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
Mar 26, 2018	2018_605213_0004	002422-18	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Secord Trails Care Community
263 Wonham Street South INGERSOLL ON N5C 3P6

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

RHONDA KUKOLY (213), ALI NASSER (523), HELENE DESABRAIS (615), NATALIE MORONEY (610)

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): February 22, 23, 26, 28, March 1, 2, 5, 6, 7, 8, 2018.

The following intakes were completed within the Resident Quality Inspection (RQI):

Follow up log #026871-17 related to order #001 issued in RQI inspection #2017_607523_0017 regarding forwarding written complaints to the Director.
Follow up log #026872-17 related to order #002 issued in RQI inspection

#2017_607523_0017 regarding investigating reports of abuse and taking appropriate actions.
Follow up log #026870-17 related to order #003 issued in RQI inspection #2017_607523_0017 regarding reporting to the Director.
Follow up log #026873-17 related to order #004 issued in RQI inspection #2017_607523_0017 regarding medication incidents.
Follow up log #015329-17 related to order #001 issued in complaint inspection #2017_3636593_0006 regarding complying with the home's falls prevention and lifts and transfers policy.
Follow up log #01532-17 related to order #002 issued in complaint inspection #2017_3636593_0006 regarding care plan based on an interdisciplinary assessment of safety risks.
Follow up log #01532-17 related to order #003 issued in complaint inspection #2017_3636593_0006 regarding care plan providing clear direction.
Critical Incident #2628-000036-17/Log #027097-17 related to alleged staff to resident physical abuse.
Critical Incident #2628-000004-18/Log #000957-18 related to alleged staff to resident physical abuse.
Critical Incident #2628-000038-17/Log #026400-17 related to alleged staff to resident verbal abuse.
Critical Incident #2628-000034-17/Log #025686-17 related to alleged resident to resident physical abuse.
Critical Incident #2628-000035-17/Log #025397-17 related to alleged resident to resident physical abuse.
Critical Incident #2628-000018-17/Log #021401-17 related to alleged resident to resident physical abuse.
Critical Incident #2628-000017-17/Log #020967-17 related to alleged resident to resident physical abuse.
Critical Incident #2628-000016-17/Log #019969-17 related to alleged resident to resident physical abuse.
Critical Incident #2628-000014-17/Log #018721-17 related to alleged resident to resident physical abuse.
Critical Incident #2628-000003-18/Log #001012-18 related to alleged resident to resident physical abuse.
Critical Incident #2628-000009-18/Log #003654-18 related to alleged resident to resident physical abuse.
Critical Incident #2628-000012-17/Log #013758-17 related to falls.
Critical Incident #2628-000011-17/Log #012184-17 related to falls.

Critical Incident #2628-000044-17/Log #029120-17 related to falls.
Critical Incident #2628-000028-17/Log #024624-17 related to falls.
Critical Incident #2628-000002-18/Log #001112-18 related to falls.
Complaint Infoline #IL-52932-LO/Log #021996-17 related to care concerns and skin and wounds.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Associate Director of Care, the Facilities Manager, the Office Manager, the Director of Resident Programs and Admissions, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a Residents' Council representative, a Family Council representative, residents and family members.

The inspectors also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, education records, meeting minutes, incident reports, as well as clinical records and plans of care for identified residents were reviewed. Inspectors observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of required information and inspection reports, and the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **6 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 135.	CO #004	2017_607523_0017	213
LTCHA, 2007 S.O. 2007, c.8 s. 22. (1)	CO #001	2017_607523_0017	213
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #002	2017_607523_0017	523
LTCHA, 2007 S.O. 2007, c.8 s. 24.	CO #003	2017_607523_0017	523
O.Reg 79/10 s. 26. (3)	CO #002	2017_363659_0002	610
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #003	2017_363659_0002	610
O.Reg 79/10 s. 8. (1)	CO #001	2017_363659_0002	610

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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

The Ministry of Health and Long-Term Care (MOHLTC) received complaint #IL-52932-LO, on a specific date, for resident #075, regarding care concerns related to skin care treatment.

Neglect is defined in Ontario Regulation 79/10, as "failure to provide a resident with the treatment, care, services or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

A review of resident #075's documentation in Point Click Care (PCC) showed that resident #075 required treatments, monitoring and assessments for skin care management. The documentation in resident #075's progress notes, care plan and Treatment Administration Record (TAR) in PCC showed inconsistency regarding direction for treatment, what treatment was provided and that the treatment was not provided as planned on several occasions. The resident's condition worsened and the resident had a significant change in status.

During an interview with resident #075, the resident said that staff don't seem to care too much about the treatments or how often they were to be done. The resident said that the treatment was not completed the last time it was scheduled to be done.

An interview with registered nursing staff member, they said that the treatment noted on the TAR for a specified period of time was likely an error in direction.

In an interview with the Director of Care (DOC), the DOC was not able to tell Inspector #610 if the documentation had been incorrect and that staff were in fact providing the treatment as documented, as the documentation was unclear in PCC. The DOC further elaborated and said that they expect that the plan of care for skin and wound treatment would provide clear direction to all staff and it had not.

The DOC also said that if the treatments were not signed for in the TAR, the treatment was not provided. The DOC further said that the last time the treatment was scheduled to be done, the registered nursing staff had not documented the treatment provided on the TAR, as they did not complete the treatment and should have. The DOC said that if staff were not able to complete the treatment as planned in the TAR, the expectation was for staff to communicate to the next shift to complete the treatment that day, and that the registered nursing staff had not done so and should have.

The licensee has failed to ensure that resident #075 was not neglected by the licensee or staff when documentation was unclear, treatments were not provided and direction was not clear when a resident had a significant worsening change in condition. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, have been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The health care record for resident #073 was reviewed and documentation indicated the resident incurred a significant change in condition. The care plan for resident #073 showed that there was an area of impaired skin integrity that required monitoring and

treatment.

Assessments in Point Click Care (PCC) for resident #073 were reviewed and showed that a weekly skin and wound assessment was completed twelve days after the home had become aware of an area of impaired skin integrity for this resident. Twenty-four days later, a weekly skin and wound assessment was completed for worsening skin integrity. However, documentation in the progress notes in PCC further showed that staff were not completing assessments using a clinically appropriate assessment tool when the impaired skin integrity had been first observed.

A review of the home’s policy “Skin and Wound Care Management Protocol” Policy #V11-G-10.80 revised April 2016, stated in part: With a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears and wounds, that registered staff would conduct a skin assessment, provide immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infections as required, update the plan of care, including the Treatment Administration Record and care plan as appropriate, and initiate electronic weekly skin assessment.

During an interview with the Associate Director of Care (ADOC) #104, the ADOC said that all registered staff were to complete weekly skin assessments in Point Click Care (PCC) and that staff receive an alert that a weekly skin assessment was required to be completed for a specific resident.

During interviews with the Executive Director #115 and the Director of Care (DOC) #100, both said that the home’s expectation was that weekly skin and wound assessments would be completed for this resident with altered skin integrity and they were not.

The licensee has failed to ensure that when resident #073 exhibited altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, to minimize the risk of altercations and potentially harmful interactions between and among residents.

Six Critical Incident reports were submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) involving responsive behaviours of resident#001 over a three month period of time. During this time period, two complaints were also received by the MOHLTC involving responsive behaviours of resident #001.

A review of the home's policy "Responsive Behaviours - Management" reviewed October 2016, was completed. The policy stated in part: The Executive Director, Administrator, Director of Care will: 1) Determine the need for additional staffing supports, i.e. access MOH High Intensity Needs. 2) Provide orientation and education programs upon hire and annually to target audiences on approaches that integrate evidence-based strategies such as GENTLECARE, Gentle Persuasive Approach (GPA), Montessori, PIECES, U-FIRST, etc. 4) Ensure all team members receive basic education on dementia. And, Registered staff will: Complete behavioural assessments based on resident need, including, but not limited to: Dementia Observation System (DOS), Behavioural Assessment Tools (BAT), Depression Scale, Mini-mental, Cohen-Mansfield Aggression Inventory.

A record review of the electronic and paper health record for resident #001 was completed. Resident #001's Minimum Data Set (MDS) assessment identified the resident having behavioural symptoms. Resident #001's Interdisciplinary Care Conference identified the resident as having responsive behaviours. The home completed a "Responsive Behaviours Referral" for increased responsive behaviours.

Progress notes in Point Click Care for resident #001 indicated the following:
- Seven incidents where resident #001 was verbally abusive towards staff.
- Two incidents where resident #001 was physically abusive towards staff.
- Nine incidents where resident #001 was verbally abusive towards staff and residents.
- Nine incidents where resident #001 was physically abusive towards staff and residents.
- Medication Administration Records (MARs) and progress notes were faxed to a Behavioural Supports Ontario (BSO) outreach team member and direction was received for new DOS and BSO charting to be started that day and to please continue to monitor.
- On an identified date, the BSO Team documented there was a one to one communication binder (black with a white label) which was where the one to one staff member was supposed to document. This binder had both DOS charting and multidisciplinary progress notes and a master signature list. It was the expectation that the one to one staff members completed both constant DOS charting through their entire shift and at least one narrative multidisciplinary progress note per shift. No matter which department or agency the one to one caregiver was from, the expectation was that it was to be completed. The note indicated that it was legal documentation and these papers would eventually be transferred to the resident's chart. This documentation needed to exist as one to one funding needed to show a need for one to one care. It was the registered staff member’s role to write one progress note per shift summarizing the residents day based on the one to one caregiver's charting.

During an interview with the Director of Care (DOC) #100, the DOC stated that it was the expectation that the DOS forms would be completed for the BSO team to use in assessing resident #001 related to behaviours. DOC #100 stated that resident #001 needed one to one staff supervision 24 hours a day for a three and one half month period of time. The one to one schedule was reviewed with the DOC, where the schedule indicated that for 66 out of 104 days there was not always a staff assigned 24 hours a day.

The home's "P.I.E.C.E.S. Dementia Observation System (DOS) Form" was reviewed for the time period of three and one half months. The forms showed that the observations of resident #001 were completed in full for the 24 hour period by staff seven days out of 105 days (6.6 percent). Observations of resident #001 were completed in part (periods of time in a 24 hour period) by staff on 35 days out of 105 days (33 percent) on the DOS.

A review of the home's schedule of one to one staffing for resident #001 was completed for a specific three week time period. During this period, the schedule showed that one to one staffing for resident #001 was in place for partial hours on 15 out of 21 days and none at all on 6 out of 21 days. A review of the home's schedule of one to one staffing for resident #001 was completed for a further period of three and one half months later. The schedule showed that one to one staffing for supervision of resident #001 was in place for a full 24 hour period for 38 out of 104 days (36.5 percent). 66 out of 104 dates showed partial hours covered or none at all (63.5 percent).

Interviews with four staff were completed including DOC #100, a registered nursing staff member, and two other staff members. In these interviews, the staff showed little or no knowledge of resident #001's disease process and specific diagnosis.

During an interview with DOC #100, they stated that the external BSO assessment package included information specific to resident #001’s disease process and diagnosis; however, they were unaware of any formal training about the disease to staff. All staff interviewed agreed it would have been beneficial to the care and services of resident #001 and safety of others to have an understanding about the disease.

The licensee has failed to ensure that procedures and interventions were developed and implemented, to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, to minimize the risk of altercations and potentially harmful interactions between and among residents

when resident #001 demonstrated responsive behaviours of verbal and physical abuse toward other residents and staff on numerous occasions and one to one staffing and DOS documentation were not implemented. [s. 55. (a)]

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 procedures and interventions to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents, are developed and implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Medication incidents reported in the home were reviewed for a three month time period. There were 26 medication incidents, including twelve in one identified month, nine in the following month and five in the following month. The medication incidents included the following incident categories:
Omission - eighteen
Wrong drug - one
Wrong dose - two
Wrong resident - one

Wrong time - one
Other – three

On an identified date, a medication incident report was reviewed with a registered nursing staff member and Inspector #213. It was noted that on an identified date, a registered nursing staff member self-reported an incident where resident #002 was scheduled to receive a specific medication at a specific time. The nurse was called to the phone in the middle of administration and when they returned following the interruption, they forgot to add the specific medication to the administration and it was not given when all of the other medications were administered to resident #002 at that time. Later that same day, the resident was assessed and treatment was provided. The omission was discovered later that same day by that nurse. The nurse notified the resident's substitute decision maker and the physician and the resident was further assessed and was found to have no ill effects.

On an identified date, a medication incident report was reviewed with a registered nursing staff member and Inspector #213. It was noted that on an identified date, a registered nursing staff member self-reported an incident where resident #054 was scheduled to receive a specific medication at a specific time and it was missed when all of that resident's other medications were administered. Later that same day, when the nurse was administering that same medication, and the nurse discovered that the earlier dose had been missed when all of the other medications were administered to resident #054 at that time. The nurse assessed resident #054 and found there were no ill effects, notified the resident's substitute decision maker and the physician.

In an interview with the Director of Care (DOC) #100, the DOC said that medication incidents have improved during that time period with improved follow-up, but that they still need to improve. The DOC said that the expectation is that staff check the Medication Administration Record (MAR) with the strip pack to ensure that all medications are administered as prescribed, including those stored separately in the controlled substance bin and that extra checks are necessary when interruptions occur.

The Medical Pharmacies policy "The Medication Pass" #3-6, dated revised January 2018, was reviewed and stated, find MAR for the resident and identify medications for the pass time, locate medications for the resident and check each medication label against MAR or eMAR to ensure accuracy.

The licensee has failed to ensure that drugs were administered to residents in

accordance with the directions for use specified by the prescriber when residents #002 and #054 did not receive medications as specified by the prescriber when all of their other medications at that time were administered. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident's right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act, was fully respected and promoted.

A review of the home's policy "Personal Information Protection" #II-B-10.30, dated July 2016, was completed. The policy stated in part: Residents File Containing Personal Information or Personal Health Information: Team members must ensure that no personal information or personal health information belonging to a resident is disclosed without that individual's consent and then only if security procedures are satisfied.

On an identified date and time, Inspector #615 entered the home and observed a medication cart at the entrance of the home, against the left wall, with the Point Click Care (PCC) screen in use and residents' personal health information in plain view. Staff, visitors and residents were walking around the area at the time of the observation. A registered nursing staff member came to the cart five minutes later and agreed that the residents' health information was exposed and at the expectation was to lock the screen when the cart was left unattended.

At the same time on that date, another registered nursing staff member was observed at another medication cart preparing medication for a resident at the entrance of the home on the right side, and walked away from their cart with the PCC screen in use, with residents' personal health information in plain view. The nurse came back after administrating the medication and agreed that the screen was left on and unattended.

On that date at a later time, a registered nursing staff member was observed administrating a medication to a resident in another area and had again, left the medication cart at the entrance of the home on the left wall with the PCC screen in use with residents' personal health information in plain view. Residents and visitors were walking past the cart. The Director of Care (DOC) #100 walked by at that time and also observed the PCC screen on, with residents' personal health information visible, and agreed it was accessible to everyone walking by the cart.

During an interview, DOC #100 stated that the expectation was that residents' personal health information should be kept confidential.

The licensee has failed to ensure that every resident's right to have their personal health information kept confidential was fully respected and promoted when on three occasions, resident's electronic health records were left open and visible on the medication cart

screen at the entrance of the home with visitors and other residents in view. [s. 3. (1) 11. iv.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, related to alleged staff to resident abuse. The report stated that a staff member witnessed two other staff members forcibly providing care to a resident on an identified date.

The home's policy #VII-G-10.00 "Prevention of Abuse and Neglect of a Resident", revision date January 2015, was reviewed and stated: All employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents, and families are required to immediately report any suspected or known incident of abuse or neglect to the Director of MOHLTC and the Executive Director/Administrator or designate in charge of the home.

A review of the home’s investigation record showed that the staff member who witnessed the alleged abuse stated that the incident happened on an identified date, and the staff member reported it to registered staff member the following day, because they were afraid of how they would be perceived by other staff.

During an interview, the Director of Care (DOC) #100 stated that the staff member reported the alleged abuse to registered staff the day after it was witnessed. The registered staff then told the DOC and called the MOHLTC after hours line. The DOC said that the expectation was that anyone suspecting abuse of a resident was to immediately report it, and that the home’s policy was not followed by the staff.

The licensee has failed to ensure that the home’s Prevention of Abuse and Neglect of a Resident policy was complied with, when a staff member reported a suspected incident of witnessed abuse of resident #001 the day after it occurred. [s. 20. (1)]

Issued on this 4th day of April, 2018

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) :	RHONDA KUKOLY (213), ALI NASSER (523), HELENE DESABRAIS (615), NATALIE MORONEY (610)
Inspection No. / No de l'inspection :	2018_605213_0004
Log No. / No de registre :	002422-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 26, 2018
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Secord Trails Care Community 263 Wonham Street South, INGERSOLL, ON, N5C-3P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JoAnn Zomer

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., 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 :

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

Order / Ordre :

The licensee must be compliant with s.19(1) of the LTCHA.

Specifically, the licensee shall ensure the following:
1. Resident #075 and all other residents, when exhibiting altered skin integrity, if clinically indicated, are reassessed at least weekly by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments, and the assessment is documented.
2. The plan of care related to altered skin integrity for resident #075, and all other residents with impaired skin integrity, will provide clear direction to staff regarding the specific treatment, the specific area and location, and the dates and times that the treatment is to be provided.
3. Treatments and care related to altered skin integrity for resident #075, and all other residents exhibiting altered skin integrity, are completed as planned.
4. Documentation of treatments provided as planned and care provided as specified in the plan, related to altered skin integrity, is accurately completed for resident #075 and all other residents exhibiting altered skin integrity.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

The Ministry of Health and Long-Term Care (MOHLTC) received complaint #IL-52932-LO, on a specific date, for resident #075, regarding care concerns related to skin care treatment.

Neglect is defined in Ontario Regulation 79/10, as "failure to provide a resident

with the treatment, care, services or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

A review of resident #075's documentation in Point Click Care (PCC) showed that resident #075 required treatments, monitoring and assessments for skin care management. The documentation in resident #075's progress notes, care plan and Treatment Administration Record (TAR) in PCC showed inconsistency regarding direction for treatment, what treatment was provided and that the treatment was not provided as planned on several occasions. The resident's condition worsened and the resident had a significant change in status.

During an interview with resident #075, the resident said that staff don't seem to care too much about the treatments or how often they were to be done. The resident said that the treatment was not completed the last time it was scheduled to be done.

An interview with registered nursing staff member, they said that the treatment noted on the TAR for a specified period of time was likely an error in direction.

In an interview with the Director of Care (DOC), the DOC was not able to tell Inspector #610 if the documentation had been incorrect and that staff were in fact providing the treatment as documented, as the documentation was unclear in PCC. The DOC further elaborated and said that they expect that the plan of care for skin and wound treatment would provide clear direction to all staff and it had not.

The DOC also said that if the treatments were not signed for in the TAR, the treatment was not provided. The DOC further said that the last time the treatment was scheduled to be done, the registered nursing staff had not documented the treatment provided on the TAR, as they did not complete the treatment and should have. The DOC said that if staff were not able to complete the treatment as planned in the TAR, the expectation was for staff to communicate to the next shift to complete the treatment that day, and that the registered nursing staff had not done so and should have.

The licensee has failed to ensure that resident #075 was not neglected by the licensee or staff when documentation was unclear, treatments were not provided and direction was not clear when a resident had a significant worsening change

in condition.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 1 as it related to one of three residents reviewed. Compliance history was a level 2 as there was unrelated non-compliance. (610)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 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 26th day of March, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

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