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
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 28, 2019	2019_601532_0001	007521-17, 008593-17, 009829-17, 009941-17, 010486-17, 011632-17, 013051-17, 013794-17, 018348-17, 021453-17, 024391-17, 024816-17, 026915-17, 027213-17, 027275-17, 027631-17, 028418-17, 028441-17, 028444-17, 028544-17, 003260-18, 003598-18, 005576-18, 005966-18, 006422-18, 008126-18, 019485-18, 022095-18, 027922-18	Complaint

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 HAMILTON ON L8N 4A6

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

St. Joseph's Health Centre, Guelph
100 Westmount Road GUELPH ON N1H 5H8

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

NUZHAT UDDIN (532), KIM BYBERG (729), VALERIE GOLDRUP (539)

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): January 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 28, 29, 30, and Febuary 1, 2019.

The following Complaints and Critical Incidents (CIs) were conducted in conjunction with this inspection:
Log #028441-17, IL-54509-LO, related to housekeeping and maintenance.
L Log #009941-17, IL-50935-LO, related to improper care.
Log #009829-17, IL-50895-LO, related to resident elopement and weight changes.
Log #028444-17, IL-54510-LO, related to alleged abuse/neglect.
Log #011632-17, related to nutrition and hydration.
Log #010486-17, related to accommodation services, availability of supplies, and weight changes.
Log #024816-17, IL-53757-LO, related to responsive behaviours, staff training and abuse/neglect.
Log #027275-17, IL-54322-LO, related to swallowing assessment, alleged abuse and altered skin integrity.
Log #008593-17, IL-50588-LO and Log #027213-17, IL-54308-LO, related to resident elopement.
Log # 018348-17, IL-52281-LO and Log #003260-18, IL-55512-LO, related to plan of care.
Log #003598-18, IL-55590-LO, related to primary physician not attending the home regularly.
Log #005966-18, IL-56179-CW, related to alleged abuse and fall prevention.
Log #021453-17, C564-000015-17, Log #013794-17, C564-000010-17, Log #027631-17, C564-000026-17, Log #026915-17, C564-000022-17, Log #007521-17, C564-000005-17, related to alleged abuse.
Log #024391-17, C564-000017-17, Log #026915-17, C564-000025-17, Log #019485-18, C564-000013-18, Log #027922-18, C564-000024-18, Log #005576-18, C564-000005-18, Log #006422-18, C564-000003-18, related to fall prevention.
Log #022095-18, C564-000021-18, related to alleged abuse and responsive

behaviours.
Log #028544-17, C564-000028-17, related to staff and resident interactions.
Log #028418-17, C564-000023-17, related to resident elopement.
Log #013051-17, C564-000008-17, related to responsive behaviours.
Log #008126-18, C564-000009-18, related to unexpected death.

Inspector Kiyomi Kornetsky #743 and Kristal Pitter #735 were present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), assistant Director of Care (ADOC), Physician, Nurse Practitioner (NP), Dietician, Diet Technician, Recreation and Program Services Manager (RPSM), Resident Assessment Instrument (RAI) Coordinator, Ward Clerk, Behaviour Support Ontario Staff (BSO), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and family members.

The inspectors also toured resident home areas and common areas, medication room, observed resident care provision, resident staff interaction, dining services, medication administration, reviewed relevant residents' clinical records, posting of required information, relevant policies and procedures pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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,
(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; O. Reg. 79/10, s. 50 (2).

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 at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

A CI identified a fall which resulted in an injury for which the resident had a procedure.

Program-Altered Skin Integrity Assessments in Point Click Care (PCC) were reviewed for the resident and no altered skin integrity assessment was found.

RPNs reported that a skin integrity assessment was to be done in PCC when a resident returned from hospital if a skin and wound issue was identified. The registered staff and the ADOC acknowledged that there was no skin integrity assessment completed in PCC for the resident.

b) A CI was submitted by the home for an incident that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

When the resident returned from hospital a completed Head to Toe assessment documented that the resident had altered skin integrity. Registered staff were to complete an altered skin and wound assessment for each of the observed impairments.

A Registered Practical Nurse (RPN) was unable to locate a completed skin and wound assessment in Point Click Care (PCC) for the resident until two weeks after their return from hospital.

The ADOC confirmed that skin and wound assessments had not been completed.

The licensee failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon return of resident from hospital. [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A complaint was received regarding the care and assessments completed by staff prior to a resident's hospital admission.

Record review completed in PCC found progress notes indicating that the resident experienced altered skin integrity within a specified time frame.

A RPN reported that if a resident had altered skin integrity, the registered staff were to complete the Altered Skin Assessment Tool weekly until the condition had healed.

According to the Skin and Wound Lead RN, the expectation for the residents presenting

with altered skin integrity was that registered staff completed an initial assessment using the Altered Skin Assessment tool, followed by weekly assessments until the wound had healed.

The Skin and Wound Lead RN confirmed that the registered staff did not complete any skin assessments using the Altered Skin Assessment tool.

The licensee failed to ensure that the resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessments; when the resident was experiencing a changing and worsening rash. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that a resident exhibiting altered skin integrity received immediate treatment and interventions to reduce or relieve their pain.

Progress notes indicated that the resident experienced altered skin integrity during a specified time frame. The resident was hospitalized and received treatment for the altered skin integrity.

A RPN documented that the staff reported altered skin integrity and the resident appeared in discomfort. The RPN made no further documentation that day regarding the resident's altered skin integrity.

Review of the resident's Medication Administration Record (MAR) showed that the resident received analgesic for pain. The resident did not receive their next dose of scheduled analgesic until a later time.

The RPN reported that if a resident was in pain, the expectation would be that registered staff assess for the location of the pain, the level of pain and they would check the resident's care orders for any As Needed (PRN) pain medication. If the pain persisted, they would complete the PainAD assessment tool in PCC. RPN could not recall if they provided any additional treatment to the resident, other than the resident's scheduled analgesic.

The licensee failed to ensure that the resident received immediate treatment and intervention to reduce or relieve their mouth pain, when the resident expressed discomfort and pain. [s. 50. (2) (b) (ii)]

4. The licensee has failed to ensure that a resident exhibiting altered skin integrity, was assessed by a registered dietician who was a member of the staff of the home.

Review of progress notes indicated that during a specified time frame the resident experienced altered skin integrity. The altered skin integrity did not resolve until after the resident was admitted to hospital.

RPNs reported that they referred residents with skin conditions to the dietician.

According the Home's policy titled ''Skin and Wound Program" and Process for actual altered skin, registered staff were directed to notify the interdisciplinary team which were the Nurse Practitioner, Program Lead and the Dietician.

The Registered Dietician (RD) confirmed that they did not receive any referrals for the resident regarding their altered skin integrity.

The licensee failed ensure that the resident who was exhibiting signs of altered skin integrity, received an assessment by a registered dietitian who was a member of the staff of the home. [s. 50. (2) (b) (iii)]

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

A CI identified a fall which resulted in an injury. A subsequent fall occurred on an identified date, which also resulted in an injury.

Progress notes for the resident stated that the fall resulted in altered skin integrity.

The program-Altered Skin Integrity Assessments in PCC was reviewed for the resident and there were no weekly altered skin integrity assessments completed.

Both a RPN and the ADOC said that it was the home's expectation that registered staff complete weekly skin integrity assessments when there was a skin and wound issue. The registered staff acknowledged that there were no weekly skin integrity assessments completed for the altered skin integrity.

The licensee failed to ensure that the resident altered skin integrity were reassessed at

least weekly by a member of the registered staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

A CI stated that an un-witnessed fall may have been caused by a resident to resident altercation. An identified resident fell and sustained an injury.

A fall risk assessment stated that the resident was at risk of falls and had no falls in the last 12 months until the above noted fall.

A fall risk assessment dated after the fall incident considered the resident risk of falls.

Post fall assessment review for the resident identified a number of falls and further review of the post fall assessments showed that a specific number of falls were related to incontinence issues.

The Team Lead for continence acknowledged the falls were related to continence. They stated that the falls team should have analyzed the falls to understand why the resident was falling.

The Team Lead for falls stated that the home used an excel tracking sheet to input all falls that occurred, to look at future falls and patterns and to adjust the time for toileting for the resident. In the case of the resident, they did not review the falls related to continence or find a pattern, nor did they collaborate with each other in the assessment of the resident.

The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other. [s. 6. (4) (a)]

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

A CI identified a number of falls resulting in injuries.

The plan of care for the resident stated that the resident required the use of an assistive device for bed mobility and transfers.

A progress note for the resident stated that an assistive device was in use.

During multiple observations no assistive device was found.

A PSW reported that the assistive device was on the Kardex but they didn't know where it was.

An RPN acknowledged that the plan of care documentation in PCC indicated falls prevention strategies were created but it was not in place.

The licensee failed to ensure that the care set out in the plan of care for the resident with respect to falls prevention strategies and transfers was provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan was not effective.

Two written complaints were received by the Ministry of Health and Long Term Care (MOHLTC) related to elopement.

The initial plan of care stated that the identified resident would exit seek and was to have an assistive device in place.

On two identified occasions the resident eloped and the assistive device failed to work.

A CI was submitted by the home for an incident of elopement. A code yellow was initiated and the identified resident was found after a specified time off the grounds of the home. The resident complained of being cold and the next morning stated they were tired and in pain.

After the third elopement, the plan of care for the resident was updated to include that the resident should not leave the unit unless they had one to one supervision for the entire period they were off the unit.

A monthly check alert was added to the resident's plan of care to ensure the assistive device was working.

The ADOC confirmed that the plan of care had not been revised with new interventions when the care was not effective in preventing the resident from eloping.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan was not effective. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other; to ensure that care set out in the plan of care is provided to the resident as specified in the plan; to ensure that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when care set out in the plan was not effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2(1) of the Act,

Verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature, or any form of verbal communication of a belittling or degrading nature, which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

This inspection was completed in response to Critical Incidents (CI) and a complaint

submitted to the Ministry of Health and Long Term Care (MOHLTC) in relation to resident to resident abuse.

a) A CI stated that an identified resident was physically abusive towards a co-resident. The identified co-resident sustained an injury related to this incident.

A PSW stated that the identified resident was aggressive and un-predictable. They said that the co-resident's family was very upset by this incident.

b) A CI stated that a staff member heard a loud noise. When entering the hallway they found an identified resident laying on the floor with a second resident close by and agitated. The identified resident sustained an injury related to this incident.

A CI stated that the fall was un-witnessed but suspected the fall was caused by a resident to resident altercation.

A complaint stated that the injury was caused by an altercation between two residents.

A PSW stated that the identified resident was aggressive. They shared that the family of the second resident that was injured was upset by this incident.

c) A CI stated that there was an unwitnessed altercation between residents. A PSW heard a resident call out and noted the identified resident near a co-resident. The identified resident indicated to staff that they hit the co-resident. The co-resident sustained an injury.

Record review also stated that the identified resident was very agitated and riled up. The registered staff sat with the co-resident and provided emotional support as the resident was emotionally upset about the situation.

The DOC stated that the resident was aggressive and violent with other residents.

Review of the resident's plan of care identified number of incidents of physical and verbal aggression directed towards other residents and staff.

d) For the purposes of the definition of "abuse" in subsection 2(1) of the Act,

Sexual abuse is defined as any non-consensual touching, behaviour or remarks of a

sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

This inspection was completed in response to sexual behaviours identified by the Inspector while completing critical incident inspections.

Record review stated that a PSW witnessed an identified resident inappropriately touching a co-resident.

The DOC said that the co-resident had dementia and would not understand what was going on.

BSO stated that there was a responsive behaviour care plan for the identified resident but nothing related to the resident exhibiting sexually inappropriate behaviours.

e) Progress notes stated that the identified resident was witnessed exhibiting sexually inappropriate behaviours towards a co-resident. A PSW notified the team lead on the floor.

BSO acknowledged the incident and stated that the team lead should have notified the ADOC or the DOC and both residents should have been assessed but this was not done.

f) A CI identified a resident to resident abuse resulting in injury to co-resident.

BSO said that the identified resident had come to the home with known disorder. Before the escalation in behaviors and before this incident the staff noticed that the resident exhibited this disorder and the staff offered snacks, engaged them in activity and administered medication to settle them. However, despite these interventions the resident engaged in a physical altercation with a co-resident before staff could intervene, resulting in injury to the co-resident.

The licensee has failed to ensure that residents were protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with LTCH Act, s. 20 (1) the licensee was required to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

Specifically, staff did not comply with the home's policy titled, Zero Tolerance of Resident Abuse and Neglect: Steps in the Process- Alleged, suspected or witnessed abuse or neglect- if the abuse or neglect was witnessed, the person witnessing the mistreatment of a client must, if possible, intervene to ensure the health, safety and wellbeing of the client.
a) Call for help if required.
b) Remove the client from the area if possible.
c) Immediately inform the Team leader and Manger/Director of care Manager on-call of the situation. Do not leave voice messages you must speak directly to a person.
d) When there was suspected injury due to physical abuse, the attending physician

should be notified.
e) The next of Kin/substitute decision maker (SDM)/Power of Attorney (POA) must be notified of the alleged, suspected or witnessed abuse or neglect within 12 hours upon becoming aware of the incident.
i) For an incident of abuse by a client to another client, the attending physician and POA for the victim and abuser must be contacted.

a) Record review stated that a PSW witnessed an identified resident exhibiting sexually inappropriate behaviours towards a co-resident. This incident was reported to the team lead, ADOC and the responsive behaviour staff.

b) Progress notes stated that on a specified date another incident of alleged sexual abuse was witnessed. The PSW notified the team lead on the floor.

BSO stated that the team lead should have notified the Assistant Director of Care or the Director of Care (ADOC /DOC) of the incidents of alleged sexual abuse. BSO checked the documentation and stated that there was no follow-up for the residents, however, both identified residents should have been assessed for harm and for any potential injuries. The BSO staff further stated that the staff should have notified the POA and documented it, however, this was also not done.

The licensee has 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 policy, the policy was complied with. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that was reported was immediately investigated.

A CI under mandatory report, category abuse/neglect was submitted to MOHLTC. The CI stated that a staff member heard a loud noise. When entering the hallway they found an identified resident laying on the floor and a second resident nearby who was agitated. The identified resident that was on the floor sustained an injury.

CI stated that the fall was un-witnessed but it was suspected to have been caused by a resident to resident altercation.

A complaint was received and it also alleged that the fall was the result of an altercation between the two residents.

The BSO Lead shared that the fall was unwitnessed but had the resident been questioned about the fall they likely would have been able to provide some information about what happened. The resident was able to verbalize. The BSO staff said that the investigation into the incident was completed by management.

The DOC was asked about the incident and they stated that the fall was un-witnessed but they were unable to provide any investigation notes for the alleged altercation between the two residents which resulted in injury.

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated abuse of a resident by anyone. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated abuse of a resident by anyone, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

a) Progress notes identified an alleged incident of sexual abuse by a resident towards another resident. The incident was reported to the team lead, ADOC and the responsive behaviour staff.

The DOC acknowledged that the incident was not reported to the Director.

b) A CI was submitted to the MOHLTC for an incident of alleged abuse.

The DOC acknowledged that the incident was not reported immediately.

c) Progress notes identified an alleged incident of sexual abuse by a resident towards another resident. A PSW notified the team lead on the floor.

When asked if there was a follow-up to this incident and if the incident was reported to the Director; the DOC said no.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who has reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any identified responsive behaviours.

Record review identified that there were a number of alleged incidents of sexually inappropriate behaviours exhibited by an identified resident towards other residents and staff.

The responsive behaviour plan of care was reviewed and it did not include the sexual behaviours for the identified resident.

The BSO Lead stated that they were not aware of the sexual behaviours and the plan of care was not based on an assessment of the identified behaviours.

The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any identified responsive behaviours. [s. 26. (3) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any identified responsive behaviours, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

This inspection was completed in response to Critical Incidents (CI) submitted to the MOHLTC related to an identified resident's responsive behaviours.

Review of the resident's clinical record identified that there were a number of incidents related to altercations and other interactions with co-residents which resulted in injuries.

The BSO Lead shared that they collaborated with the Psycho-geriatric Resource Consultant (PRC) who suggested a number of interventions. Supplementary staffing was also provided but discontinued when other problems ensued.

Record review showed that an external supplementary staffing was provided to the resident for a limited time.

The HIN form for supplementary staffing indicated that there were three submissions for an identified month, two four hour shifts and one seven and half hour shift.

Progress notes and the HIN Form indicated that the resident continued to have responsive behaviours towards other residents and staff.

In an interview the DOC said that the resident had responsive behaviours with other co-residents and staff. The DOC said that due to the resident responsive behaviours towards staff and because of staff shortage, they did not use their supplementary staffing with the resident. The DOC said that the resident was sent to the hospital but the hospital would send the resident back.

The physician said that the resident did well with one to one staffing but it was always a challenge to provide this due to finances and staffing issues. The physician stated the resident's situation should have been managed in more of a holistic manner.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the organized program of hydration included a system to evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

This inspection was completed due to a complaint received by the MOHLTC regarding

the care and assessments completed by staff.

A record review in PCC progress notes found that a resident experienced a change in health status due to an infection. The resident was sent to hospital and the Discharge Summary from the hospital indicated that the resident had been treated for identified complications.

The resident's care plan indicated their daily fluid goal per day. A review of the resident's food and fluid intake for an identified period of time indicated that the intake was below the required amount.

When asked who was responsible for recording the residents' daily hydration intake, a PSW replied that PSWS recorded the daily fluid intake for each resident in POC. When asked who monitored the daily hydration intake total, they responded that it was the RD.

RPNs also confirmed that PSWs recorded residents' daily intake into POC, and that the registered staff did not review the residents' daily hydration totals. They reported that that the RD was responsible for monitoring those values. When asked how they would know if a resident had met their minimum hydration needs for the day, the RPN replied that it was based on observation of the resident and through their assessments.

The Dietician Technician (DT) and the RD were both unsure as to who was responsible for monitoring the residents' hydration totals in POC on a daily basis. DT assumed that the PSWs and registered staff monitored this value as they were front line staff. According to the DT, they, along with the RD, reviewed the hydration reports for residents on a quarterly and annual basis, but not daily.

When asked if registered staff were responsible for knowing the daily hydration goals of each resident, the RD replied that the daily hydration needs for each resident were printed on the resident's kardex; and according to the RPN the plan of care for each resident was easily accessible to them.

Staff acknowledged that no one monitored residents' recorded daily hydration totals, and that they were also unclear as to who was responsible for monitoring these values.

The licensee failed to ensure that the nutrition and hydration program included a system to evaluate the fluid intake of residents. O.Reg.79/10,s. 68(2)(d). [s. 68. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the organized program of hydration includes a system to evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted:

Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in

accordance with that Act and every resident has the right to participate fully in the development, implementation, review and revision of his or her plan of care.

a) This inspection was completed due to a complaint received by the MOHLTC regarding a resident's Substitute Decision Maker (SDM) not being informed about the changes to the plan of care.

An identified resident's SDM reported concerns that they were not informed when the resident's plan of care was revised and changes were made.

Progress notes were reviewed and there was no documentation to support that the SDM had been contacted about the changes to the plan of care.

According to an RPN, it was the home's process that the resident's SDM be informed of any changes related to their care and that a progress note be written documenting that they were informed. The RPN reviewed the identified resident's progress notes and could not locate any documentation indicating that the resident's SDM was informed.

The licensee has failed to ensure that the resident's SDM was allowed to participate fully in the review and revision of the resident's care plan. (729)

b) On an identified date it was observed that an RN was administering medication when they left the medication cart unlocked and the computer screen with resident's health information displayed. The RN was observed from 1208 hours until 1217 hours, and they continued to leave the screen open with resident's personal health information displayed.

The RN shared that they should have locked the screen and should not have left the cart open but did not realize it.

The DOC said that the expectation was that the medication cart should have been secured and locked during medication pass and the computer screen with resident's personal health information closed, when the RN left the cart to administer medication to residents.

The licensee has failed to ensure that resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act. [s. 3. (1) 11.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment specifically wheel chairs were kept clean and sanitary.

The MOHLTC received a call to the action line by a family member sharing that an identified resident's assistive device was not clean and sanitary.

An observation showed that the assistive device was not kept clean and sanitary.

A PSW shared that the assistive device should be cleaned by the night staff or whomever notices that it was dirty.

A review of the POC documentation showed that the resident's assistive device should have been cleaned on an identified date.

The DOC shared that if assistive devices were found to be unclean, the staff were to clean them. It was also scheduled in the night shift PSW's POC task list to be completed. They shared that housekeeping had a system to look at the assistive devices when they were cleaning the resident rooms.

The licensee failed to ensure that the home, furnishings and equipment specifically assistive device were kept clean and sanitary. [s. 15. (2) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to respond to the complainant indicating what the licensee did to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief.

A CI was submitted to the MOHLTC in relation to multiple concerns regarding staff to resident interactions that were brought forward to the home in a written complaint.

During an interview the complainant reported that a response was not received from the licensee about the complaint.

No documentation was found indicating that the licensee provided a response to the complainant with respect to the identified concerns for the resident, upon review of the progress notes in Point Click Care (PCC), and the DOC notes related to the investigation of the complaint.

During interviews with the DOC they reported that a response was not provided to the complainant.

The licensee failed to respond to the complainant indicating what the licensee did to resolve the complaint regarding the identified resident, or that the licensee believed the complaint to be unfounded and the reasons for the belief. [s. 101. (1) 3.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that where an incident occurred that caused an injury to a resident for which the resident was taken to a hospital, but the licensee was unable to determine within one business day whether the injury had resulted in a significant change in the resident's health condition, the licensee was to determine that the injury had resulted in a significant change in the resident's health condition or remained unsure whether the injury had resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

A CI report was submitted by the home for an incident that caused injury to a resident for which the resident was taken to hospital and which had resulted in a significant change in the resident's health status.

The CI report was not submitted by the home until ten days after the fall.

No phone notification to the MOHLTC could be located.

When asked about the home's expectation to inform the Director, ADOC stated that they should have notified the Director within 24 hours of the incident.

The licensee failed to ensure the Director was informed of the incident no later than three business days after the occurrence of the incident. [s. 107. (3.1) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.
Note: This subsection does not apply with respect to drugs that a resident is permitted to keep on his or her person or in his or her room in accordance with subsection 131 (7). r. 129. (1) (a)

An RN was observed administering medication when they left the medication cart unlocked. The RN was reminded by the Inspector, however, they continued to leave the medication cart unlocked.

The RN was observed from 1208 hours until 1217 hours, and again at 1220 hours and they continued to leave the cart unlocked.

The RN shared that they should have locked the screen and should not have the left medication cart open but did not realize it. They were asked if that was the expectation as there were visitors close to the cart and the registered staff's back was towards the medication cart. They said that they never locked the cart when they were in the dining room as they were not far from it.

The DOC said that the expectation was that the medication cart was to be secured and locked during medication pass. [s. 129. (1) (a)]

Issued on this 14th day of March, 2019

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

Original report signed by the inspector.

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) /
Nom de l'inspecteur (No) : NUZHAT UDDIN (532), KIM BYBERG (729), VALERIE GOLDRUP (539)

Inspection No. /
No de l'inspection : 2019_601532_0001

Log No. /
No de registre : 007521-17, 008593-17, 009829-17, 009941-17, 010486-17, 011632-17, 013051-17, 013794-17, 018348-17, 021453-17, 024391-17, 024816-17, 026915-17, 027213-17, 027275-17, 027631-17, 028418-17, 028441-17, 028444-17, 028544-17, 003260-18, 003598-18, 005576-18, 005966-18, 006422-18, 008126-18, 019485-18, 022095-18, 027922-18

Type of Inspection /
Genre d'inspection: Complaint

Report Date(s) /
Date(s) du Rapport : Feb 28, 2019

Licensee /
Titulaire de permis : St. Joseph's Health System
50 Charlton Avenue East, Room M146, HAMILTON, ON, L8N-4A6

LTC Home /
Foyer de SLD : St. Joseph's Health Centre, Guelph
100 Westmount Road, GUELPH, ON, N1H-5H8

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : David Wormald

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To St. Joseph's Health System, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be complaint with r. 50. (2) (a) (ii), (b) (i), (ii), (iii) and (iv), of the LTCHA.

Specifically, the licensee must:

a) Ensure that the identified residents and all other residents of the home shall receive a skin assessment by a member of the registered nursing staff upon return from hospital;
b) Ensure that the identified resident and all other residents of the home receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment;
c) Ensure that the identified and all other residents of the home exhibiting altered skin integrity receive immediate treatment and interventions to reduce or relieve their pain;
d) Ensure that the identified resident and all other residents exhibiting altered skin integrity, are assessed by a registered dietician who is a member of the staff of the home;
e) Ensure that the identified resident and all other residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

1. The licensee failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

a) A CI identified a fall which resulted in an injury for which the resident had a procedure.

Program-Altered Skin Integrity Assessments in Point Click Care (PCC) were reviewed for the resident and no altered skin integrity assessment was found.

RPNs reported that a skin integrity assessment was to be done in PCC when a resident returned from hospital if a skin and wound issue was identified. The registered staff and the ADOC acknowledged that there was no skin integrity

assessment completed in PCC for the resident.

b) A CI was submitted by the home for an incident that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

When the resident returned from hospital a completed Head to Toe assessment documented that the resident had altered skin integrity. Registered staff were to complete an altered skin and wound assessment for each of the observed impairments.

The Registered Practical Nurse (RPN) was unable to locate a completed skin and wound assessment in Point Click Care (PCC) for the resident until two weeks after their return from hospital.

The ADOC confirmed that skin and wound assessments had not been completed.

The licensee failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon return of resident from hospital. (539)

2. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A complaint was received regarding the care and assessments completed by staff prior to a resident's hospital admission.

Record review completed in PCC found progress notes indicating that the resident experienced altered skin integrity within a specified time frame.

A RPN reported that if a resident had altered skin integrity, the registered staff were to complete the Altered Skin Assessment Tool weekly until the condition had healed.

According to the Skin and Wound Lead RN, the expectation for the residents presenting with altered skin integrity was that registered staff completed an initial assessment using the Altered Skin Assessment tool, followed by weekly assessments until the wound had healed.

The Skin and Wound Lead RN confirmed that the registered staff did not complete any skin assessments using the Altered Skin Assessment tool.

The licensee failed to ensure that the resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessments; when the resident was experiencing a changing and worsening rash. (729)

3. The licensee has failed to ensure that a resident exhibiting altered skin integrity received immediate treatment and interventions to reduce or relieve their pain.

Progress notes indicated that the resident experienced altered skin integrity during a specified time frame. The resident was hospitalized and received treatment for the altered skin integrity.

A RPN documented that the staff reported altered skin integrity and the resident appeared in discomfort. The RPN made no further documentation that day regarding the resident's altered skin integrity.

Review of the resident's Medication Administration Record (MAR) showed that the resident received analgesic for pain. The resident did not receive their next dose of scheduled analgesic until a later time.

The RPN reported that if a resident was in pain, the expectation would be that registered staff assess for the location of the pain, the level of pain and they would check the resident's care orders for any As Needed (PRN) pain medication. If the pain persisted, they would complete the PainAD assessment tool in PCC. The RPN could not recall if they provided any additional treatment to the resident, other than the resident's scheduled analgesic.

The licensee failed to ensure that the resident received immediate treatment and intervention to reduce or relieve their mouth pain, when the resident expressed discomfort and pain. (729)

4. The licensee has failed to ensure that a resident exhibiting altered skin integrity, was assessed by a registered dietician who was a member of the staff of the home.

Review of progress notes indicated that during a specified time frame the resident experienced altered skin integrity. The altered skin integrity did not resolve until after the resident was admitted to hospital.

RPNs reported that they referred residents with skin conditions to the dietician.

According the Home's policy titled ''Skin and Wound Program and Process" for actual altered skin, registered staff were directed to notify the interdisciplinary team which were the Nurse Practitioner, Program Lead and the Dietician.

The Registered Dietician (RD) confirmed that they did not receive any referrals for the resident regarding their altered skin integrity.

The licensee failed ensure that the resident who was exhibiting signs of altered skin. (729)

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

A CI identified a fall which resulted in an injury. A subsequent fall occurred on ar identified date, which also resulted in an injury.

Progress notes for the resident stated that the fall resulted in altered skin integrity.

The program-Altered Skin Integrity Assessments in PCC was reviewed for the resident and there were no weekly altered skin integrity assessments completed.

Both a RPN and the ADOC said that it was the home's expectation that registered staff complete weekly skin integrity assessments when there was a skin and wound issue. The registered staff acknowledged that there were no weekly skin integrity assessments completed for the altered skin integrity.

The licensee failed to ensure that the resident altered skin integrity were reassessed at least weekly by a member of the registered staff.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 2 pattern more than the fewest number of residents were affected. The home had a level 3 history of 1 or more related non-compliance (NC) in last 3 years that included:
Voluntary plan of correction (VPC) issued June 2, 2017 (2017_610633_0004). (539)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
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 28th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

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