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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 25, 2017	2016_419658_0015	027032-16	Complaint

Licensee/Titulaire de permis

MEADOW PARK (LONDON) INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

MEADOW PARK (LONDON) INC.
1210 SOUTHDALE ROAD EAST LONDON ON N6E 1B4

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

NEIL KIKUTA (658)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 31, December 6, 7, 8, 14, 16, and 19, 2016.

A Written Notification and Compliance Order under O. Reg. 79/10, s. 50 (2), identified in concurrent inspection #2016_419658_0013 will be issued in this report.

A Written Notification and Voluntary Plan of Correction under LTCHA, 2007, c. 8, s. 6 (10), identified in concurrent inspection #2016_419658_0013 will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Medical Director, the Restorative Care Coordinator, the Environmental Services Supervisor, one Staff Educator, the Registered Dietitian, one Registered Nurse, two Registered Practical Nurses, four Personal Support Workers, and three residents.

The inspector reviewed clinical records and plans of care for relevant residents, pertinent policies, procedures, and program evaluations, and the staff schedule. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, staff to resident interactions, and medication administration and storage areas.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 has failed to ensure that a resident exhibiting 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.

Jarlette Health Services policy on the Skin and Wound Care Program Version #2 last revised September 19, 2016, stated in part that a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds would have a completed wound assessment and treatment record completed with initiation of impaired skin integrity and with any change in treatment.

On a specified date, a Registered Nurse (RN) said that for a new wound, including skin tears and pressure ulcers, registered staff were required to assess and document the skin breakdown in a wound assessment and treatment note under the assessments tab in PointClickCare (PCC).

A) Review of an identified resident's progress notes in PCC indicated that on a specified date, the resident had a fall and sustained areas of altered skin integrity. There was no wound assessment and treatment record completed in the assessments tab, but rather a wound note assessment progress note was completed on another specified date, four

days after the resident had sustained the areas of altered skin integrity.

On a specified date, the identified resident was assessed by the physician and documented that the resident had another area of altered skin integrity. Further review showed that no area of altered skin integrity assessment and treatment record was completed by registered staff.

The Medical Director (MD) clarified that they had initially assessed the resident’s areas of altered skin integrity and noted that it was an open area.

On a specified date, the DOC explained that registered staff were responsible for assessing areas of altered skin integrity and completing the wound assessment and treatment note during the reported shift.

B) A skin progress note in PCC on a specified date noted that an identified resident had skin breakdown. The skin note identified the measurements of the area and the treatment intervention, but did not capture the same parameters as those utilized in a wound assessment and treatment record.

The Skin and Wound Care Program policy stated in part that skin progress notes would be completed for altered skin integrity other than a wound. The identified resident's skin breakdown constituted actual alteration in skin integrity and required the use of a wound assessment and treatment record to be completed.

On a specified date, the DOC acknowledged that a wound assessment and treatment record had not been completed by registered staff regarding the new skin breakdown, and that it was required to be done.

C) On a specified date, an inspector reviewed a Critical Incident System report submitted to the Director related to alleged abuse. Further review of the home's internal investigation report and the resident's progress notes on a specified date, showed that the identified resident had an area of altered skin integrity. The origin of the area of altered skin integrity was unknown but was thought to have occurred during care on a specified date.

The licensee's Skin and Wound Care policy titled "PCC Wound Assessment and Treatment" with an effective date of September 16, 2016, stated that a wound assessment and treatment assessment would be completed by registered staff for a

resident at the time of any impairment of skin integrity including a specific type of altered skin integrity.

The licensee's Treatment Administration Record policy with a revised date of July 24, 2015, stated that all treatments required a written order signed by the prescriber with ordering authority, and that all treatments administered as a nursing measure would be identified as such.

The identified resident's care plan showed a potential for breakdown in structural integrity of skin caused by pressure. The care plan outlined specific interventions for treatment as per the physician's orders. Further review of the resident's physician's orders showed that none of the treatments identified as specific interventions in the care plan were ordered by the prescriber.

A PCC daily progress note on a specified date, showed that a PSW notified the nurse that the identified resident had a large area of altered skin integrity. The nurse further documented that the resident felt they received the area of altered skin integrity during care while repositioned in bed. There was no documentation to show that a wound assessment and treatment assessment had been completed in PCC or that the substitute decision maker (SDM) had been notified regarding the area of altered skin integrity.

On a specified date, the DOC said that the identified resident did not have an area of altered skin integrity and that the medication ordered for the treatment was a nursing best practice measure. The DOC further explained that a wound assessment and treatment assessment was needed to be completed on a resident when bruising or impaired skin integrity was noted, and acknowledged that this had not been done on a specified date, when the area of altered skin integrity was identified. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian (RD).

Jarlette Health Services policy on the Skin and Wound Care Program Version #2 last revised September 19, 2016, stated in part that a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds would be referred to the registered dietitian electronically through PointClickCare (PCC). The registered dietitian would ensure that those residents with altered skin integrity were

assessed within seven days of referral.

Interviews conducted with registered staff members including an identified Staff Educator, Registered Nurse, and two Registered Practical Nurses all stated that they would complete a referral to the dietitian for any wounds including skin tears and pressure ulcers.

A) Review of an identified resident's electronic medical health records indicated that they had sustained four different areas of altered skin integrity in a span of approximately four months.

On a specified date, the RD explained that registered staff were required to complete a nutritional referral form on PCC under the assessments tab for any residents who had altered skin integrity. The RD stated that they had not received any referrals for the identified resident related to altered skin integrity for three of the four areas of altered skin integrity. The RD acknowledged that they had received a nutritional referral for one of the areas of altered skin integrity, but had not completed the assessment.

On a specified date, the Director of Care said that all wounds and impaired skin integrity would be referred to and assessed by the dietitian.

B) Record review showed that a specified resident had developed an area of altered skin integrity on a specified date, and skin breakdown at another location on another specified date.

Review of the identified resident's electronic health records showed that no referral was completed by registered staff to the RD regarding the two areas of altered skin integrity.

On a specified date, the Director of Care acknowledged that a referral to the RD was not completed by registered staff for the areas of altered skin integrity, and stated that it was their expectation that the RD was notified of all areas of altered skin integrity. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that a resident exhibiting 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.

Jarlette Health Services policy on the Skin and Wound Care Program Version #2 last

revised September 19, 2016, stated in part that a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds would have a wound progress note completed weekly.

On a specified date, an identified Registered Nurse said that all areas of altered skin integrity would be reassessed at least weekly by registered staff and documented in a wound assessment note under PointClickCare (PCC).

A) Registered staff documented on a specified date that an identified resident had areas of altered skin integrity. The only wound notes were completed on three specified dates. Review of the resident’s treatment administration record (TAR) indicated that the identified resident was being treated for areas of altered skin integrity over a four month period. Documentation in the progress notes indicated that a weekly reassessment of altered skin integrity was not being completed.

Review of the identified resident's TAR showed that a dressing was initiated for another area of altered skin integrity on a specific date, and discontinued 14 days later. During the specified dates, the identified resident's progress notes had no wound notes indicating reassessment of the area of altered skin integrity.

B) On a specified date, registered staff documented a new area of altered skin integrity related to an identified resident. Wound notes were completed on 14 specific dates during a four month period. The dates of completion of the wound notes identified that weekly reassessments for the area of altered skin integrity were not being completed by registered staff.

A skin note on a specific date, documented that the identified resident had new skin breakdown. In review of PCC, there were no wound notes completed to support weekly reassessment of the skin breakdown.

On a specified date, the DOC said that all areas of altered skin integrity should be reassessed weekly.

The scope of this area of non-compliance was determined to be a level two, where a pattern was demonstrated throughout the home. The severity was determined to be a level two, related to minimal harm or potential for actual harm. There was a history of related non-compliance in the last three years as evidenced by a WN being issued in inspection report #2015_416515_0009, and a WN and VPC being issued in inspection

report #2014_255516_0013. [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. 6. Plan of care

Specifically failed to comply with the following:

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 resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A) On a specified date, an identified resident sustained two areas of altered skin integrity following a fall. The identified resident's care plan was reviewed and revised on a specified date, four days after the areas of altered skin integrity appeared, to reflect the new areas of altered skin integrity as well as the prescribed treatment.

In PointClickCare (PCC), a wound note on a specified date indicated that both areas of altered skin integrity were healed. On another specified date, an electronic medication administration record (eMAR) note stated that the prescribed treatments for the resident's areas of altered skin integrity were not completed as the areas of altered skin integrity were healed.

On a specified date several months after the eMAR note was documented, an inspector observed the specified resident sitting in their recliner in their room with no dressings or area of altered skin integrity at the specified location.

Record review of the identified resident's quarterly physician medication review was completed and signed by the physician on a specified date. The quarterly physician medication review indicated a check mark under the “continue” column for the treatment related to the resident’s two areas of altered skin integrity. A registered staff member documented in an eMAR note four days prior to the quarterly physician medication review, that the area was healed.

On a specified date, the Medical Director (MD) explained that before continuing a treatment they would observe the resident and assess the continued use of the ongoing treatment. The MD could not explain why the treatment related to the identified resident's areas of altered skin integrity were continued when they had been healed for over two months as indicated by numerous progress notes by registered staff.

The identified resident's electronic treatment administration record (eTAR) for a specified month included orders to treat the resident’s areas of altered skin integrity. One of the orders provided staff direction to treat the area of altered skin integrity. Of the 13 days that this treatment was ordered in the specified month, eight out of 13 were signed as “drug refused,” three out of 13 were not signed for by registered staff, and two out of 13 were signed as administered.

Record review of the identified resident's care plan on a specified date indicated no changes related to the areas of altered skin integrity or the prescribed treatment since a specified date, yet registered staff were documenting just over a month after the initiation of the treatment order that care was no longer necessary because the areas of altered skin integrity were healed.

On a specified date, an identified Registered Practical Nurse (RPN) explained that registered staff were required to update the care plans of residents, but that they did not know how to update or who was responsible for updating the care plan related to skin issues.

On a specified date, the Director of Care (DOC) stated that registered staff were responsible for updating the care plans of residents, and that they expected that the plan of care would be updated when skin and wound issues were resolved.

B) Record review of a specified resident's care plan directed staff to ask the resident if they desired to have a bowel movement at each care time and offer the resident a

toileting device.

When the inspector approached the identified resident to interview them on their personal care needs, the resident was unable to be interviewed, and was unable to appropriately answer any of the questions posed by the inspector.

The most recent assessment of continence completed on a specified date under the assessments tab identified that the identified resident was incontinent of bowels, but did not mention the use of the toileting device. The most recent Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment and Resident Assessment Protocol (RAP) indicated that the specified resident did not use the toileting device.

On a specified date, two Personal Support Workers (PSW) said that the identified resident did not use the specific toileting device for bowel movements. An identified Registered Practical Nurse (RPN) and a representative of the continence committee reaffirmed that the resident did not the toileting device.

C) Record review of a specified resident's care plan and kardex stated that the resident was continent and had complete urinary control.

In an interview on a specified date, the identified resident explained that staff were responsive when they required toileting assistance.

Review of a seven day look back period for the identified resident's PointOfCare (POC) toileting response history documented by PSWs in the home had indicated that the resident was incontinent seven out of seven days during at least one shift.

The most recent assessment of continence noted that the identified resident was incontinent of urine mostly at night. The most recent RAI-MDS and RAP identified that the resident was frequently incontinent of urine and utilized an incontinence product.

On a specified date a PSW explained that the identified resident was sometimes incontinent, and another PSW said that the resident had occasional accidents during the day, but was a heavy wetter during the night. An identified RPN stated that the resident did require care during the night, and that the resident's care plan should have been changed to occasionally incontinent to reflect the current level of care.

On February 15, 2017, the DOC acknowledged that the plan of care of both residents

were not reviewed and revised as their care needs changed or care set out in the plan was no longer necessary, and that it was the responsibility of registered staff to update the plan of care whenever there was a change with the resident.

D) On a specified date, an RN documented in a wound assessment note that they had assessed an identified resident and noted an area of altered skin integrity. The RN initiated a treatment and indicated that they had notified the Physician. On a specified date, the Physician assessed the identified resident and documented that the resident had an area of altered skin integrity, and that treatment direction and changing position frequently were advised.

On a specified date, the licensee submitted in a critical incident report outlining that the identified resident had been neglected by a registered staff. In the report, the identified resident approached an RPN to request they receive care related to their altered skin integrity.

In an interview, the identified RPN explained that the resident had asked them to look at their area of altered skin integrity, but that there was no treatment in the Treatment Administration Record (TAR). The RPN said that there was no dressing ordered during their shift for the resident on the specified date, and had not assessed the resident's area of altered skin integrity because of this. Home investigation notes showed that on a specified date, the RPN was not aware of the resident's area of altered skin integrity.

The identified resident's TAR indicated that a treatment for the area of altered skin integrity had a specific revision date, and a start date of one day after the specified date, yet had initially been treated for four days prior to the initial specified date. Review of the identified resident's medical health records showed no transcription of the treatment in the Prescriber's Order Form.

Jarlette Health Services Treatment Administration Record policy with an effective date of May 1, 2007, and a revised date of July 24, 2015, stated in part that:

- "All treatments administered shall be documented on the resident's personal Treatment Administration Record (TAR)."; and
- "All treatments shall have a written order signed by the prescriber with ordering authority (Ie. Physician, Nurse Practitioner, dentist etc.)."

Through inspection, it was determined that the identified resident had an assessment

completed by a registered staff member related to their new area of altered skin integrity on a specified date. However, the TAR was not updated until four days later to reflect the treatment, there was no written order signed by a prescriber to direct staff on how to initially treat the area of altered skin integrity, and the resident's care plan was not reviewed and revised until 12 days after the area of altered skin integrity was initially assessed.

On a specified date, the DOC said that the nurse who completed a skin and wound assessment should have updated the plan of care with the appropriate treatment, and inputted a treatment order to be signed by the prescriber.

The scope of this area of non-compliance was determined to be a pattern. The severity was determined to be a level two, related to minimal harm or potential for actual harm. There was a history of related non-compliance in the last three years as evidenced by a WN and VPC being issued in inspection report #2016_45760_0027. [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 residents are 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; (b) the resident's care
needs change or care set out in the plan is no longer necessary; or (c) care set out in the
plan has not been effective, to be implemented voluntarily.

WN #3: 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 has failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the resident's skin condition, including altered skin integrity.

Jarlette Health Services policy on the Skin and Wound Care Program Version #2 last revised September 19, 2016, stated in part that a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds would be referred to restorative care. The policy also stated that restorative care would ensure that any resident with pressure ulcers would be assessed for positioning and seating, and clearly document transfer and positioning strategies on the plan of care.

On a specified date, the Medical Director (MD) documented in a progress note that they had assessed an identified resident with an area of altered skin integrity. A treatment was started on a specified date.

On three specified dates, an inspector observed the identified resident sitting in their recliner in their room. Two identified Personal Support Workers (PSW) and a Staff Educator all explained that the identified resident often sat in their recliner for long periods of time. On a specified date, the identified resident told the inspector that it was painful when sitting.

On a specified date, the Restorative Care Coordinator (RCC) said that they never received a referral related to the identified resident's area of altered skin integrity. The RCC and Director of Care (DOC) stated that it was required for registered staff to complete the referral to the RCC so that an assessment could be completed for the identified resident's area of altered skin integrity.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to minimal harm or potential for actual harm. There was a history of unrelated non-compliance in the last three years. [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 that a plan of care was based on, at a minimum, interdisciplinary assessment of the resident's skin condition, including altered skin integrity, to be implemented voluntarily.

Issued on this 18th day of July, 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NEIL KIKUTA (658)
Inspection No. / No de l'inspection :	2016_419658_0015
Log No. / Registre no:	027032-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 25, 2017
Licensee / Titulaire de permis :	MEADOW PARK (LONDON) INC 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	MEADOW PARK (LONDON) INC. 1210 SOUTHDALE ROAD EAST, LONDON, ON, N6E-1B4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nicole Ross

To MEADOW PARK (LONDON) INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

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 will ensure compliance with O. Reg. 79/10, s. 50 (2) by ensuring that all residents who exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are appropriately assessed. The licensee must immediately initiate steps towards protecting resident #015 and all other residents who exhibit or develop altered skin integrity while in the care of the long-term care home. This includes, but is not limited to:

- Assessing resident #015 specifically and any other residents as required for any altered skin integrity using a clinically appropriate assessment instrument specifically designed for skin and wound assessment that reflects the tools identified in the skin and wound program in the home;
- Referring all residents who exhibit altered skin integrity to a registered dietitian who will then conduct an assessment, and implement any changes made to the resident's plan of care relating to nutrition and hydration;
- Ensuring resident #015 specifically and any other residents as required who exhibit altered skin integrity are reassessed at least weekly by a member of the registered nursing staff; and
- Ensuring that implemented interventions for all residents exhibiting altered skin integrity are monitored and evaluated appropriately.

The licensee will also ensure that all registered staff are re-educated on the home's skin and wound program.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting 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.

Jarlette Health Services policy on the Skin and Wound Care Program Version #2 last revised September 19, 2016, stated in part that a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds would have a completed wound assessment and treatment record completed with initiation of impaired skin integrity and with any change in treatment.

On a specified date, a Registered Nurse (RN) said that for a new wound, including skin tears and pressure ulcers, registered staff were required to assess

and document the skin breakdown in a wound assessment and treatment note under the assessments tab in PointClickCare (PCC).

A) Review of an identified resident's progress notes in PCC indicated that on a specified date, the resident had a fall and sustained areas of altered skin integrity. There was no wound assessment and treatment record completed in the assessments tab, but rather a wound note assessment progress note was completed on another specified date, four days after the resident had sustained the areas of altered skin integrity.

On a specified date, the identified resident was assessed by the physician and documented that the resident had another area of altered skin integrity. Further review showed that no area of altered skin integrity assessment and treatment record was completed by registered staff.

The Medical Director (MD) clarified that they had initially assessed the resident's areas of altered skin integrity and noted that it was an open area.

On a specified date, the DOC explained that registered staff were responsible for assessing areas of altered skin integrity and completing the wound assessment and treatment note during the reported shift.

B) A skin progress note in PCC on a specified date noted that an identified resident had skin breakdown. The skin note identified the measurements of the area and the treatment intervention, but did not capture the same parameters as those utilized in a wound assessment and treatment record.

The Skin and Wound Care Program policy stated in part that skin progress notes would be completed for altered skin integrity other than a wound. The identified resident's skin breakdown constituted actual alteration in skin integrity and required the use of a wound assessment and treatment record to be completed.

On a specified date, the DOC acknowledged that a wound assessment and treatment record had not been completed by registered staff regarding the new skin breakdown, and that it was required to be done.

C) On a specified date, an inspector reviewed a Critical Incident System report submitted to the Director related to alleged abuse. Further review of the home's internal investigation report and the resident's progress notes on a specified

date, showed that the identified resident had an area of altered skin integrity. The origin of the area of altered skin integrity was unknown but was thought to have occurred during care on a specified date.

The licensee's Skin and Wound Care policy titled "PCC Wound Assessment and Treatment" with an effective date of September 16, 2016, stated that a wound assessment and treatment assessment would be completed by registered staff for a resident at the time of any impairment of skin integrity including a specific type of altered skin integrity.

The licensee's Treatment Administration Record policy with a revised date of July 24, 2015, stated that all treatments required a written order signed by the prescriber with ordering authority, and that all treatments administered as a nursing measure would be identified as such.

The identified resident's care plan showed a potential for breakdown in structural integrity of skin caused by pressure. The care plan outlined specific interventions for treatment as per the physician's orders. Further review of the resident's physician's orders showed that none of the treatments identified as specific interventions in the care plan were ordered by the prescriber.

A PCC daily progress note on a specified date, showed that a PSW notified the nurse that the identified resident had a large area of altered skin integrity. The nurse further documented that the resident felt they received the area of altered skin integrity during care while repositioned in bed. There was no documentation to show that a wound assessment and treatment assessment had been completed in PCC or that the substitute decision maker (SDM) had been notified regarding the area of altered skin integrity.

On a specified date, the DOC said that the identified resident did not have an area of altered skin integrity and that the medication ordered for the treatment was a nursing best practice measure. The DOC further explained that a wound assessment and treatment assessment was needed to be completed on a resident when bruising or impaired skin integrity was noted, and acknowledged that this had not been done on a specified date, when the area of altered skin integrity was identified.

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was

assessed by a registered dietitian (RD).

Jarlette Health Services policy on the Skin and Wound Care Program Version #2 last revised September 19, 2016, stated in part that a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds would be referred to the registered dietitian electronically through PointClickCare (PCC). The registered dietitian would ensure that those residents with altered skin integrity were assessed within seven days of referral.

Interviews conducted with registered staff members including an identified Staff Educator, Registered Nurse, and two Registered Practical Nurses all stated that they would complete a referral to the dietitian for any wounds including skin tears and pressure ulcers.

A) Review of an identified resident's electronic medical health records indicated that they had sustained four different areas of altered skin integrity in a span of approximately four months.

On a specified date, the RD explained that registered staff were required to complete a nutritional referral form on PCC under the assessments tab for any residents who had altered skin integrity. The RD stated that they had not received any referrals for the identified resident related to altered skin integrity for three of the four areas of altered skin integrity. The RD acknowledged that they had received a nutritional referral for one of the areas of altered skin integrity, but had not completed the assessment.

On a specified date, the Director of Care said that all wounds and impaired skin integrity would be referred to and assessed by the dietitian.

B) Record review showed that a specified resident had developed an area of altered skin integrity on a specified date, and skin breakdown at another location on another specified date.

Review of the identified resident's electronic health records showed that no referral was completed by registered staff to the RD regarding the two areas of altered skin integrity.

On a specified date, the Director of Care acknowledged that a referral to the RD was not completed by registered staff for the areas of altered skin integrity, and

stated that it was their expectation that the RD was notified of all areas of altered skin integrity.

3. The licensee has failed to ensure that a resident exhibiting 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.

Jarlette Health Services policy on the Skin and Wound Care Program Version #2 last revised September 19, 2016, stated in part that a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds would have a wound progress note completed weekly.

On a specified date, an identified Registered Nurse said that all areas of altered skin integrity would be reassessed at least weekly by registered staff and documented in a wound assessment note under PointClickCare (PCC).

A) Registered staff documented on a specified date that an identified resident had areas of altered skin integrity. The only wound notes were completed on three specified dates. Review of the resident's treatment administration record (TAR) indicated that the identified resident was being treated for areas of altered skin integrity over a four month period. Documentation in the progress notes indicated that a weekly reassessment of altered skin integrity was not being completed.

Review of the identified resident's TAR showed that a dressing was initiated for another area of altered skin integrity on a specific date, and discontinued 14 days later. During the specified dates, the identified resident's progress notes had no wound notes indicating reassessment of the area of altered skin integrity.

B) On a specified date, registered staff documented a new area of altered skin integrity related to an identified resident. Wound notes were completed on 14 specific dates during a four month period. The dates of completion of the wound notes identified that weekly reassessments for the area of altered skin integrity were not being completed by registered staff.

A skin note on a specific date, documented that the identified resident had new skin breakdown. In review of PCC, there were no wound notes completed to support weekly reassessment of the skin breakdown.

On a specified date, the DOC said that all areas of altered skin integrity should be reassessed weekly.

The scope of this area of non-compliance was determined to be a level two, where a pattern was demonstrated throughout the home. The severity was determined to be a level two, related to minimal harm or potential for actual harm. There was a history of related non-compliance in the last three years as evidenced by a WN being issued in inspection report #2015_416515_0009, and a WN and VPC being issued in inspection report #2014_255516_0013.
(658)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Neil Kikuta

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