Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2017	2017_689586_0010	025501-17	Resident Quality Inspection

Licensee/Titulaire de permis

CITY OF HAMILTON
77 James Street North, Suite 400 HAMILTON ON L8R 2K3

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

MACASSA LODGE
701 UPPER SHERMAN AVENUE HAMILTON ON L8V 3M7

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

JESSICA PALADINO (586), LISA VINK (168), ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 10, 14, 15 and 16, 2017.

The following Critical Incident System (CIS) Inspections were conducted concurrently with the RQI:
022276-16 - Falls Prevention & Management;
011122-17 - Falls Prevention & Management;
023374-17 - Falls Prevention & Management;
028576-16 - Falls Prevention & Management;
005246-17 - Falls Prevention & Management;
019740-17 - Falls Prevention & Management;
007825-17 - Falls Prevention & Management; and,
018053-17 - Falls Prevention & Management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Administrative Assistant, Director of Nursing (DON), Nurse Managers (NM), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, and families.

During the course of the inspection, the inspectors reviewed resident health records, internal incident investigation notes, policies and procedures, and staff schedules, interviewed staff and observed resident care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

8 WN(s)
6 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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 residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Interview with RPN #124 and RN #150 verified the expectation that areas of altered skin integrity were assessed and documented weekly in the clinical record.

A. Resident #001 was identified with altered skin integrity. A review of the clinical record did not include a reassessment of all areas altered skin integrity on a weekly basis.

i) An area of altered skin integrity was identified in 2017. The clinical record did not include a weekly reassessment of the area for approximately four weeks beginning the following month.

ii) An area of altered skin integrity was included in the progress notes in 2017, which was observed to have worsened by the following month. A review of the clinical record did not include any weekly reassessments of the area.

Interview with RN #150, following a review of the clinical record verified that the identified areas were not assessed weekly for the time periods identified, as required. (168).

B. Resident #034 was identified with altered skin integrity. A review of the clinical record did not include a reassessment of all areas altered skin integrity on a weekly basis. An area of altered skin integrity was identified in identified in 2017 and worsened by the following month. The clinical record did not include a weekly reassessment of the area between during two separate months within the time that it was discovered and worsened. Interview with RPN #134, following a review of the clinical record, verified that the identified areas were not assessed weekly for the time periods identified, as required. (586). [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

On an identified date in November 2017, the C1W servery was open and fully accessible. The area was not under supervision of staff in the immediate area.

The servery included an unlocked cupboard under the sink with a bottle of a stainless steel cleaner. The label identified the product "danger" with a statement of risk of eye damage. On the servery counter was a hot water dispenser, which was operational and when the faucet was manually pushed drained very hot water.

Dietary staff member #120 entered the servery area a few minutes later and identified that the servery had a door, which could be locked. That the swing door was propped open with a serving cart, as they were setting up the dining rooms on C1 concurrently, and demonstrated how it closed and locked. They identified that they did not have a key to secure the cupboard under the sink where the cleaner was stored and confirmed that the door to the servery should be kept closed and locked with the water dispenser and cleaner accessible. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home was a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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 failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #030 was at risk for falls and had a significant history of falling. According to a CIS log, the resident experienced a fall on an identified date in 2016, resulting in significant injuries.

The resident's health record was reviewed. A progress note written by the physician on an identified date in 2017, identified the resident's fall risk and included the importance of specific interventions to be put into place for the resident.

Progress notes from 2017, written by registered staff, indicated that the resident was exhibiting behaviours that increased their falls risk, as mentioned in the physician's progress note. One note from RPN #125 included a plan for the resident moving forward to mitigate this risk.

Review of the resident's documented plan of care, which front line staff use to direct

care, did not include any interventions to mitigate the resident's risk of falling related to the identified behaviours. In an interview with the DOC, NM #1 and NM #2 on November 15, 2017, they acknowledged that the resident's plan of care did not include interventions related to this. [s. 6. (1) (a)]

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

During the RQI, the Long-Term Care (LTC) Inspector observed resident#500 unattended on a toilet in the tub room. The call bell was located behind the resident. The door to the tub room was propped open. There was a mechanical lift left a few feet in front of the resident. They were not secured to the toilet or the mechanical lift. The resident was leaning back, slouched backwards on the toilet with their eyes closed. There were no PSWs in the hallway or in visual sight of the tub room. The LTC Inspector approached RPN #131 who was in a resident room with the medication cart. The RPN was requested by the LTC Inspector to observe the resident. The RPN confirmed the resident had a history of falls, was a falls risk and should not be left unattended on the toilet.

A review of the resident's documented plan of care, which front line staff used to direct care, listed conditions that put the resident at risk for falls. The plan of care further provided that resident #500 required a certain number of staff for assistance as well as interventions used to mitigate the risk of falls.

The RPN was observed to locate the PSWs responsible for providing care to the resident. Two PSW came to care for the resident and stated to the RPN that they had transferred the resident to the toilet and had left the resident unattended.

The RPN confirmed the resident was not to be left alone, unattended on the toilet. The care was not provided to resident #500 as specified in the plan of care. [s. 6. (7)]

3. The licensee 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 change or care set out in the plan was no longer necessary.

Resident #001 was observed in a wheelchair without a specific intervention applied. Interviews conducted with the resident's SDM and PSW staff #122 and #123 each verified that the resident no longer used the PASD. Interview conducted with RPN #124

verified that the resident no longer used the PASD.

A review of the plan of care included a focus statement related to personal assistance services devices (PASD) used by the resident for comfort and positioning, which included the use of the specific PASD that they no longer use, and did not include the use of another PASD that they do currently use.

Interview conducted with RN #150, following a review of the plan of care, verified that the plan was not updated with changes in the resident's care needs related to PASD usage. [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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Ontario Regulation 79/10, section 68 requires "a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter".

The home's policy, "Resident Height" (FS-09-01-24, last revised October 12, 2015), directed staff to measure and document each resident's height on admission and annually thereafter.

During the inspection it was identified that not all residents had their heights taken and recorded annually. Records identified that eight of eight residents reviewed, who were in the home for over thirteen months, did not have their height completed on an annual basis. Interview with the DOC on November 15, 2017, acknowledged and confirmed that resident heights were taken on admission and on an as needed basis; however, were not done annually. LTC Inspector #168 interviewed the RD who further confirmed this.

Staff did not comply with the home's policy, "Resident Height" as directed. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: 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 every resident's plan of care was 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.

A. Resident #033 had a newly identified area of altered skin integrity identified in 2017. Review of their documented plan of care, which front line staff use to direct care, did not include any mention of the area of altered skin integrity, including identification of the issue or goals and interventions put into place. This was confirmed by RPN #134 following a review of the clinical record.

B. Resident #033 had an area of altered skin integrity identified in 2017 and worsened the following month. Review of their documented plan of care, which front line staff use to direct care, did not include any mention of the area of altered skin integrity, including identification of the issue or goals and interventions put into place. This was confirmed by RPN #134 following a review of the clinical record. [s. 26. (3) 15.]

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 every resident's plan of care is 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 #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

A. Observation of a specific home area had an open door where the home stored lifts and treatment carts. The medication room was observed to be located within this room, but was locked. Another door adjacent to the medication room was open and led into a treatment room which contained wound supplies, such as gauze, soaps and disinfectants in closed containers. There were two treatment carts stored in this room that were observed to be unlocked. The top drawer of one of the treatment carts contained prescription cream that had been identified with a resident name and drug identification number (DIN).

B. Observation of a specific home area contained a linen cart that was left unattended outside a resident room where the room door was closed. The linen cart had a basket of 11 prescription creams with resident names and DINs. In an interview with PSW #135, they indicated that PSWs leave the linen cart and prescription creams outside the resident's room, unlocked and unsecured, while they provide care and then lock up the cart, containing the prescription creams, at the end of their care rounds.

Interview with RPN #121, on November 10, 2017, verified that the treatment room and treatment carts should be locked and secured when a specific storage room, and that medications should be secured and locked. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and was reported to the resident, the resident's substitute-decision maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

On request the home provided a copy of medication incident reports for the past six months.

A review of the incident reports and specific resident clinical health records did not include documentation that immediate reactions were taken to assess and maintain the resident's health nor that all incidents were reported to all requires parties.

i) Residents #023 and #024 were involved in medication incidents in 2017. A review of the medication incident report and progress notes for the time period around the errors did not include immediate actions to assess and maintain the resident's health, that the residents nor their SDMs were notified of the incidents. There was no documentation that the pharmacy or physicians were notified of the errors, prior to the time of the quarterly analysis at the Professional Health Advisory Committee (PHAC) meeting. Interview with the DON and Nurse Managers verified that there was no documentation to support that immediate actions were taken to assess and maintain the resident's health nor that all of the required parties were notified of the errors.

ii) Resident #021 was involved in a medication incident in 2017, which was discovered days after the incident. A review of the medication incident report and progress notes for the time period around the time of the error did not include immediate actions to assess and maintain the resident's health. Interview with the DON and Nurse Managers verified that there was no documentation to support that immediate actions were taken to assess and maintain the resident's health. [s. 135. (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 every medication incident which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that they responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Discussion with the Residents' Council Assistant identified the current process in place when concerns or recommendations were made by the Residents' Council, to include a written response to the issue(s) in the meeting minutes and post the minutes within 10 days of the meeting date.

It was confirmed by the Assistant and the President of Residents' Council that the Food Council was part of the Residents' Council; however, was a opportunity to meet with the Director of Food Services.

A review of Residents' Council Meeting Minutes, including minutes from the Food Council, identified that a response was not consistently provided, in writing, related to concerns or recommendations.

i) Minutes from the meeting held at a specific meeting in 2017, included concerns related to food production and quality and dining service. Interview with the Assistant verified that the identified issues were discussed; however, were not responded to in writing.

ii) Minutes from the meeting held at a specific meeting 2017, included recommendations related to food item preferences. Interview with the Assistant verified that although she did not attend the meeting, the identified issues were not responded to in writing. [s. 57. (2)]

Issued on this 11th day of December, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PALADINO (586), LISA VINK (168), ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2017_689586_0010
Log No. / No de registre :	025501-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 29, 2017
Licensee / Titulaire de permis :	CITY OF HAMILTON 77 James Street North, Suite 400, HAMILTON, ON, L8R-2K3
LTC Home / Foyer de SLD :	MACASSA LODGE 701 UPPER SHERMAN AVENUE, HAMILTON, ON, L8V-3M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shawn Gadsby

To CITY OF HAMILTON, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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. Review the clinical record of all residents in the home who exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, to determine;

a) if skin assessments were conducted by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and ensure that for those who have not been assessed receive assessments;

b) if they were assessed at least weekly by a member of the registered nursing staff; and,

c) if they were referred to and assessed by the RD, ensure that for those who have not been receive referrals and assessments.

2. Review each of the residents' plans of care and update it to include the current status of each area of altered skin integrity, as well as goals and interventions currently in place.

3. Establish an auditing process to ensure ongoing compliance.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect of the risk of harm toward residents #001, #033, and #034, the scope of a widespread issue, and the licensee's history of non-compliance (VPC) on the May 2, 2016, Resident Quality Inspection with the r. 50 (2) (b) related to the home's skin and wound program.

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.

RN #150 communicated the expectation that all areas of altered skin integrity were to be assessed when first identified and documentation of this assessment

would be recorded in the resident's clinical record in Point Click Care (PCC), assessment tab, as a Wound Assessment Flow Sheet (WAFS).

A. A review of the clinical record identified that resident #001 had multiple areas of altered skin integrity.

i) The progress notes included an area of altered skin integrity in 2017. The area did not have an assessment completed until it was assessed by the nurse practitioner (NP) seven days later in the progress notes.

ii) Progress notes included a second area of altered skin integrity in 2017, when it was referred to the NP.
This area was assessed nine days later in the progress notes.

iii) Progress notes identified that the resident had care provided away from the home, which resulted in an area of altered skin integrity in 2017. There was no initial assessment in the clinical record of the area.

RN #150 verified that the resident did not have an assessment of the areas completed, as required when first identified using a clinically appropriate assessment instrument. (168).

B. A review of the clinical record identified that resident #033 had one newly identified area of altered skin integrity.

The progress notes included an area of altered skin integrity in 2017. The area did not have an initial WAFS assessment completed. RPN #134 verified that the resident did not have an assessment of the areas completed, as required when first identified using a clinically appropriate assessment instrument. (586). (168)

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian (RD) who was a member of the staff of the home, and that any changes made to the plan of care related to nutrition and hydration were implemented.

RPN #124 identified that residents with areas of altered skin integrity would be referred to the RD for assessment on a case by case basis, based on specific factors and as suggested by the NP.

Interview with RN #150 identified that all residents with areas of altered skin integrity would be referred to the RD for assessment, that an electronic referral would be submitted to the RD in PCC.

The DON and nurse managers confirmed the expectation that all residents with altered skin integrity would be referred to the RD for assessment.

A. A review of the clinical record identified that resident #001 had altered skin integrity. A review of the clinical record identified that the resident had areas of altered skin integrity identified in 2017, and two additional areas the following month in 2017. There was no documentation in the clinical record of a referral to the RD or of any assessments completed by the RD as a result of the changes in skin integrity, which was confirmed by RN #150 following a review of the clinical record.

Interview with the RD confirmed that they had not completed an assessment of the resident, since their admission to the home and had not received any referrals related to altered skin. (168).

B. A review of the clinical record identified that resident #033 had a newly identified area of altered skin integrity identified in 2017. There was no documentation in the clinical record of a referral to the RD or of any assessments completed by the RD as a result of the changes in skin integrity, which was confirmed by RPN #134 following a review of the clinical record.

C. A review of the clinical record identified that resident #033 had an area of altered skin integrity identified in 2017 and worsened the following month. There was no documentation in the clinical record of a referral to the RD or of any assessments completed by the RD as a result of the changes in skin integrity, which was confirmed by RPN #134 following a review of the clinical record. (586). (168)

3. The licensee failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Interview with RPN #124 and RN #150 verified the expectation that areas of

altered skin integrity were assessed and documented weekly in the clinical record.

A. Resident #001 was identified with altered skin integrity. A review of the clinical record did not include a reassessment of all areas altered skin integrity on a weekly basis.

i) An area of altered skin integrity was identified in 2017. The clinical record did not include a weekly reassessment of the area for approximately four weeks beginning the following month.

ii) An area of altered skin integrity was included in the progress notes in 2017, which was observed to have worsened by the following month. A review of the clinical record did not include any weekly reassessments of the area.

Interview with RN #150, following a review of the clinical record verified that the identified areas were not assessed weekly for the time periods identified, as required. (168).

B. Resident #034 was identified with altered skin integrity. A review of the clinical record did not include a reassessment of all areas altered skin integrity on a weekly basis. An area of altered skin integrity was identified in identified in 2017 and worsened by the following month. The clinical record did not include a weekly reassessment of the area between during two separate months within the time that it was discovered and worsened. Interview with RPN #134, following a review of the clinical record, verified that the identified areas were not assessed weekly for the time periods identified, as required. (586). (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 02, 2018

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
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 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 29th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Jessica Paladino

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