitnessed fall, the resident was to have a Head Injury Routine (HIR) done.

The home’s procedure, “HIR, showed that when a HIR was initiated, staff were to collect and document the resident’s vital signs, pupil reaction to light, range of motion and alertness at the following intervals: every 30 minutes for the first two hours, every hour for the next four hours, every four hours for the next 24 hours and every shift for the next 24 hours.

Review of the HIR completed for the identified resident after their unwitnessed falls showed that it was not done.

The licensee failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the procedure was complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the procedure is complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a person had reasonable grounds to suspect that abuse of a resident by anyone occurred that resulted in harm or risk of harm, that they immediately reported the suspicion and the information upon which it was based to the Director.

This inspection was completed as a follow up to CO #008 from inspection 2018_610633_0022 related to abuse.

A) The home submitted a Critical Incident (CI) report, which occurred on specified date, related to an incident of alleged sexual abuse.

The progress note indicated that the ADON and DON were notified of the incident on the same day that the incident was reported.

The DON acknowledged that they were made aware of the incident of alleged sexual abuse, but the incident was not reported to the Director immediately.

The licensee failed to ensure that when a person had reasonable grounds to suspect that abuse of a resident by anyone occurred that resulted in harm or risk of harm, that they immediately reported the suspicion and the information upon which it was based to the Director [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a person had reasonable grounds to suspect that abuse of a resident by anyone occurred that resulted in harm or risk of harm, that they immediately reported the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfection of the supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

An identified resident's observation on two different dates showed that their personal assistance services device was dirty.

The DON acknowledged that the personal assistance services device was dirty and shared that they did not have a cleaning schedule for the personal equipment.

The licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfection of the supplies and devices, including personal assistance services devices, assistive aids and positioning aids. [s. 87. (2) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the identified resident’s substitute decision maker (SDM) of care was notified within 12 hours of becoming aware of any alleged incident of abuse of the resident.

The home submitted a CI report to the MLTC, related to an incident of alleged sexual abuse towards an identified resident.

Record review showed that the incident was reported on a specified date and that the SDM of care was not notified about the incident until four days later.

The DON acknowledged that the resident's SDM of care was not notified about the incident four days after but should have been notified within 12 hours of becoming aware.

The licensee failed to ensure that the resident’s SDM was notified within 12 hours of becoming aware of any alleged incident of abuse of the resident. [s. 97. (1) (b)]

WN #11: 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. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.
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 within one business day after the occurrence of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

A CI report was submitted to the MLTC related to an incident that caused an injury resulting in an identified resident being transferred to the hospital with a significant change in their health status.

The Minimum data set (MDS) assessment completed for a significant change in the identified resident's health status, determined that the resident went from independent with their mobility to requiring extensive assistance.

The ADON shared they completed the CIS report, three days after the incident occurred, but understood that this was not in keeping with the legislation.

The licensee failed to inform the Director within one business day after the occurrence of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition. [s. 107. (3)]

Issued on this 3 rd day of September, 2019 (A2)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by NUZHAT UDDIN (532) - (A2)
Inspection No. / No de l'inspection :	2019_800532_0007 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	026735-18, 032369-18, 001808-19, 002570-19, 002571-19, 002572-19, 002573-19, 002574-19, 002575-19, 002576-19, 002577-19, 003989-19, 005142-19, 005573-19, 012867-19 (A2)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 03, 2019(A2)
Licensee / Titulaire de permis :	LaPointe-Fisher Nursing Home, Limited 1934 Dufferin Avenue, WALLACEBURG, ON, N8A-4M2
LTC Home / Foyer de SLD :	LaPointe-Fisher Nursing Home 271 Metcalfe Street, GUELPH, ON, N1E-4Y8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dahlia Burt-Gerrans

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

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

To LaPointe-Fisher Nursing Home, Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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: 2018_610633_0022, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, s.8(3).

Specifically, the licensee must:
a) ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception for this requirement.

Grounds / Motifs :

1. The licensee has failed to comply with CO #002 from inspection 2018_610633_0022 made under LTCHA 2007, s. 8(3), issued on April 16, 2019, with a compliance due date of March 1, 2019.

The licensee was ordered to:

The licensee must be compliant with LTCHA 2007, s. 8(3).

Specifically, the licensee must:
a) ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception for this requirement.

The licensee failed to complete step a) of order #002 related to 24/7 RN.

The registered staff schedules were reviewed for the period of March 1, 2019, to June 16, 2019. The schedules identified there was no RN who was both an employee of the licensee and a member of the regular nursing staff present and working in the home on six identified dates.

The DON said that there was no RN in the home on the identified dates, when the DON or the ADON were on call.

The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception for this requirement. [s. 8. (3)]

The scope of this issue was a level 3, widespread as there is the potential for all residents to be impacted. The severity of the issue was determined to be level 2, potential for actual harm. The home has a level 5 history of non-compliance that included:

-CO #001 from inspection 2018_580568_008 issued August 8, 2018, compliance due date October 19, 2018;
- CO #002 from inspection 2018_610633_0022 issued January 16, 2019, compliance due date March 1, 2019. (729)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 30, 2020

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2018_610633_0022, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, s. 20. (1).

Specifically, the licensee must:
a) ensure that all staff follow the home's abuse policy related to reporting.
b) ensure that all staff follow the home's abuse policy related to investigations.
c) ensure that training is provided to registered staff and management of the home related to the home's prevention of abuse and neglect policy, specifically reporting and investigations.
d) ensure that all staff sign off on the completed training and records are kept in the home.

Grounds / Motifs :

1. The licensee has failed to comply with CO #003 from inspection 2018_610633_0022 made under LTCHA 2007, s. 20. (1), issued on April 16, 2019, with a compliance due date of March 1, 2019.

The licensee must be compliant with LTCHA 2007, s. 20. (1) related to the abuse policy.

Specifically, the licensee must:

a) ensure that all staff follow the home's abuse policy related to reporting.
b) ensure that all staff follow the home's abuse policy related to investigations.

The licensee did not complete part a) and part b) of order #003.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy, titled "Abuse – Resident/Staff", stated:
Reporting an incident:
"All staff were required to immediately report to the appropriate supervisor in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect.
Management staff:
When a manager/ designate or other receives an investigation report (internal) from an employee on a suspected or alleged, or actual incident of abuse or neglect, they will immediately report to the Ministry of Long-Term Care (MLTC).
Management staff investigating the incident:
Staff must investigate immediately all reports of abuse or neglect, in accordance with the investigation procedures set out in this document".

A Critical Incident (CI) was submitted to MLTC on an identified date related to two incidents of alleged emotional abuse.

Investigation notes and the DOC acknowledged that an identified RN made them aware of the reported incident, but they did not immediately investigate the incident or report it to the MLTC.

Another incident of alleged emotional abuse was reported on a different date by the same identified resident to a staff member of the home.

RN acknowledged that they did not report the incident to the on-call manager immediately but asked the resident to write their concerns down.

The licensee has failed to ensure that the written policy related to immediate investigation and reporting of abuse was complied with.

The scope of this issue was a level 1, isolated. The severity of the issue was determined to be a level 2, minimal discomfort to the resident. The home has a level 5 history of non-compliance that included:

-VPC from inspection 2017_604519_0006 issued May 17, 2017;
-CO #002 from inspection 2018_580568_0008 issued August 8, 2018 and compliance date of October 19, 2018.
-CO #003 from inspection 2018_610633_0022 issued January 16, 2019 and compliance date March 1, 2019. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2019

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2018_610633_0022, CO #006;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 30 (2).

Specifically, the licensee must:
a) ensure that turning and repositioning and the resident's responses to the turning and repositioning are documented by the personal support workers (PSWs) and maintained in the clinical records at the home.
b) ensure that training related to proper completion of the turning and repositioning, documentation is provided to all staff that are responsible for personal care for the residents.
c) ensure that a written record is kept of the training that includes the content and date of staff completion.
d) develop and implement an on-going auditing process to ensure the documentation for turning and repositioning for identified residents and any other resident is being completed. Include who will be responsible for doing the audits and evaluating the results.

Grounds / Motifs :

1. The licensee was ordered to be compliant with O. Reg. 79/10, s. 30 (2).

Specifically, the licensee was to ensure:
a) develop and implement a process to ensure that the records of the contracted ET Nurse/Wound Care Specialist were completed by them and maintained in the clinical records of all residents at the home.
b) the home's skin and wound care policy was reviewed and revised to include this process. The date of the review, who attended, the changes made and the date the change was implemented must be documented.

The licensee completed steps a) and b) in CO #006. The licensee failed to comply with LTCHA 2007, s. 30. (2).

The licensee failed to ensure that resident #015 and #017 were turned and repositioned as part of their skin and wound care program, and that responses to the interventions were documented.

A RN said that an identified resident had an area of altered skin integrity and that staff were to turn and reposition the resident every two hours to promote wound healing and prevent further skin breakdown. Staff were to document this intervention on a flow sheet called, Care Repositioning Schedule.

A review of the Care Repositioning Schedule flow sheets completed for the resident for a specified time frame showed that the staff failed to document that the resident had been turned and repositioned on identified dates.

The licensee failed to ensure that the resident was turned and repositioned as part of their skin and wound care program, and that responses to the interventions were documented (738)

2. A review of the homes skin and wound care program, titled “Prevention of Pressure Injuries” stated that residents would be repositioned every two hours or more frequently during waking hours, depending on the resident's condition and the tolerance of tissue load. During the night residents would be repositioned at minimum twice if clinically indicated.

A review of the document titled “Care Repositioning Schedule” for an identified resident for a specified time frame showed that there was no documentation completed for the resident at specified times.

The ADON shared that the resident was on the turning and repositioning program and their documentation was incomplete. There was a gap in documentation for a specified time frame.

The licensee failed to ensure that the resident was turned and repositioned as part of their skin and wound care program, and that responses to the interventions were documented.

The scope of this issue was a level 2, pattern. The severity of the issue was determined to be a level 2, minimal risk of harm. The home has a level 5 history of non-compliance that included:
CO #006 from inspection 2018_610633_0022 issued January 16, 2019 and compliance date April 19, 2019. (729)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 18, 2019(A2)

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2018_610633_0022, CO #008;

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 must be compliant with s. 50 (2)(b)(i)(ii)(iv) of O. Reg. 79/10.

Specifically the licensee must:
a) ensure that the identified resident and all residents exhibiting altered skin integrity receive 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.
b) ensure that the identified residents and all residents exhibiting altered skin integrity receive immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection.
c) ensure that identified residents and all residents exhibiting altered skin integrity are reassessed at least weekly by a member of the registered nursing staff.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA 2007, s. 50(2)(b)(i)(ii)(iv), from inspection 2018_610633_0022 issued on April 16, 2019, with a compliance due date of April 19, 2019.

The licensee was ordered to be compliant with O.Reg. 79/10 s. 50(2)(b)(ii)(iv).

Specifically, the licensee was to ensure:
a) ensure that residents exhibiting altered skin integrity receives immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection.
b) ensure that residents #002 and #004 and all residents are reassessed at least weekly by a member of the registered nursing staff.

The licensee has failed to complete steps a) and b) related to skin and wound care.

1. The licensee failed to ensure that an identified resident 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 when an identified resident exhibited altered skin integrity.

This inspection was completed as a follow up to CO #008 from inspection 2018_610633_0022 related to skin and wound care assessments, immediate treatment and interventions.

An initial skin and wound assessment completed for a resident stated they had an area of altered skin integrity.

A PSW shared that they had reported to registered staff that the resident had an area of altered skin integrity approximately six weeks prior to the initial wound assessment that was completed. Two or three weeks after they initially reported the altered skin integrity, The PSW reported to the RN that the dressing required changing.

The ADON shared that there was no documentation of any areas of altered skin integrity in the resident's clinical record.

The licensee failed to ensure that specified resident's 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 when the resident exhibited altered skin integrity. (729)

2. The licensee has failed to ensure that resident #017 received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

The licensee has failed to ensure that an identified resident received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

This inspection was completed as a follow up to CO #008 from inspection 2018_610633_0022 related to following the skin and wound care program.

An initial skin and wound assessment completed on a specified dated stated that the resident had altered skin integrity that had been infected and the resident was experiencing pain during the treatment.

A PSW shared that they had reported to registered staff that the resident had altered skin integrity approximately six weeks prior to the initial wound assessment.

A review of the resident ‘s treatment record showed that there was no documentation of any treatment initiated or signed as completed for areas of altered skin integrity.

A pain assessment was completed for the resident but it indicated that the resident did not have pain, and their pain score was one out of ten.

A RN stated that when they were carrying out the treatment for the resident they were in a lot of pain and the RN called the physician to obtain an order for a routine analgesic.

The licensee failed to ensure that the resident received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection when an area of altered skin integrity was initially reported. (729)

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

This inspection was completed as a follow up to CO #008 from inspection 2018_610633_0022 related to following the skin and wound care.

A review of an identified resident's electronic Treatment Administration Record (eTAR) showed that they had an area of altered skin integrity.

A review of the weekly Skin Assessments completed for the resident showed that the staff failed to examine the length and width of the altered skin integrity on a specified date.

The home's Skin and Wound Care Management policy, showed that staff were to examine the length and width of altered skin integrity when completing an assessment of the area.

The ADON said that the expectation was the same with every skin integrity issue. The registered staff were expected to assess it at least once weekly and they were required to measure the length and width of the area of altered skin integrity and whether it was improving or deteriorating.

The licensee failed to ensure that the resident exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

The scope of this issue was a level 2, pattern. The severity of the issue was determined to be a level 3, actual risk of harm. The home has a level 5 history of related non-compliance that included:

-VPC from inspection 2017_604519_0004 issued March 10, 2017;
-VPC from inspection 2018_723606_0007 issued June 26, 2018;
-CO #003 from inspection 2018_580568_0008 issued August 8, 2018 and compliance date of October 19, 2018;
-written notification (WN) from inspection 2018_580568_0009 issued October 2, 2018.
-DR/CO #008 from inspection 2018_610633_0022 issued January 16, 2019 and compliance date March 1, 2019. (738)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Sep 30, 2019

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee must be compliant with LTCHA 2007, s.19 (1).

Specifically the licensee must:
a) ensure that residents #001 and #017 and all residents of the home are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee failed to ensure that resident #001 was protected from abuse by anyone.

As per O.Reg 79/10 s. 2.(1) emotional abuse is defined as any threatening, insulting intimidating or humiliating gestures, actions behaviour or remarks including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are preformed by anyone other than a resident.

As per O.Reg 79/10 s. 2.(1) emotional abuse is defined as any threatening, insulting intimidating or humiliating gestures, actions behaviour or remarks including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are preformed by anyone other than a resident.

A Critical Incident (CI) was submitted to MLTC on an identified date related to two incidents of alleged emotional abuse between staff and a resident.

The identified resident verified the incidents and stated that they felt emotionally upset by them.

The identified staff involved in the alleged emotional abuse acknowledged the situation that the resident had described.

The licensee failed to ensure that identified resident was protected from emotional abuse. (532)

(A1)
2. The licensee failed to ensure that resident #017 was not neglected by the licensee or staff.

As per O.Reg 79/10 s.5 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Resident #017's diagnosis included an open wound on their hip. They required total assistance with the help of two people for bed mobility, transferring, dressing and grooming and toileting care needs.

The Minimum Data Set (MDS) assessment completed on June 4, 2019, with a locked date of June 18, 2019, stated that resident #017 did not have any pressure ulcers or a history of resolved pressure ulcers.

An initial skin and wound assessment completed on June 29, 2019, for resident #017, stated they had an unstageable pressure injury on their left hip. The pressure injury had firmly adhered hard, black eschar was present covering fifty to seventy-five percent of the wound bed. The peri-wound area was hot, odour present and resident #017 was experiencing pain during the dressing change.

On July 1, 2019, the physician ordered an antibiotic for the infection and a narcotic analgesic for resident #017's pain.

Documentation in the progress notes in PCC on June 26, 2019, stated that resident #017 was complaining of pain on their buttocks. They were given Tylenol analgesic for the pain. RPN #122 stated that they did not complete an assessment of the area to determine the source of pain.

PSW #110 shared that they had reported to registered staff that resident #017 had a reddened area on their left hip and the registered staff put a two by two gauze on the area. Although they were unsure of when the dressing was applied, they remembered reporting the skin concern approximately six weeks prior to the initial wound assessment that was completed on June 29, 2019.

PSW #110 shared that two or three weeks after they initially reported the altered skin integrity, they were providing care for resident #017 and noted that the dressing was black and had an odour. PSW #110 reported the state of the dressing to RN #105. PSW #110 stated that RN #105 was not able to find any documentation related to resident #017's left hip.

PSW #115 shared that they provided bathing care for resident #017 and observed that the resident had an open area on their left hip for quite awhile. They remembered seeing a bandage on the resident's left hip on many occasions but they assumed everyone knew it was there.

RN #105 shared that approximately one month ago, PSW #110 asked that the dressing be changed for resident #017. RN #105 stated that when they did their

assessment, resident #017 had a brown dressing on their arm and there was only a scab under the dressing. RN #105 stated they did not assess resident #017's left hip as they were not aware that the resident had altered skin integrity in that area.

RN #106, the homes' wound care lead, shared that they did the initial wound assessment on June 29, 2019, when they were notified of the open area on the left hip. At that time the wound had a dry dressing on the area, the wound had an odour, black eschar was present, and the resident was in pain during the dressing change. They shared with the Inspector that the altered skin integrity did not occur overnight.

ADON #102 said they were aware of the unstageable pressure injury for resident #017. They were conducting an investigation into how it had been missed and it was ongoing. They stated that there was no documentation in the resident's clinical record for any areas of altered skin integrity on residents #017's arm or their left hip prior to June 29, 2019.

The licensee failed to protect resident #017 from neglect, when a pressure ulcer was not assessed and left untreated for upwards of four weeks. Resident #017 developed an infection, the pressure ulcer deteriorated, and the resident suffered pain requiring a new order for narcotic analgesic.

The scope of this issue was a level 2, pattern. The severity of the issue was determined to be a level 3, actual risk of harm. The home has a level 3 history of non-compliance that included:
-VPC from inspection 2018_580568_0008 issued April 26, 2018. (729)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :** Sep 30, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 3 rd day of September, 2019 (A2)

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Amended by NUZHAT UDDIN (532) - (A2)

Service Area Office / Bureau régional de services : Central West Service Area Office