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

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Public Copy/Copie 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
May 30, 2019	2019_605213_0019	008785-18, 009179-18, 022631-18, 023198-18, 028410-18, 028825-18, 033246-18, 001125-19, 002074-19, 006138-19, 006310-19	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

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

Sunset Manor Home for Senior Citizens
49 Raglan Street COLLINGWOOD ON L9Y 4X1

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

RHONDA KUKOLY (213), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 13, 14, 15, 16, 2019.

The following were completed during this inspection:
Log #008785-18, Critical Incident #M581-000019-18 related to falls
Log #009179-18, Critical Incident #M581-000020-18 related to falls
Log #022631-18, Critical Incident #M581-000027-18 related to responsive behaviours
Log #023198-18, Critical Incident #M581-000028-18 related to responsive behaviours
Log #028410-18, Critical Incident #M581-000034-18 related to responsive behaviours
Log #028825-18, Critical Incident #M581-000036-18 related to responsive behaviours
Log #033246-18, Critical Incident #M581-000039-18 related to responsive behaviours
Log #001125-19, Critical Incident #M581-000002-19 related to alleged staff to resident emotional abuse
Log #002074-19, Infoline #IL-63721-CW, an anonymous complaint concerning alleged staff to resident abuse
Log #006138-19, Critical Incident #M581-000006-19 related to falls
Log #006310-19, Critical Incident #M581-000007-19 related to a missing controlled substance.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, the Associate Director of Care, the Supervisor of Resident Care, the Quality Lead, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents and family members.

The Inspectors also made observations and reviewed health records, policies and procedures, education records, internal investigation records, evaluations, employee records and other relevant documentation.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **2 VPC(s)**
- **2 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

A complaint was received by the Ministry of Health and Long Term Care alleging that

residents had reported to them that they were afraid of a staff member. The complainant shared that a resident suffered an injury during a transfer with this staff member.

In an interview with a resident, the resident recalled the transfer and that they got an injury during the transfer and required treatment for the injury. The resident did not wish to identify the staff member involved.

In an interview with a second resident, this resident reported that they suffered an injury when they were transferred by the same staff member.

Incident reports in Point Click Care (PCC) were reviewed and it was noted that the two above noted residents suffered seven injuries (four for the first resident and three for the second) during transfers over an eleven month period. Two of the seven skin tears suffered during transfers with staff occurred with the same staff member. Four of the other skin tears occurred involved five different staff members and one of the injuries that occurred during a transfer by staff did not identify the staff involved.

In an interview with a staff member, they shared that they were involved in the transfers with both residents when they suffered an injury.

Training records for the Safe Lifts and Transfers training in 2018 were requested and the Associate Director of Resident Care (ADORC) provided records titled "Competency for Mechanical Lifts". These records were reviewed and indicated six out of twelve registered nurses, twenty out of twenty-nine registered practical nurses and seventy-two out of ninety-eight personal support workers received the training dating from May 29 to August 1, 2018.

In an interview with the Director of Resident Care (DORC), ADORC and the Quality Lead (QL), they said that there was no investigation related to the injury that occurred during a transfer for the two residents. They said that they hadn't noted a pattern of skin tears that occurred during transfers in the home but that two residents incurring seven injuries during transfers with staff over the past year was concerning. They said that training regarding safe lifts and transfers was completed in 2018, but that the training was conducted by the physiotherapy company Achieva Physiotherapy. Achieva trained the home's Safe Lifts and Transfers (SALT) team and then the team trained the staff in the home. They said that they determined that the training that was done in 2018 was not correct, that they had trained that foot rests did not need to be removed from wheelchairs during a transfer and that the second person involved in a mechanical lift could be

anyone in the home and only needed to be within sight of the transfer. They said that as a result, the SALT team had just been retrained correctly and were going to be re-training all staff related to safe lifts and transfers, but hadn't started yet.

The home's policy "Minimal Lift Procedures" #NPC-G-95 was reviewed and stated:
1. Comprehensive, initial and ongoing training is essential for Staff competency and confidence when performing their tasks. Training on proper body mechanics, policies, assessments, logo identification, performing Resident lifts and transfers and proper equipment usage will translate into an empowered Staff.
2. A properly trained Staff Member will perform their daily duties diligently while minimizing their exposure to risk of injury.
3. Each new Employee upon hire will receive training outlining the safe lifting, handling and positioning program.
4. Each Employee will receive yearly refresher training on the use of equipment.
5. If at any time an Employee feels that they require training on any task, they must notify their Supervisor.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting two residents when they suffered injuries on seven different occasions during transfers, over an eleven month period of time. [s. 36.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and was reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

The home reported a critical incident system (CIS) report to the Ministry of Health and Long Term Care related to an incident that resulted in a transfer to hospital and a significant change in condition. The incident resulted in an injury and subsequent altered skin integrity.

The health records for this resident were reviewed in Point Click Care (PCC). The only wound assessment completed was dated twenty days after they returned from hospital. There were no further wound assessments completed in PCC including no weekly wound assessments.

A complaint was received by the Ministry of Health and Long Term Care alleging that residents had shared with them that a resident suffered an injury that included altered skin integrity during a transfer with a staff member.

The health records for this resident were reviewed in Point Click Care (PCC). Progress notes indicated that the resident suffered an injury that included altered skin integrity was transferred to hospital. The first wound assessment completed related to the altered skin integrity was dated twenty-three days after the resident returned from hospital with altered skin integrity.

The Supervisor of Resident Care (SRC), who was the lead for the Skin and Wound program in the home as well as a Registered Nurse (RN) and the Inspector reviewed the health records for the two residents. The SRC and RN agreed that an initial wound assessment was not completed for the first resident until twenty days after the resident's return from hospital with altered skin integrity and no weekly wound assessments were completed. They also agreed that no initial wound assessment was completed for the second resident until twenty-three days after the resident's return from hospital with altered skin integrity. They both agreed that the expectation in the home was that an initial wound assessment should have been completed upon return from hospital and that weekly wound assessments should have been completed until the wounds were healed.

Initial wound assessments were not completed for a resident for twenty days and for another resident for twenty-three days for areas of altered skin integrity. Weekly wound assessments were not completed at all for first resident resident. [s. 50. (2)]

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A complaint was received by the Ministry of Health and Long Term Care (MOHLTC), alleging that residents had reported to them that they were afraid of an identified staff member as they were rough with them during care. The complainant was an employee of the home.

In an interview with the complainant, they said that they did not report the comments of the residents to registered staff or the management of the home. When asked if the complainant had received training related to resident rights and the prevention of abuse and neglect, they said yes, in 2018 and 2019 and they were aware of their responsibility to report suspected abuse.

The home's policy "Zero Tolerance of Abuse and Neglect #ADM F-10", dated effective April 2017 was reviewed. The policy stated: staff must immediately report every alleged, suspected or witnessed incidents of: a) abuse of resident by anyone, b) neglect of a resident by the licensee, a staff member (or affiliate) of the home. Staff must follow two types of procedures (internal and external) for the reporting of all alleged, suspected or witnessed incidents of abuse or neglect, in accordance with the investigation procedures as outlined in section two of this document. All staff, volunteers and affiliated personnel are required to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC. Note: The Registered Nurse (RN) on duty at the home is responsible for completing reports using Critical Incident System to the MOHLTC. The RN may make the MOHLTC report together with the person who witnessed the incident of abuse or neglect. To immediately report to the RN in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect.

In interviews with the Director of Resident Care (DORC), Associate Director of Resident Care (ADORC) and the Administrator, they said that they were unaware of a complaint of suspected alleged abuse of residents by a staff member and that it had not been reported to them.

A staff member of the home was aware of complaints of rough care from an identified staff member and did not immediately report these complaints to registered staff or management of the home. [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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; corrective action was taken as necessary; and a written record was kept of everything required.

The home reported a critical incident report to the Ministry of Health and Long Term Care on related to a missing controlled substance on the same date.

A review of health records for a resident was completed. The resident was supposed to receive an identified controlled substance three times daily. For one of the doses, documentation stated "drug not available". Physician's orders were reviewed and found no order related to hold the medication on that date.

In an interview with a Registered Practical Nurse (RPN), the RPN said that they discovered the controlled substance was missing at a specific administration time. They said that they were unsure if the resident had received an extra dose the previous shift

that day in error and therefore did not administer the dose due at that time.

In an interview with the Director of Resident Care (DORC) and the Associate Director of Resident Care (ADORC), they said that they were unaware if the resident had received their dose of the controlled substance at the time it was found to be missing. After reviewing the eMAR for that month, the ADORC agreed that as there was no order to hold the medication, the resident should have received the medication as ordered and therefore an omission medication incident occurred.

The medication incidents binder was reviewed including medication incident reports and the monthly analysis of incidents. No medication incidents were found related to the missing controlled substance. No medication incidents were found related to the omission of the dose when the medication had been found to be missing. Neither the missing controlled substance, nor the omission of the dose of the controlled substance were included in the analysis of medication incidents.

In an interview with the ADORC, they said that they complete the review and analysis of medication incidents on a monthly basis and they didn't realize that a medication incident wasn't completed for the missing controlled substance. The ADORC said that they submitted a critical incident report for the missing controlled substance, but didn't consider that there was also an omission incident.

All medication incidents and adverse drug reactions were not documented, reviewed and analyzed; corrective action was taken as necessary; and a written record kept of everything required when medication incident reports were not completed and therefore also not analyzed, for a missing controlled substance and an omission. [s. 135. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed; corrective action was taken as necessary; and a written record kept of everything required, to be implemented voluntarily.

WN #5: 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) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that results in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident, followed by the report.

Ontario Regulation 79/10 states significant change means a major change in the resident's health condition that,
(a) will not resolve itself without further intervention,
(b) impacts on more than one aspect of the resident's health condition, and
(c) requires an assessment by the interdisciplinary team or a revision to the resident's plan of care

A complaint was received by the Ministry of Health and Long Term Care alleging that residents had reported to them that they were afraid of a staff member. The complainant shared that a resident suffered an injury during a transfer with this staff member.

Incident reports in Point Click Care (PCC) were reviewed and it was noted that on an identified date, the resident was being transferred by staff and suffered an injury resulting in altered skin integrity and a transfer to hospital.

A review of the MOHLTC Critical Incident System (CIS) was completed and no critical incidents were reported related to an incident on the date of the incident report, involving an injury including altered skin integrity requiring a transfer to hospital and treatment.

In an interview with the Director of Resident Care (DORC), the Associate Director of Resident Care (ADORC) and the Quality Lead, when asked if they reported a CIS for the incident involving a resident where they sustained an injury including altered skin integrity and requiring a transfer to hospital, they said no, they hadn't thought of the incident in that manner, requiring a CIS report.

The Director was not informed of an incident that caused injury to a resident resulting in a transfer to hospital, treatment and a significant change in the resident's health condition. [s. 107. (3) 4.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home reported a critical incident report to the Ministry of Health and Long Term Care on related to a missing controlled substance on the same date.

A review of health records for a resident was completed. The resident was supposed to receive a controlled substance three times daily. The electronic medication administration record (eMAR) indicated on an identified date stated, "drug not available". Physician's orders were reviewed and found no order related to hold the medication.

In an interview with a Registered Practical Nurse (RPN), the RPN said that they discovered the controlled substance was missing at the administration time. They said that they were unsure if the resident had received an extra dose during the previous shift that day in error and therefore did not administer the dose.

In an interview with the Director of Resident Care (DORC) and the Associate Director of Resident Care (ADORC), they said that they were unaware if the resident had received their dose of the controlled substance when it was found to be missing. After reviewing the eMAR for that month, the ADOC agreed that as there was no order to hold the medication, the resident should have received the medication. They said the RPN should have taken the medication from a later time slot in the blister card and notified pharmacy to replace that dose, or received direction from the physician or nurse practitioner regarding administration.

A resident was not administered their medication in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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*

Issued on this 3rd day of June, 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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RHONDA KUKOLY (213), MELANIE NORTHEY (563)
Inspection No. / No de l'inspection :	2019_605213_0019
Log No. / No de registre :	008785-18, 009179-18, 022631-18, 023198-18, 028410-18, 028825-18, 033246-18, 001125-19, 002074-19, 006138-19, 006310-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 30, 2019
Licensee / Titulaire de permis :	Corporation of the County of Simcoe 1110 Highway 26, Midhurst, ON, L9X-1N6
LTC Home / Foyer de SLD :	Sunset Manor Home for Senior Citizens 49 Raglan Street, COLLINGWOOD, ON, L9Y-4X1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Martina Wynia

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

To Corporation of the County of Simcoe, 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 36.
Specifically the licensee must:
a) Ensure that staff use safe transferring and positioning techniques when transferring resident #015, #017 and all other residents requiring assistance with transferring and positioning.
b) Ensure that all nursing staff, including Registered Nurses, Registered Practical Nurses and Personal Support Workers, as well as any other staff performing resident transfers, receive training in using safe transferring and positioning techniques and devices. Training is to include transfers completed with and without mechanical lifts.
c) Ensure that a written record is kept of the training including staff names, dates and training content, to ensure that all nursing staff received the training.
d) Ensure that the above training is incorporated into new staff orientation.
e) Track skin tears and their cause, noting any trends, investigate any skin tears involving staff and take appropriate actions.
f) Ensure that the tracking, investigations and actions taken are documented and kept.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

A complaint was received by the Ministry of Health and Long Term Care alleging that residents had reported to them that they were afraid of a staff member. The complainant shared that a resident suffered an injury during a transfer with this staff member.

In an interview with a resident, the resident recalled the transfer and that they got an injury during the transfer and required treatment for the injury. The resident did not wish to identify the staff member involved.

In an interview with a second resident, this resident reported that they suffered an injury when they were transferred by the same staff member.

Incident reports in Point Click Care (PCC) were reviewed and it was noted that the two above noted residents suffered seven injuries (four for the first resident and three for the second) during transfers over an eleven month period. Two of the seven skin tears suffered during transfers with staff occurred with the same staff member. Four of the other skin tears occurred involved five different staff members and one of the injuries that occurred during a transfer by staff did not identify the staff involved.

In an interview with a staff member, they shared that they were involved in the transfers with both residents when they suffered an injury.

Training records for the Safe Lifts and Transfers training in 2018 were requested and the Associate Director of Resident Care (ADORC) provided records titled "Competency for Mechanical Lifts". These records were reviewed and indicated six out of twelve registered nurses, twenty out of twenty-nine registered practical nurses and seventy-two out of ninety-eight personal support workers received the training dating from May 29 to August 1, 2018.

In an interview with the Director of Resident Care (DORC), ADORC and the Quality Lead (QL), they said that there was no investigation related to the injury that occurred during a transfer for the two residents. They said that they hadn't noted a pattern of skin tears that occurred during transfers in the home but that two residents incurring seven injuries during transfers with staff over the past year was concerning. They said that training regarding safe lifts and transfers was completed in 2018, but that the training was conducted by the physiotherapy company Achieva Physiotherapy. Achieva trained the home's Safe Lifts and Transfers (SALT) team and then the team trained the staff in the home. They said that they determined that the training that was done in 2018 was not correct, that they had trained that foot rests did not need to be removed from wheelchairs during a transfer and that the second person involved in a

mechanical lift could be anyone in the home and only needed to be within sight of the transfer. They said that as a result, the SALT team had just been retrained correctly and were going to be re-training all staff related to safe lifts and transfers, but hadn't started yet.

The home's policy "Minimal Lift Procedures" #NPC-G-95 was reviewed and stated:
1. Comprehensive, initial and ongoing training is essential for Staff competency and confidence when performing their tasks. Training on proper body mechanics, policies, assessments, logo identification, performing Resident lifts and transfers and proper equipment usage will translate into an empowered Staff.
2. A properly trained Staff Member will perform their daily duties diligently while minimizing their exposure to risk of injury.
3. Each new Employee upon hire will receive training outlining the safe lifting, handling and positioning program.
4. Each Employee will receive yearly refresher training on the use of equipment.

5. If at any time an Employee feels that they require training on any task, they must notify their Supervisor.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting two residents when they suffered injuries on seven different occasions during transfers, over an eleven month period of time.

The severity of this issue was a level 3 as there was actual risk to the residents. The scope was level 2 as two out of three residents were affected. Compliance history was a level 3 as the home has a history of non-compliance in this subsection of the legislation including:
January 9, 2019 Voluntary Plan of Correction issued in inspection #2019_760527_0001
May 9, 2018 Voluntary Plan of Correction issued in inspection #2018_742527_0009
(213)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2019

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

Order # / Ordre no : 002

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 all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receive 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 and was reassessed at least weekly by a member of the registered nursing staff when clinically indicated.
b) Ensure that all registered nursing staff receive training in the types of impaired skin integrity, required assessments, timelines for assessments and the home's protocols related to skin and wound assessments.
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 A tracking and weekly auditing system is developed, implemented and documented for all residents exhibiting altered skin integrity to ensure all residents exhibiting any and all types of altered skin integrity, including skin tears, are receiving the required assessments and treatments in accordance with the home's policies and procedures to ensure consistency and completion.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and was reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

The home reported a critical incident system (CIS) report to the Ministry of Health and Long Term Care related to an incident that resulted in a transfer to hospital and a significant change in condition. The incident resulted in an injury and subsequent altered skin integrity.

The health records for this resident were reviewed in Point Click Care (PCC). The only wound assessment completed was dated twenty days after they returned from hospital. There were no further wound assessments completed in

PCC including no weekly wound assessments.

A complaint was received by the Ministry of Health and Long Term Care alleging that residents had shared with them that a resident suffered an injury that included altered skin integrity during a transfer with a staff member.

The health records for this resident were reviewed in Point Click Care (PCC). Progress notes indicated that the resident suffered an injury that included altered skin integrity was transferred to hospital. The first wound assessment completed related to the altered skin integrity was dated twenty-three days after the resident returned from hospital with altered skin integrity.

The Supervisor of Resident Care (SRC), who was the lead for the Skin and Wound program in the home as well as a Registered Nurse (RN) and the Inspector reviewed the health records for the two residents. The SRC and RN agreed that an initial wound assessment was not completed for the first resident until twenty days after the resident's return from hospital with altered skin integrity and no weekly wound assessments were completed. They also agreed that no initial wound assessment was completed for the second resident until twenty-three days after the resident's return from hospital with altered skin integrity. They both agreed that the expectation in the home was that an initial wound assessment should have been completed upon return from hospital and that weekly wound assessments should have been completed until the wounds were healed.

Initial wound assessments were not completed for a resident for twenty days and for another resident for twenty-three days for areas of altered skin integrity. Weekly wound assessments were not completed at all for first resident resident.

The severity of this issue was a level 3 as there was actual risk to the residents. The scope was level 2 as two out of three residents were affected. Compliance history was a level 3 as the home has a history of non-compliance in this subsection of the legislation including:
October 18, 2017 Voluntary Plan of Correction 2017_484646_0014.

(213)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 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 30th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

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

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