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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELISSA CHISHOLM (188)
Inspection No. / No de l'inspection :	2011_099188_0035
Type of Inspection / Genre d'inspection:	Follow up
Date of Inspection / Date de l'inspection :	Dec 20, 21, 22, 29, 2011; Jan 13, 2012
Licensee / Titulaire de permis :	THE CITY OF GREATER SUDBURY 200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3
LTC Home / Foyer de SLD :	PIONEER MANOR 960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TONY PARMAR

To THE CITY OF GREATER SUDBURY, 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)

Linked to Existing Order / Lien vers ordre existant: 2011_099188_0019, CO #004

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee shall ensure that the lap table and wheelchair for an identified resident are appropriate based on the resident's condition. The licensee shall ensure that, as part of the home's restorative care program, when equipment, including wheelchairs and physical restraints, are used with respect to residents, the equipment is appropriate for that resident based on the resident's condition.

Grounds / Motifs :

1. The licensee failed to ensure the equipment, specifically the lap table used for an identified resident was appropriate based on the resident's condition. The resident received a new wheelchair and lap table which was identified by nursing staff as inappropriate for the resident, a referral to PT/OT was completed at that time. Inspector noted no further action was taken to ensure the equipment used for this resident was appropriate. Inspector noted several days later the resident sustained an injury as a result of this inappropriate equipment. Inspector noted that a second referral to PT/OT was sent at the request of the resident's family. Inspector noted the resident was assessed the following day by the physiotherapist and a change was made to the equipment.

Inspector noted a seating review was completed three weeks later which identifies the equipment continues to be inappropriate and the need for new equipment from the vendor, however it was currently unavailable. No action was taken at this time to provide the resident with different equipment even though it had previously been identified inappropriate.

One week later the inspector noted an entry in the progress notes identifying the resident as sustaining an injury caused by the equipment. Inspector noted no interventions were put in place to ensure the equipment was appropriate for the resident based on the resident's condition following this incident. The following day documentation reflects the first injury and also speculates the resident sustained additional injury from the same equipment. Inspector noted that the resident received loaner equipment from the home the following day. The licensee failed to ensure that equipment used for this resident was appropriate based on the resident's condition. [O. Reg. 79/10, s.30(1)(2)] (188)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 13, 2012

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2011_099188_0019, CO #003

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee shall ensure that an identified resident, and all residents of the home, are administered only drugs that have been prescribed for them.

Grounds / Motifs :

1. Inspector reviewed the health care record for an identified resident on December 20, 2011. Inspector noted the Medication Administration Record (MAR) for December 2011 identifies that this resident received a drug. Inspector reviewed the physician's orders for this resident and noted no physician's order for this drug. The licensee failed to ensure that no resident is administered a drug unless that drug has been prescribed for that resident. [O.Reg. 79/10, s.131(1)] (188)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 13, 2012

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 : 003

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

Linked to Existing Order / Lien vers ordre existant:

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Order / Ordre :

The licensee shall ensure that the substitute decision-makers for an identified resident and all residents of the home, are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Grounds / Motifs :

1. Inspector reviewed the plan of care for an identified resident. The resident's plan of care identifies the substitute decision-maker (SDM) is to be contacted with any change to the resident's condition. Progress notes identify the residents condition changed and that a family member was notified. The progress note does not identify which family member was notified. Inspector spoke with the registered practical nurse (RPN) who reported to the inspector that it was reported to a family member that was not the resident's SDM. Inspector spoke with the SDM who confirmed that it was another family member and not the SDM that was notified. The licensee failed to ensure that the resident's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(5)] (188)
2. Inspector reviewed the plan of care for an identified resident. The resident's plan of care identifies the substitute decision-maker (SDM) is to be contacted with any change to the resident's condition including injuries. Progress notes indicate the resident' sustained an injury. Inspector noted no documentation identifying the SDM was notified of this injury. Inspector spoke with the SDM who confirmed that no notification of the injury sustained, and that the family only became aware after visiting the resident. The licensee failed to ensure that the resident's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(5)] (188)
3. Inspector reviewed the plan of care for an identified resident. The resident's plan of care identifies the substitute decision-maker (SDM) is to be contacted prior to any medication changes. Inspector spoke with the resident's SDM who confirmed this request. Inspector reviewed the medication administration record (MAR) for this resident and noted the resident received a new medication. Inspector noted no documentation identifying attempts were made to notify the resident's SDM. Inspector spoke with the resident's SDM who confirmed finding out about the new medication several days after it was initiated and administered to the resident. The licensee failed to ensure that the resident's substitute decision-makers were given an opportunity to participate fully in the development and implementation of the resident's plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(5)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 13, 2012

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant:

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that an identified resident, and all residents of the home exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument. The licensee shall ensure that two identified residents and all other residents of the home who exhibit altered skin integrity, receives an assessment at least weekly by a member of the registered nursing staff.

Grounds / Motifs :

1. Inspector reviewed the health care record for an identified resident. Inspector noted in the progress notes it identifies the resident had altered skin integrity requiring treatment by nursing staff. Inspector did not locate an assessment, completed by the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment for this identified wound. Inspector spoke to a Program Coordinator related to this resident's wound. The Program Coordinator reviewed the unit's wound care book where the assessment and documentation should be kept and was unable to locate an assessment. The licensee failed to ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument. [O.Reg. 79/10, s.50(2)(b)(i)] (188)
2. Inspector reviewed the health care record for an identified resident. Inspector noted this resident sustained a skin tear requiring treatment. Although this was documented in the progress notes and supported by the physicians order, inspector was unable to locate an assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. Inspector spoke with a Program Coordinator, on December 20, 2011. The Program Coordinator also searched the units skin and wound care binder and was unable to locate an assessment. The licensee failed to ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument. [O.Reg. 79/10, s.50(2)(b)(i)] (188)
3. Inspector reviewed the health care record for a resident on December 20, 2011. Inspector noted this resident had a physician's order for treatment of an open area. Inspector spoke with a RPN on December 20, 2011, who confirmed the resident continues to have an open area. Inspector reviewed the "Wound Assessment Record" for this resident, located in the unit's wound care binder, and noted that the last documented assessment of the residents open area was completed three months prior. Inspector noted no other assessment of the wound was completed on the "Wound Assessment Record". Inspector reviewed the progress notes and MARS for this resident and noted that the resident continues to receive treatment for the open area; however weekly re-assessment has not been completed. The licensee failed to ensure that a resident who is exhibiting altered skin integrity, receives an assessment at least weekly by a member of the registered nursing staff. [O.Reg. 79/10, s.50(2)(b)(iv)] (188)
4. Inspector reviewed the health care record for a resident on December 20, 2011. Inspector noted that the resident has an open area. Inspector reviewed the "Wound Assessment Record" for this resident, located in the unit's wound care binder, and noted that the last documented assessment of the resident's open area was dated three months prior. Inspector reviewed the progress notes and MARS for this resident and noted that the resident continues to receive treatment for the open area, however weekly re-assessment has not been completed. The licensee failed to ensure that a resident who is exhibiting altered skin integrity, receives an assessment at least weekly by a member of the registered nursing staff. [O. Reg. 79/10, s.50(2)(b)(iv)] (188)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 13, 2012

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
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 13th day of January, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MELISSA CHISHOLM

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Dec 20, 21, 22, 29, 2011; Jan 13, 2012	2011_099188_0035	Follow up

Licensee/Titulaire de permis

THE CITY OF GREATER SUDBURY
200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3

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

PIONEER MANOR
960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Manager of Resident Care, Program Coordinators, the Manager of Therapeutic Services, Registered Staff members, Personal Support Workers (PSWs), Physiotherapists, Physiotherapist Assistants, residents and families

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed health care records, reviewed various policies and procedures and observed dining room service.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the equipment, specifically the lap table used for an identified resident was appropriate based on the resident's condition. The resident received a new wheelchair and lap table which was identified by nursing staff as inappropriate for the resident, a referral to PT/OT was completed at that time. Inspector noted no further action was taken to ensure the equipment used for this resident was appropriate. Inspector noted several days later the resident sustained an injury as a result of this inappropriate equipment. Inspector noted that a second referral to PT/OT was sent at the request of the resident's family. Inspector noted the resident was assessed the following day by the physiotherapist and a change was made to the equipment.

Inspector noted a seating review was completed three weeks later which identifies the equipment continues to be inappropriate and the need for new equipment from the vendor, however it was currently unavailable. No action was taken at this time to provide the resident with different equipment even though it had previously been identified inappropriate.

One week later the inspector noted an entry in the progress notes identifying the resident as sustaining an injury caused by the equipment. Inspector noted no interventions were put in place to ensure the equipment was appropriate for the resident based on the resident's condition following this incident. The following day documentation reflects the first injury and also speculates the resident sustained additional injury from the same equipment. Inspector noted that the resident received loaner equipment from the home the following day. The licensee failed to ensure that equipment used for this resident was appropriate based on the resident's condition. [O. Reg. 79/10, s.30(1)(2)]

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. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. Inspector reviewed the health care record for an identified resident on December 20, 2011. Inspector noted the Medication Administration Record (MAR) for December 2011 identifies that this resident received a drug. Inspector reviewed the physician's orders for this resident and noted no physician's order for this drug. The licensee failed to ensure that no resident is administered a drug unless that drug has been prescribed for that resident. [O.Reg. 79/10, s.131(1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following subsections:

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. Inspector reviewed the health care record for a resident. Inspector noted a progress note completed by the physiotherapist following an assessment identifies new toileting routine. Inspector spoke with a personal support worker who confirmed the new toileting routine. Inspector noted the care plan under a section titled toileting conflicting directions related to the toileting routine. The licensee failed to ensure that the plan of care provides clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1) (c)]
2. Inspector reviewed the plan of care for an identified resident. The resident's plan of care identifies the substitute decision-maker (SDM) is to be contacted prior to any medication changes. Inspector spoke with the resident's SDM who confirmed this request. Inspector reviewed the medication administration record (MAR) for this resident and noted the resident received a new medication. Inspector noted no documentation identifying attempts were made to notify the resident's SDM. Inspector spoke with the resident's SDM who confirmed finding out about the new medication several days after it was initiated and administered to the resident. The licensee failed to ensure that the resident's substitute decision-makers were given an opportunity to participate fully in the development and implementation of the resident's plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(5)]
3. Inspector reviewed the plan of care for an identified resident. The resident's plan of care identifies the substitute decision-maker (SDM) is to be contacted with any change to the resident's condition including injuries. Progress notes indicate the resident' sustained an injury. Inspector noted no documentation identifying the SDM was notified of this injury. Inspector spoke with the SDM who confirmed that no notification of the injury sustained, and that the family only became aware after visiting the resident. The licensee failed to ensure that the resident's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(5)]
4. Inspector reviewed the plan of care for an identified resident. The resident's plan of care identifies the substitute decision-maker (SDM) is to be contacted with any change to the resident's condition. Progress notes identify the residents condition changed and that a family member was notified. The progress note does not identify which family member was notified. Inspector spoke with the registered practical nurse (RPN) who reported to the inspector that it was reported to a family member that was not the resident's SDM. Inspector spoke with the SDM who confirmed that it was another family member and not the SDM that was notified. The licensee failed to ensure that the resident's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care. [LTCHA 2007, S.O. 2007, c.8, s.6(5)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. Inspector reviewed the health care record for an identified resident. Inspector noted this resident sustained a skin tear requiring treatment. Although this was documented in the progress notes and supported by the physicians order, inspector was unable to locate an assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. Inspector spoke with a Program Coordinator, on December 20, 2011. The Program Coordinator also searched the units skin and wound care binder and was unable to locate an assessment. The licensee failed to ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument. [O.Reg. 79/10, s.50(2)(b)(i)]
2. Inspector reviewed the health care record for an identified resident. Inspector noted in the progress notes it identifies the resident had altered skin integrity requiring treatment by nursing staff. Inspector did not locate an assessment, completed by the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment for this identified wound. Inspector spoke to a Program Coordinator related to this resident's wound. The Program Coordinator reviewed the unit's wound care book where the assessment and documentation should be kept and was unable to locate an assessment. The licensee failed to ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument. [O.Reg. 79/10, s.50(2)(b)(i)]
3. Inspector reviewed the health care record for a resident on December 20, 2011. Inspector noted that the resident has an open area. Inspector reviewed the "Wound Assessment Record" for this resident, located in the unit's wound care binder, and noted that the last documented assessment of the resident's open area was dated three months prior. Inspector reviewed the progress notes and MARS for this resident and noted that the resident continues to receive treatment for the open area, however weekly re-assessment has not been completed. The licensee failed to ensure that a resident who is exhibiting altered skin integrity, receives an assessment at least weekly by a member of the registered nursing staff. [O. Reg. 79/10, s.50(2)(b)(iv)]
4. Inspector reviewed the health care record for a resident on December 20, 2011. Inspector noted this resident had a physician's order for treatment of an open area. Inspector spoke with a RPN on December 20, 2011, who confirmed the resident continues to have an open area. Inspector reviewed the "Wound Assessment Record" for this resident, located in the unit's wound care binder, and noted that the last documented assessment of the residents open area was completed three months prior. Inspector noted no other assessment of the wound was completed on the "Wound Assessment Record". Inspector reviewed the progress notes and MARS for this resident and noted that the resident continues to receive treatment for the open area; however weekly re-assessment has not been completed. The licensee failed to ensure that a resident who is exhibiting altered skin integrity, receives an assessment at least weekly by a member of the registered nursing staff. [O.Reg. 79/10, s.50(2)(b)(iv)]

Additional Required Actions:

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

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 3.	CO #001	2011_099188_0019	188
LTCHA, 2007 S.O. 2007, c.8 s. 31.	CO #002	2011_099188_0019	188
O.Reg 79/10 r. 59.	WN #1	2011_099188_0019	188
LTCHA, 2007 S.O. 2007, c.8 s. 76.	WN #1	2011_099188_0019	188

Issued on this 8th day of February, 2012

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