Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 27, 2019	2019_739694_0008 (A2) (Appeal\Dir#: DR# 125)	001478-18, 001770-18, 003437-18, 008997-18, 012915-18, 023311-18, 001143-19	Complaint

Licensee/Titulaire de permis

Southampton Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Southampton Care Centre
140 Grey Street Southampton ON N0H 2L0

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

Amended by Wendy Lewis (Director) - (A2)(Appeal\Dir#: DR# 125)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#003.
The Director's review was completed on August 27, 2019.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 125.
A copy of the Director Order is attached.

Issued on this 27th day of August, 2019 (A2)(Appeal\Dir#: DR# 125)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

Southampton Care Centre
140 Grey Street Southampton ON N0H 2L0

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

Amended by Wendy Lewis (Director) - (A2)(Appeal/Dir# DR# 125)

Amended 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): May 2, 3, 6, 7, 8, 9, 10, 14, and 15, 2019.

The following intakes were completed during this inspection:

Log #001478-18, IL #18277, related to Prevention of Abuse and Neglect, #001770 -18 related to admission to the home and care, #023311-18, IL #59373, related to admission to the home, #003437-18, IL #55558, and #008997-18, related to fall prevention, #012915-18, IL #57360, related to sufficient staffing and #001143-19, IL #63427, skin and wound care.

This inspection was completed concurrently with Critical Incident System inspection #2019_739694_0007.

During the course of the inspection the inspectors toured the home and observed residents care, services and activities. Clinical records and plans of care for identified residents were reviewed. Also, relevant documents were reviewed including but not limited to the home's documentation and procedures as related to the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW)/ Health Care Aides (HCA), family members and residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Dining Observation
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

A) The clinical record for a resident was reviewed and identified the resident experienced an area of altered skin integrity since June 2018.

There were no documented assessments completed by the resident's physician in

relation to the altered skin integrity. The resident was seen by the specialist in December 2018 at which time the resident was diagnosed with a condition. The treatment administration record (TAR) stated the resident was to have skin treatments applied each evening shift. The TAR was not signed on a number of occasions, to indicate that the treatment had been administered. The TAR showed that another treatment was to be administered, but there was no documentation by registered staff to indicate that the treatment was provided on a number of occasions in November and December 2018.

B) The clinical record for a resident was reviewed and identified the resident developed an area of altered skin integrity in June 2018. According to the resident's TAR, treatment was to be applied once every few days. The TAR was not signed on a number of occasions in August, September, November, December, 2018, January and February 2019, to indicate that the treatment had been provided. According to the documentation, the area of altered skin integrity worsened.

C) The clinical record for a resident was reviewed and identified the resident developed an area of altered skin integrity in September 2018, and another area in October 2018. According to the resident's TAR, registered staff were to apply a treatment each day. There was no documentation on the TAR to indicate that the treatment was provided on a number of occasions in November, December 2018, January, March and April 2019.

In separate interviews, staff stated treatment of all skin and wounds was completed by registered staff according to the resident's TAR and signed off when the treatment was given. The DOC confirmed that blank spaces on the record meant it could not be confirmed if the treatment was provided. If the resident was not available, the registered staff would still sign and use the legend at the bottom of the TAR to give a reason the treatment was not provided.

D) The registered dietitian (RD) assessed a resident in September 2018, and wrote an order that the resident was to have a specific intervention completed weekly as they continued to experience rapid weight loss.

The TAR and weights and vitals summary were reviewed. On a number of dates in November and December 2018, the intervention was not completed. The resident experienced weight loss in the month of November and December 2018.

The licensee failed to ensure residents were provided care in relation to skin and wound and nutrition as specified in the plan of care. [s. 6. (7)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

The home's staffing plan, staffing schedules, and registered staff shift replacement information was reviewed by a LTCH (Long Term Care Home) Inspector. During a specified time period there were a number of shifts that did not have an RN that was an employee of the licensee and a member of the regular nursing staff on duty.

The DOC was interviewed and confirmed that the home had not been able to fill the RN staffing complement. The DOC stated they worked some of the shifts, in addition to their DOC hours, and acknowledged there was to be an RN on duty and present in the facility at all times.

The home failed to ensure an RN, that was an employee of the licensee and a member of the regular nursing staff of the home, was on duty and present in the home, except as provided for in the regulations. [s. 8. (3)]

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. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee failed to take into account the assessments and information under subsection 43(6), and approve an applicant's admission to the home unless:
a) The home lacked the physical facilities necessary to meet the applicant's care requirements;
b) The staff of the home lack the nursing expertise necessary to meet the applicants care requirements; or
c) Circumstances exist which were provided for in the regulations as being a ground for withholding approval.

As a result of a complaint inspection related to a declined admission, the home's records regarding refusal to approve applicants was reviewed. It was identified that applicants admission to the Long-Term Care Home (LTCH) had been declined.

1.) An applicant had been deemed eligible for admission to long-term care by a Placement Coordinator at the South West Local Health Intergration Network (LHIN) in November 2017, and had applied to Southampton Care Centre at that time.

In December 2017, the Administrator sent a letter to the applicant's substitute decision maker (SDM) refusing to accept the resident for placement. The reason cited in the letter for refusal was that the home lacked the nursing expertise necessary to safely meet the applicant's needs.

2.) An applicant had been deemed eligible for admission to long-term care by a Placement Coordinator at the South West LHIN in August 2018 and had applied to Southampton Care Centre at that time.

In August 2018, the Administrator sent a letter to the applicant's SDM refusing to accept the resident's application for admission to Southampton Care Centre. The reason cited for the refusal was that the home lacked the physical facilities necessary to safely meet the applicant's needs.

3.) An applicant had been deemed eligible for admission to long-term care by a Placement Coordinator at the South West LHIN in September 2018, and had applied to Southampton Care Centre at that time.

In October 2018, the home sent a letter to the applicant's SDM refusing their application for admission to Southampton Care Centre. The reason cited in the letter for refusal was that the home lacked the nursing expertise necessary to safely meet the applicant's needs.

During an interview with the Administrator, the home's manager of applications for all admissions, they confirmed refused admission to each of the identified applicants for the reasons of nursing expertise or physical facilities. The Inspector discussed with the Administrator that the home had access to High Intensity Needs (HIN) funding from the Ministry of Health and Long-Term Care (MOHLTC). The home had an internal and external Behavioural Support Ontario (BSO) teams, use of wander-guard banners to deter residents from wandering into other resident rooms, and an alarm system in the building.

The Administrator stated because they already had a number of residents that wandered and were exit seeking as well and other residents with increased monitoring, they felt they did not have enough staff and could not keep the residents safe.

The licensee failed to ensure that there was sufficient evidence to validate refusal of specific applicant's application for admission to the home. [s. 44. (7)]

Additional Required Actions:

(A2)(Appeal/Dir# DR# 125)
The following order(s) have been rescinded: CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, and the procedure was complied with.

In accordance with O. Reg. 79/10, s. 48(1) and in reference to s. 49(1), the licensee was required to have a falls prevention and management program that provided strategies to monitor residents.

Specifically, staff did not comply with the licensee's policy "Resident Rights, Care and Services- Required Programs – Falls Prevention and Management – Program", that directed staff to initiate head injury routine (HIR) if head injury was evident and for all unwitnessed falls.

A) A resident had an unwitnessed fall in on a specified date and the HIR was incomplete. On another date, the same month, the resident had an unwitnessed fall. The HIR was incomplete on the day the fall occurred.

B) A resident had an unwitnessed fall in September 2018. The HIR was incomplete on the day the fall occurred. The resident had another unwitnessed fall on another date in September 2018. The HIR was not completed at several intervals on the day of the fall, and the next day. The HIR was to be completed daily for seven days and was not completed on specific dates in October 2018. On a separate date in October 2018, the resident had another unwitnessed fall. The HIR was incomplete a number of times on the day the fall occurred. The HIR was to be completed daily for seven days and was not completed on specific dates in October 2018.

C) A resident had an unwitnessed fall in March 2018. The HIR was not completed at several intervals on the day of the fall. On a specific date in May 2018, the resident had an unwitnessed fall. The HIR was not completed.

In an interview with the DOC they said it was an expectation of registered staff to complete the HIR. They acknowledged the HIR monitoring was incomplete for the identified residents.

The licensee failed to ensure their strategy related to the implementation and completion of HIR was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that 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 staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

During interviews with staff they stated that while providing care, all areas of altered skin integrity were to be immediately reported to the registered staff who then completed an assessment. In separate interviews with registered staff, they stated that all new areas of altered skin integrity, were to be assessed by registered staff using the Wound Assessment Tool. Weekly assessments of the areas were to be assessed by the wound nurse, who was a registered staff member of the home scheduled one day a week to assess all areas of altered skin integrity. A resident, was identified by staff as having many areas of altered skin integrity.

The DOC confirmed there was no documentation of a Wound Assessment for any of the identified areas of altered skin integrity when the resident experienced a new area of altered skin integrity.

The licensee failed to ensure a wound assessment, using a clinically appropriate assessment instrument, was completed by any of the registered staff for a resident when they experienced areas of altered skin integrity. [s. 50. (2) (b) (i)]

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

A) The clinical record for a resident was reviewed. The resident developed an area of altered skin integrity in June 2018. On a specific date in June 2018, a registered staff identified a new area of altered skin integrity.

The clinical record was reviewed, documentation identified that Weekly assessments were not completed.

The resident developed an new area of altered skin integrity in September 2018. A review of the documentation identified that weekly assessments were not completed by registered staff on a number of occasions in October, December 2018, January, and February 2019.

B) In June 2018, a registered staff member completed documentation that indicated a resident had a new area of altered skin integrity. The clinical record was reviewed which identified that weekly assessments were not completed on a number of occasions in June, July, August, September and December 2018, as

well as January, February, April and May, 2019. Based on assessments completed the area of altered skin integrity increased in size during the last few months.

C) In September 2018, a registered staff member completed documentation that indicated a resident had a new area of altered skin integrity. In October 2018, documentation was completed by another registered staff member for a new area of altered skin integrity. Further review of the documentation identified that weekly assessments were not completed by registered staff for one of the areas on a number of occasions in September and October 2018. Weekly assessments were also not completed by registered staff for the second area on a number of occasions in October 2018, January, February, April, and May 2019. The wound measurements of the second area increased in November, December 2018, January, February, March and April 2019.

In interviews with registered staff and the DOC, they confirmed registered staff were expected to complete a weekly skin or wound assessment for all areas of altered skin integrity.The DOC confirmed there were missing weekly assessments for areas of altered skin integrity.

The licensee failed to ensure that when residents had altered skin integrity, they were reassessed at least weekly by a member of the registered staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

1. The licensee failed to ensure a written record relating to the evaluation of the home's staffing plan included the names of the persons who participated in the evaluation, a summary of changes made, and the date that those changes were implemented.

The licensee's document entitled Operational Pandemic/Influenza Outbreak Contingency Plan, contained the staffing plan. This document did not include names of attendees who participated, a summary of changes made to the home's staffing plan, or the date any changes were implemented.

The Administrator stated that the staffing plan was reviewed and revised annually but there was no written record of a staffing evaluation having been completed.

The home failed to ensure the evaluation of the home's staffing plan included the names of participants in the evaluation, a summary of the changes made, and the date those changes were implemented. [s. 31. (4)]

Issued on this 27th day of August, 2019 (A2)(Appeal/Dir# DR# 125)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Wendy Lewis (Director) - (A2) (Appeal/Dir# DR# 125)
Inspection No. / No de l'inspection :	2019_739694_0008 (A2)(Appeal/Dir# DR# 125)
Appeal/Dir# / Appel/Dir#:	DR# 125 (A2)
Log No. / No de registre :	001478-18, 001770-18, 003437-18, 008997-18, 012915-18, 023311-18, 001143-19 (A2)(Appeal/Dir# DR# 125)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 27, 2019(A2)(Appeal/Dir# DR# 125)
Licensee / Titulaire de permis :	Southampton Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	Southampton Care Centre 140 Grey Street, Southampton, ON, N0H-2L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brenda Ohm

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Southampton Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee shall:
a) Ensure that care set out in the plan of care for residents related to skin/wound treatments, is provided to the resident as specified in the plan.
b) Ensure that care set out in the plan of care related to specific measurements, is provided to the resident as specified in the plan.

Grounds / Motifs :

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

A) The clinical record for a resident was reviewed and identified the resident experienced an area of altered skin integrity since June 2018.

There were no documented assessments completed by the resident's physician in relation to the altered skin integrity. The resident was seen by the specialist in December 2018 at which time the resident was diagnosed with a condition. The treatment administration record (TAR) stated the resident was to have skin treatments applied each evening shift. The TAR was not signed on a number of occasions, to indicate that the treatment had been administered. The TAR showed that another treatment was to be administered, but there was no documentation by registered staff to indicate that the treatment was provided on a number of occasions in November and December 2018.

B) The clinical record for a resident was reviewed and identified the resident developed an area of altered skin integrity in June 2018. According to the resident's TAR, treatment was to be applied once every few days. The TAR was not signed on a number of occasions in August, September, November, December, 2018, January and February 2019, to indicate that the treatment had been provided. According to the documentation, the area of altered skin integrity worsened.

C) The clinical record for a resident was reviewed and identified the resident developed an area of altered skin integrity in September 2018, and another area in October 2018. According to the resident's TAR, registered staff were to apply a treatment each day. There was no documentation on the TAR to indicate that the treatment was provided on a number of occasions in November, December 2018, January, March and April 2019.

In separate interviews, staff stated treatment of all skin and wounds was completed by registered staff according to the resident's TAR and signed off when the treatment was given. The DOC confirmed that blank spaces on the record meant it could not be confirmed if the treatment was provided. If the resident was not available, the registered staff would still sign and use the legend at the bottom of the TAR to give a reason the treatment was not provided.

D) The registered dietitian (RD) assessed a resident in September 2018, and wrote an order that the resident was to have a specific intervention completed weekly as they continued to experience rapid weight loss.

The TAR and weights and vitals summary were reviewed. On a number of dates in November and December 2018, the intervention was not completed. The resident experienced weight loss in the month of November and December 2018.

The licensee failed to ensure residents were provided care in relation to skin and wound and nutrition as specified in the plan of care. [s. 6. (7)]

The scope of the non-compliance was level 3, widespread. The severity of the non-compliance was level 2, minimal harm or minimal risk. The home has a level 3 compliance history of one or more non-compliance in the last three full years with this section of the LTCHA, that included;
-Written notification (WN) & voluntary plan of correction (VPC) issued December 22,

2016 (2016_325568_0028).

(694)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 06, 2019(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 8 (3) of the LTCHA.

Specifically the licensee shall ensure that at least one Registered Nurse (RN), who is both an employee of the licensee and a member of the regular nursing staff, is on duty and present in the home at all times, except as provided for in the regulations.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee failed to ensure that at least one registered nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

The home's staffing plan, staffing schedules, and registered staff shift replacement information was reviewed by a LTCH (Long Term Care Home) Inspector. During a specified time period there were a number of shifts that did not have an RN that was an employee of the licensee and a member of the regular nursing staff on duty.

The DOC was interviewed and confirmed that the home had not been able to fill the RN staffing complement. The DOC stated they worked some of the shifts, in addition to their DOC hours, and acknowledged there was to be an RN on duty and present in the facility at all times.

The home failed to ensure an RN, that was an employee of the licensee and a member of the regular nursing staff of the home, was on duty and present in the home, except as provided for in the regulations. [s. 8. (3)]

The scope of the non-compliance was level 3, widespread as all residents are affected. The severity of the non-compliance was level 2, minimal harm or minimal risk. The home has a level 3 compliance history with one or more non-compliance in the last three full years with this section of the LTCHA, that included;
-Written notification (WN) issued September 5, 2018 (2018_735659_0013).
(735)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 01, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

(A2)(Appeal/Dir# DR# 125)
The following Order(s) have been rescinded:

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. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 8 (1).

Specifically, the home shall
a) Ensure that residents who has an unwitnessed fall or fall with an evident head injury, has a head injury routine completed.
b) Ensure that all registered nursing staff receive training on the home's current head injury routine.
c) Ensure that a written record is kept of the training including staff names, dates and training content, to ensure that all registered nursing staff received the training.
d) Ensure that the above training is incorporated into new staff orientation.
e) Ensure that a tracking and auditing system is developed, implemented and documented for all residents who have fallen to ensure the head injury strategy is being completed in accordance with the home's policy and procedure.

Grounds / Motifs :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, and the procedure was complied with.

In accordance with O. Reg. 79/10, s. 48(1) and in reference to s. 49(1), the licensee was required to have a falls prevention and management program that provided strategies to monitor residents.

Specifically, staff did not comply with the licensee's policy "Resident Rights, Care and Services- Required Programs – Falls Prevention and Management – Program", that directed staff to initiate head injury routine (HIR) if head injury was evident and for all unwitnessed falls.

A) A resident had an unwitnessed fall in on a specified date and the HIR was incomplete. On another date, the same month, the resident had an unwitnessed fall. The HIR was incomplete on the day the fall occurred.

B) A resident had an unwitnessed fall in September 2018. The HIR was incomplete on the day the fall occurred. The resident had another unwitnessed fall on another date in September 2018. The HIR was not completed at several intervals on the day of the fall, and the next day. The HIR was to be completed daily for seven days and was not completed on specific dates in October 2018. On a separate date in October 2018, the resident had another unwitnessed fall. The HIR was incomplete a number of times on the day the fall occurred. The HIR was to be completed daily for seven days and was not completed on specific dates in October 2018.

C) A resident had an unwitnessed fall in March 2018. The HIR was not completed at several intervals on the day of the fall. On a specific date in May 2018, the resident had an unwitnessed fall. The HIR was not completed.

In an interview with the DOC they said it was an expectation of registered staff to complete the HIR. They acknowledged the HIR monitoring was incomplete for the identified residents.

The licensee failed to ensure their strategy related to the implementation and completion of HIR was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

The scope of the non-compliance was level 3, widespread as it related to three out of three residents that were inspected. The severity of the non-compliance was level 2, minimal harm or minimal risk. The home has a level 3 compliance history of one or more non-compliance in the last three full years with this section of the LTCHA, that

included;
-Written notification (WN) issued September 5, 2018 (2018_735659_0013). (694)

(694)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 06, 2019(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 005

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 must be compliant with O.Reg. 79/10, s. 50(2).

Specifically the licensee must:
a) Ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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
b) Ensure that residents exhibiting altered skin integrity, are reassessed at least weekly by a member of the registered nursing staff when clinically indicated.
c) Ensure that all registered nursing staff receive training on the types of altered skin integrity, required assessments, timelines for assessments and the home's protocols related to skin and wound assessments.
d) Ensure that a written record is kept of the training including staff names, dates and training content, to ensure that all registered nursing staff received the training.
e) Ensure that the above training is incorporated into new staff orientation.
f) Ensure that a tracking and weekly auditing system is developed, implemented and documented for all residents exhibiting altered skin integrity to ensure the required assessments and treatments are being completed in accordance with the legislation and the home's policies and procedures.

Grounds / Motifs :

1. The licensee 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 staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

During interviews with staff they stated that while providing care, all areas of altered skin integrity were to be immediately reported to the registered staff who then completed an assessment. In separate interviews with registered staff, they stated that all new areas of altered skin integrity, were to be assessed by registered staff using the Wound Assessment Tool. Weekly assessments of the areas were to be assessed by the wound nurse, who was a registered staff member of the home

scheduled one day a week to assess all areas of altered skin integrity. A resident, was identified by staff as having many areas of altered skin integrity.

The DOC confirmed there was no documentation of a Wound Assessment for any of the identified areas of altered skin integrity when the resident experienced a new area of altered skin integrity.

The licensee failed to ensure a wound assessment, using a clinically appropriate assessment instrument, was completed by any of the registered staff for a resident when they experienced areas of altered skin integrity. [s. 50. (2) (b) (i)]

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

A) The clinical record for a resident was reviewed. The resident developed an area of altered skin integrity in June 2018. On a specific date in June 2018, a registered staff identified a new area of altered skin integrity.

The clinical record was reviewed, documentation identified that Weekly assessments were not completed.

The resident developed an new area of altered skin integrity in September 2018. A review of the documentation identified that weekly assessments were not completed by registered staff on a number of occasions in October, December 2018, January, and February 2019.

B) In June 2018, a registered staff member completed documentation that indicated a resident had a new area of altered skin integrity. The clinical record was reviewed which identified that weekly assessments were not completed on a number of occasions in June, July, August, September and December 2018, as well as January, February, April and May, 2019. Based on assessments completed the area of altered skin integrity increased in size during the last few months.

C) In September 2018, a registered staff member completed documentation that indicated a resident had a new area of altered skin integrity. In October 2018, documentation was completed by another registered staff member for a new area of altered skin integrity. Further review of the documentation identified that weekly

assessments were not completed by registered staff for one of the areas on a number of occasions in September and October 2018. Weekly assessments were also not completed by registered staff for the second area on a number of occasions in October 2018, January, February, April, and May 2019. The wound measurements of the second area increased in November, December 2018, January, February, March and April 2019.

In interviews with registered staff and the DOC, they confirmed registered staff were expected to complete a weekly skin or wound assessment for all areas of altered skin integrity.The DOC confirmed there were missing weekly assessments for areas of altered skin integrity.

The licensee failed to ensure that when residents had altered skin integrity, they were reassessed at least weekly by a member of the registered staff. [s. 50. (2) (b) (iv)]

The scope of the non-compliance was level 3, widespread. The severity of the non-compliance was level 3, actual harm. The home has a level 3 compliance history of one or more non-compliance in the last three full years with this section of the LTCHA, that included;
-Written notification (WN) & voluntary plan of correction (VPC) issued December 22, 2016 (2016_325568_0028).

(694)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 06, 2019(A1)

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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 27th day of August, 2019 (A2)(Appeal/Dir# DR# 125)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by Wendy Lewis (Director) - (A2)
(Appeal/Dir# DR# 125)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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