Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 28, 2020	2019_773155_0016 (A1)	011053-19, 011054-19, 011629-19, 014005-19, 014751-19, 014752-19, 016915-19, 017450-19	Follow up

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

Amended by SHARON PERRY (155) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance order #001 and #002 compliance due date changed from February 21, 2020 to April 3, 2020.

Issued on this 28th day of January, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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Amended by SHARON PERRY (155) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 28, 29, 30, 31,

November 1, 4, 5, 6 and 7, 2019.

Katy Harrison #766 was also present during this inspection.

The following intakes were completed within this Follow up inspection:

Log 014751-19 and 014752-19 follow up to compliance orders #002 and #003 from inspection number 2019_773155_0010;

Log 011053-19 and 011054-19 follow up to compliance orders #001 and #002 from inspection number 2019_605213_0019;

Log 014005-19 related to alleged staff to resident neglect and

Log 016915-19, log 011629-19 and log 017450-19 related to falls resulting in injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Administrative Assistant, Professional Standards Supervisor, Registered Dietitian (RD), Dietary Supervisor, Maintenance worker, Quality Improvement Coordinator, Resident Care Supervisor, Registered Nurse, Registered Practical Nurses, Dietary Aide, Personal Support Workers and residents.

The inspectors also toured resident living areas; observed resident-staff interactions; reviewed relevant clinical records, policies and procedures, education records, schedules, and the home's investigation notes.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

8 WN(s)
5 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2019_773155_0010	155
O.Reg 79/10 s. 36.	CO #001	2019_605213_0019	606

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. 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 failed to ensure that the hydration program included:
- the implementation, in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures related to hydration, and
-the implementation of interventions to mitigate and manage the risks.

Review of the homes policy Hydration Assessment and Management DM-45 effective September 2019, stated that if a resident's fluid intake was less than seven glasses for three or more days, the PSW would notify the Registered Staff to complete a referral to the Registered Dietitian to assess for dehydration. Registered staff would assess the resident for signs and symptoms of dehydration and include the findings on the referral to the Registered Dietitian.

Review of the homes policy Referral to Dietitian NPC E-35 effective September 2019, stated that the RN/RPN would complete the electronic Dietitian Referral Form and forward it to the Registered Dietitian when the resident had poor fluid intake over a 72 hour period and exhibited signs and symptoms of dehydration.

During an interview with Registered Dietitian (RD) #110 they shared that they were involved in the review of the policies, but did not realize that there was different direction given in the policies. They felt there should be a referral if there was poor fluid intake over a 72 hours period and the resident exhibited signs and symptoms of dehydration.

During interviews with Director of Resident Care (DRC) #100 and the Professional Standards Supervisor #102 they shared they did not realize that there was different direction given in the policies. They said the registered staff were to complete a referral to the RD to assess for dehydration if the resident's fluid intake was less than seven glasses for three or more days. Registered staff were to assess the resident for signs and symptoms of dehydration and include the assessment in the referral for the RD.

a) Review of resident #002's care plan stated that their fluid requirement was 1200 ml/day (6.5 glasses) and that they were a moderate risk for dehydration. Review of resident #002's fluid intake documented in point of care showed that for an identified period of time, there were nine days that resident #002's fluid intake was less than 6.5 glasses and was as low as 2.5 glasses.

Review of resident #002's clinical record was done and there was no referral to the RD for a dehydration assessment nor was there any assessment done by registered staff for dehydration during the identified period. Resident #002's care plan did not include any interventions to mitigate the risk for dehydration.

b) Review of resident #003's care plan stated that their fluid requirement was 1600 mls per day and that they were a moderate risk for dehydration. Interventions listed were to remind the resident to finish their fluids at meals and to keep specific fluids in their room and offer sips often.

Review of resident #003's fluid intake documented in point of care showed that for fourteen days, they consumed an average of 4.9 glasses of fluid per day with the most being 6.25 glasses and the lowest being 3 glasses per day.

Review of resident #003's clinical record was done and there was no referral to the RD for a dehydration assessment nor was there any assessment done by registered staff for dehydration during the identified period of time.

During multiple observations of resident #003 there were no specific fluids found

in their room.

c) Review of resident #005's care plan stated that their fluid requirement was 2100 mls per day (11 glasses) and they were a high risk for dehydration. Interventions listed were to keep water at bedside and offer before, during and after care. Staff were to encourage sips of fluids often.

Review of resident #005's fluid intake documented in point of care showed that for a thirteen days, they consumed an average of 4.8 glasses of fluid per day with the most being 6 glasses and the lowest being 3 glasses per day.

Review of resident #005's clinical record was done and there was no referral to the RD for an assessment for dehydration nor was there any assessment done by registered staff for dehydration during October 2019.

During observations of resident #005 there was a water bottle on their bedside table, however the water remained at the same level in the bottle on November 1, 4 and 5th. On an identified date, resident #005 rang their bell and asked PSW #124 for a drink. PSW #124 told resident #005 that the nourishment cart was coming and left resident #005 without giving them a drink. Resident #005 was given a drink from the nourishment cart 45 minutes after the initial request.

RPN #106 shared that when a resident was on the list for having less than seven glasses of fluids for three days that the information was shared at report for the staff to know to encourage fluids for the residents. They shared that residents were offered fluids at meals, from nourishment cart and by "sip and go". The shared that "sip and go" was to offer residents fluids when they went into their room or when approached if sitting in a common area. They said they did not send referrals to the RD if the resident had less than seven glasses for three days.

RD #110 shared they did not receive any dietary referrals for resident #002, #003 and #005 related to dehydration or low fluid intake.

DRC #100 reviewed resident #002, #003 and #005's fluid intakes listed above and reviewed their clinical records for referrals to the RD. DRC #100 acknowledged that there were no referrals to the RD for resident #002, #003 and #005 during October 2019 related to low fluid intake. They shared the expectation was that a referral to the RD was to be made when a resident had a

fluid intake of less than seven glasses for three or more days. They also shared that registered staff were to assess the resident for signs and symptoms of dehydration and include the findings in the referral to the RD. There were no assessments of dehydration documented for these residents. [s. 68. (2) (a)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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).

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 resident #014 received a skin assessment by a member of the registered nursing staff within 24 hours upon return from hospital.

The clinical record for resident #014 was reviewed. The resident went to hospital. The resident underwent a procedure at the hospital and then returned to the home. A skin assessment was not done until 13 days after the resident returned to the home.

In separate interviews with DRC #100 and RPN #117, they reviewed the resident's clinical record and their internal 'risk rounds meeting' minutes and could not locate a skin assessment that had been completed earlier than 13 days after return.

A skin assessment by a member of the registered staff was not completed for resident #014 when they returned from hospital. [s. 50. (2) (a) (ii)]

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

a) The clinical record of resident #004 was reviewed. During an identified period of time, the resident had areas of altered skin integrity. Weekly skin assessments were not completed for the identified areas of altered skin integrity.

b) The clinical record of resident #011 was reviewed. During an identified period of time, the resident had areas of altered skin integrity. Weekly skin assessments were not completed for the identified areas of altered skin integrity.

RPN #106 said that documented skin assessments differed depending on the type of altered skin integrity. Registered staff were unsure what the area of altered skin integrity would be considered. The staff described the treatment and that it was provided twice a day. DRC #100 shared staff were expected to complete weekly assessments and the treatments according to the TAR.

c) The clinical record of resident #014 was reviewed. The resident had an area of altered skin integrity. A weekly wound assessment was not completed.

RPN #106, #112, #113, #117 and DRC #100 agreed that resident #004, #011 and #014's skin concerns all fit the definition of altered skin integrity and required weekly skin assessments and treatments to be provided according to the resident's TAR. RPN #117 explained they were scheduled to work as the home's wound care nurse six shifts per month. The RPN said they were directed to only keep a list of residents in the home that had skin tears or pressure areas. Residents with other skin integrity issues were not tracked. RPN #117 also said there was no system in place to ensure weekly assessments were completed on residents that were exhibiting an area of altered skin integrity.

The DRC #100 and Professional Standard Supervisor #102 confirmed education related to the skin and wound was a part of the home's annual training. The home did not provide education for registered staff about the types of impaired skin integrity, required assessment, timelines for the assessments and the home's

protocols. As of October 30, 2019, only 54 percent of registered staff had completed the home's annual training program. The home's annual training did not include training related to the types of impaired skin integrity, required assessments, timelines for the assessments or the home's protocols related to skin and wound. Professional Standards Supervisor #102 felt registered staff should already know this from their professional training.

DRC #100 said staff have access to the home's policies through the internal internet database if they wanted to review them. The policy titled, "Wound Management Program", policy number NPC D-35, effective September 2019, stated registered staff were to complete assessments as outlined in the program and complete all appropriate referrals. DRC #100 agreed the policy did not provide clear direction regarding the required assessments, timelines for the assessments or what referrals were to be completed for residents with altered skin integrity.

RPN #117 and DRC #100 reviewed the clinical records with the inspector. They acknowledged resident #004, #011, and #014 had a number of weekly assessments that were not completed.

The licensee failed to ensure that residents #004, #011 and #014 when exhibiting altered skin integrity, were reassessed at least weekly by a member of the registered staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

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

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

During the follow up inspection related to compliance order #002, inspection # 2019_605213_0019, O.Reg 79/10 s. 50 (2), completing weekly assessments for residents that were exhibiting altered skin integrity, it was noted that a number of entries were blank on the treatment administration records (TAR) for the period reviewed.

a) Resident #004's Treatment Administration Record (TAR) was reviewed. The resident had areas of altered skin integrity. Staff were to ensure a procedure was done once per day. In August 2019, two of the thirteen (15 per cent), in September 2019, three of thirty (10 per cent) and in October 2019, six of the thirty (20 per cent) of the entries were blank.

On other area for resident #004 another treatment was to be done daily. In September 2019, three of the seventeen (18 per cent) and October 2019, five of the twenty seven (19 per cent) of the entries were blank.

Another treatment was to be done twice daily. In September 2019, four of the eighteen (20 per cent) and in October 2019, twelve of sixty (20 per cent) of the entries were blank.

b) Resident #011's TAR was reviewed. The resident had areas of altered skin integrity. An identified area of altered skin integrity was to have a treatment and two entries were blank. Weekly wound assessments for another area of altered skin integrity were on the resident TAR to be completed by registered staff. On

two identified dates, the wound assessment were signed in the TAR, but there was no wound assessments completed in Point Click Care.

In separate interviews with DRC #100 and RPN #117, they said if the registered staff did not sign the TAR, then they were unable to determine if the treatment was provided. They explained the home did not have a system in place and no follow up was done with staff to determine why treatments were not signed for or why assessments were signed as completed, but the assessments were not completed.

The licensee failed to ensure that the provision of care set out in the plan of care for resident #004 and #011's wound treatments was documented [s. 6. (9) 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 provision of the care set out in the plan of care is documented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or Regulation required the licensee to have, institute or otherwise put in place any policy or procedure, the policy and procedure was complied with.

Section 49(1) of O. Reg. 79/10 required the licensee to ensure the falls prevention management program provided strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, the licensee failed to comply with its policy entitled", Head Injury" NPC E-20 last revised September 2019 which stated that any resident who potentially may have sustained an injury to the head (abrasion, cut, swelling, bump or sudden onset of vomiting) would be promptly assessed and have a head injury routine initiated. The home's Head Injury Record (HIR) stated that the the resident was to be assessed every 15 minutes for an hour, every hour for four hours, and every four hours for 24 hours.

A Critical Incident Report for an identified date, reported resident #010 was found with areas of altered skin integrity/abrasion on their head. The resident stated they sustained a head injury.

Resident #010's progress notes stated that the resident was assessed and HIR monitoring was initiated. Review of the resident's HIR record stated the resident was not assessed as required at 0100 hours and 0500 hours and documentation showed that the resident was sleeping.

The DRC acknowledged that staff were expected to follow the home's HIR policy and should have completed the assessment as required for resident #010 at 0100 hours and 0500 hours.

The licensee failed to ensure that home's HIR policy was completed as required for resident #010's head injury. [s. 8. (1) (a),s. 8. (1) (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 the plan, policy, protocol, procedure, strategy or system put is place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Critical Incident Report on an identifed date, reported resident #010 was found with an area of altered skin integrity/ abrasion and told the staff they sustained a head injury.

Resident #010's plan of care identified the resident as a risk for falls and one of the interventions directed staff to ensure that the resident's manual bed alarm on their bed was turned on when they were in it.

Resident #010's Documentation Survey Report v2 for an identified period of time, was reviewed and stated that staff were to complete a task called a safety

measure and directed staff to document either a "1-yes" or "2-no" after checking that the bed alarm was in place and monitored to ensure that it was functioning every shift. Review of the 2200-0600 hours (hrs) documentation showed 22 shifts with missing documentation to indicate that this intervention/task was completed.

PSWs #103 and #127 stated that staff were to check and ensure that resident #010's bed alarm was on and functioning, and was documented in Point of Care (POC) every shift. This was confirmed by the Director of Resident Care (DRC).

The licensee has failed to ensure that staff documented that resident #010's bed alarm was checked to ensure that it was on and functioning. [s. 30. (2)]

2. Resident #011's plan of care identified the resident to be at risk of falling and one of the interventions was for the resident to have a bed alarm when they were in bed.

Resident #011's Documentation Survey Report v2 for an identified period of time, directed the staff to check the bed alarm and document either "2-yes" or "1-no" that the safety measure was in place and/or functioning. The Documentation Survey Report v2 for the identified period of time, had six shifts with missed documentation to indicate that the task had been completed.

The licensee failed to ensure that staff documented that resident #011's bed alarm was checked to ensure that it was on and functioning. [s. 30. (2)]

3. Resident #014's plan of care stated the resident was identified to be at risk of falling. One of the interventions directed the staff to ensure that the resident had on hip protectors at all times.

Resident #014's Documentation Survey Report v2 for an identified period of time, directed staff to ensure that the resident wore hip protectors and document that the task was completed. The Documentation Survey Report v2 for the identified period of time, for the 2200 hrs-0600 hrs shifts had a total of 17 shifts where there was no documentation to show that the task was completed.

The licensee failed to ensure that staff documented that resident #014's hip protectors were on. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that they complied with this Act, the regulations, and every directive issued, order made or agreement entered into under this Act.

The licensee has failed to comply with compliance order #001 from inspection #2019_605213_0019 issued on May 30, 2019, with a compliance date of August 31, 2019. The licensee was ordered to complete the following:

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.

The licensee completed parts a, c, and d, but did not complete parts b, e, and f of the order.

The licensee failed to ensure:
b) 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 was to include transfers completed with and without mechanical lifts.
e) to track skin tears and their cause, noting any trends, investigate any skin tears involving staff and take appropriate actions; and
f) Ensure that the tracking, investigations and actions taken are documented and kept.

1. Review of the home's Mechanical Lift and Transfer Training LTC-NPC-G-95 training records for the nursing department showed that 24 staff members had not received training on the home's Mechanical Lift and Transfer policy LTC-NPC-G-95. This was confirmed by the Director of Resident Care (DRC).

2. Resident #015's Risk Management Report for an identified date, stated that the resident sustained an area of altered skin integrity of unknown origin.

Resident #020's Risk Management Report for an identified date, stated that the resident sustained an area of altered skin integrity when a staff member unintentionally scratched the resident during care.

Resident #019's Risk Management Report for an identified date, stated that the resident sustained an area of altered skin integrity of unknown origin.

Residents' #015, #020 and #019's clinical records including the progress notes, Risk Management Reports, Treatment Administration Records (TARs), Skin Assessments did not show any investigation or actions taken as a follow up to the incident and as required by Order #001 part e) and f).

The DRC stated that the investigation as to the cause of the skin tear and the action(s) taken were to be documented in the resident's clinical records including the Risk Management Report, progress notes, and assessments. [s. 101. (3)]

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 licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts, to be implemented voluntarily.

WN #7: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director that included the names of any staff members who where present or discovered the incident.

Three Critical Incident System (CIS) reports showed that the PSWs who discovered and reported the incidents to the charge nurse were not included in the initial and the amended CIS reports. The DRC acknowledged that the names of the PSWs that discovered and reported the incidents to the charge nurses should have been included in the CI reports and were not.

The licensee failed to ensure that the names of the staff who discovered the incidents were included in the CI reports. [s. 107. (4) 2. ii.]

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 when the Director is informed of an incident under subsection (1), (3), (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the names of any staff members or other persons who were present or discovered the incident, to be implemented voluntarily.

WN #8: 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 resident #001 was not neglected by the licensee or staff.

The following is further evidence to support compliance order #001 issued on July 10, 2019, during inspection # 2019_773155_0010 to be complied by July 18, 2019.

As per O. Reg 79/10 s.5 neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On an identified date, a CI report was submitted to the MLTC which stated that resident #001 had been having identified symptoms for a period of time. The physician had been advised on an identified date and ordered treatment. Resident #001 continued to have symptoms and the physician was notified again on two identified dates, however there were no new orders. Resident #001 was hospitalized.

Resident #001's clinical record and the home's professional standards report identified the following:
- During an identified period of time, the resident had 30 episodes of symptoms with the physician not being informed until four months after the symptoms started. Even at that time, the notification to the physician only included a brief statement of symptoms.
- Family were not notified of the symptoms until seven months after the start of the symptoms.
- There were no care plan entries to direct staff as to interventions related to the symptoms.
- The resident had specific interventions related to diet and required assistance and monitoring during meals however, identified liquids were left at the bedside which they would consume independently at night.
- Medications were crushed for administration and pharmacy had identified multiple medications that were contraindicated for crushing.
- The resident had a long history of bowel problems yet there was no care plan entry to address these.

DRC #100 shared that resident #001 was mentioned at morning report on a few occasions related to the symptoms. Staff said that the doctor was aware. DRC #100 shared that they reviewed resident #001's record and noted that resident #001 had symptoms for an identified period of time. The DRC said that there was a pattern of inaction by staff in that the doctor and family were not notified in a timely manner and interventions were not put in place to address some of the symptoms. Because of this inaction they felt there was neglect and a critical incident report was submitted to the Ministry of Long-Term Care.

Professional Standards Supervisor #102 shared that they did a review of resident #001's record after the critical incident report was submitted to the Ministry of Long-Term Care and their investigation showed that resident #001 was neglected as there was a pattern of inaction and lack of communication amongst the care team in the home regarding resident #001's care.

The licensee has failed to ensure that resident #001 was not neglected by the licensee or staff. [s. 19. (1)]

Issued on this 28th day of January, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SHARON PERRY (155) - (A1)
Inspection No. / No de l'inspection :	2019_773155_0016 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	011053-19, 011054-19, 011629-19, 014005-19, 014751-19, 014752-19, 016915-19, 017450-19 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 28, 2020(A1)
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 Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To 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(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_773155_0010, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(b) the identification of any risks related to nutrition care and dietary services and hydration;

(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

(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).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 68. (2).

Specifically the licensee must:
a) Review the home's policies titled Hydration Assessment and Management DM-45 and Referral To Dietitian NPC E-35 to ensure that both policies provide clear direction on when a referral is to be sent to the Dietitian in relation to fluid intake.

b)Determine how the registered staff are to assess the resident for signs and symptoms of dehydration and where this will be documented.

c) After the revision of the home's policies titled Hydration Assessment and Management DM-45 and Referral To Dietitian NPC E-35, provide education to all registered staff to ensure they are aware of when a referral is to be sent to the Dietitian for fluid intake, how they are to be assessing residents for signs and symptoms of dehydration, and where it will be documented. The education provided shall be documented and include the date and identity of the staff educated. These records will be kept in the home.

d) Ensure that interventions put in place for residents #003, #005 and any other residents regarding hydration are implemented to mitigate and manage the risks.

e) Implement a written plan/audit to ensure that residents with poor fluid intake are identified and appropriate interventions and referrals are utilized to mitigate risks for all residents. The audit shall be documented and include the date and the identity of the staff who completed it. The audits shall be kept in the home.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #003 from inspection 2019_773155_0010(A1) issued September 19, 2019 with a compliance due date of October 9, 2019.

The licensee was ordered to:
The licensee must be compliant with O.Reg. 79/10 s.68(2).
Specifically, the licensee must:

a) Review the policies and procedures relating to nutrition care, dietary services and hydration with a registered dietitian who is a member of the staff of Sunset Manor.

b) Provide education to all direct care staff regarding the following policies/procedures:
i) Hydration Assessment and Management- policy number DM G-45,
ii) Hydration Assessment and Management Program Algorithm-policy number DM G-45-05,
iii) Referral to Dietitian-policy number NPC H-45,
iv) Food Intake Study-policy NPC H-05,
v) Monitoring Food and Fluid Intake-policy NPC H-30, and
vi)any other relevant policies.
The education provided shall be documented and include the date and identity of the staff educated. These records will be kept in the home.

c) Ensure that resident #002, #006 and any other residents have been assessed for any risks related to nutrition care, dietary services and hydration and that interventions are implemented to mitigae and manage the risks.

d) Develop and implement a written plan/audit to ensure that residents with poor fluid intake are identified and appropriate interventions and referrals are utilized to mitigate risks for resident #002, #006 and any other residents. The audit shall be documented and include the date and the identity of the staff who completed the audits. The audits shall be kept in the home.

The licensee completed steps a and b.

The licensee failed to complete c) and d).

1. The licensee failed to ensure that the hydration program included:
- the implementation, in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures related to hydration, and
-the implementation of interventions to mitigate and manage the risks.

Review of the homes policy Hydration Assessment and Management DM-45 effective September 2019, stated that if a resident's fluid intake was less than seven glasses for three or more days, the PSW would notify the Registered Staff to

complete a referral to the Registered Dietitian to assess for dehydration. Registered staff would assess the resident for signs and symptoms of dehydration and include the findings on the referral to the Registered Dietitian.

Review of the homes policy Referral to Dietitian NPC E-35 effective September 2019, stated that the RN/RPN would complete the electronic Dietitian Referral Form and forward it to the Registered Dietitian when the resident had poor fluid intake over a 72 hour period and exhibited signs and symptoms of dehydration.

During an interview with Registered Dietitian (RD) #110 they shared that they were involved in the review of the policies, but did not realize that there was different direction given in the policies. They felt there should be a referral if there was poor fluid intake over a 72 hours period and the resident exhibited signs and symptoms of dehydration.

During interviews with Director of Resident Care (DRC) #100 and the Professional Standards Supervisor #102 they shared they did not realize that there was different direction given in the policies. They said the registered staff were to complete a referral to the RD to assess for dehydration if the resident's fluid intake was less than seven glasses for three or more days. Registered staff were to assess the resident for signs and symptoms of dehydration and include the assessment in the referral for the RD.

a) Review of resident #002's care plan stated that their fluid requirement was 1200 ml/day (6.5 glasses) and that they were a moderate risk for dehydration. Review of resident #002's fluid intake documented in point of care showed that for an identified period of time, there were nine days that resident #002's fluid intake was less than 6.5 glasses and was as low as 2.5 glasses.

Review of resident #002's clinical record was done and there was no referral to the RD for a dehydration assessment nor was there any assessment done by registered staff for dehydration during the identified period. Resident #002's care plan did not include any interventions to mitigate the risk for dehydration.

b) Review of resident #003's care plan stated that their fluid requirement was 1600 mls per day and that they were a moderate risk for dehydration. Interventions listed were to remind the resident to finish their fluids at meals and to keep specific fluids in

their room and offer sips often.

Review of resident #003's fluid intake documented in point of care showed that for fourteen days, they consumed an average of 4.9 glasses of fluid per day with the most being 6.25 glasses and the lowest being 3 glasses per day.

Review of resident #003's clinical record was done and there was no referral to the RD for a dehydration assessment nor was there any assessment done by registered staff for dehydration during the identified period of time.

During multiple observations of resident #003 there were no specific fluids found in their room.

c) Review of resident #005's care plan stated that their fluid requirement was 2100 mls per day (11 glasses) and they were a high risk for dehydration. Interventions listed were to keep water at bedside and offer before, during and after care. Staff were to encourage sips of fluids often.

Review of resident #005's fluid intake documented in point of care showed that for a thirteen days, they consumed an average of 4.8 glasses of fluid per day with the most being 6 glasses and the lowest being 3 glasses per day.

Review of resident #005's clinical record was done and there was no referral to the RD for an assessment for dehydration nor was there any assessment done by registered staff for dehydration during October 2019.

During observations of resident #005 there was a water bottle on their bedside table, however the water remained at the same level in the bottle on November 1, 4 and 5th. On an identified date, resident #005 rang their bell and asked PSW #124 for a drink. PSW #124 told resident #005 that the nourishment cart was coming and left resident #005 without giving them a drink. Resident #005 was given a drink from the nourishment cart 45 minutes after the initial request.

RPN #106 shared that when a resident was on the list for having less than seven glasses of fluids for three days that the information was shared at report for the staff to know to encourage fluids for the residents. They shared that residents were offered fluids at meals, from nourishment cart and by "sip and go". The shared that

"sip and go" was to offer residents fluids when they went into their room or when approached if sitting in a common area. They said they did not send referrals to the RD if the resident had less than seven glasses for three days.

RD #110 shared they did not receive any dietary referrals for resident #002, #003 and #005 related to dehydration or low fluid intake.

DRC #100 reviewed resident #002, #003 and #005's fluid intakes listed above and reviewed their clinical records for referrals to the RD. DRC #100 acknowledged that there were no referrals to the RD for resident #002, #003 and #005 during October 2019 related to low fluid intake. They shared the expectation was that a referral to the RD was to be made when a resident had a fluid intake of less than seven glasses for three or more days. They also shared that registered staff were to assess the resident for signs and symptoms of dehydration and include the findings in the referral to the RD. There were no assessments of dehydration documented for these residents.

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issued was a level 3 as it related to all three residents reviewed. The home had a level 3 compliance history as there was previous non-compliance to the same subsection that included compliance order #003 from inspection 2019_773155_0010(A1) issued September 19, 2019 with a compliance due date of October 9, 2019.

(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 03, 2020(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Linked to Existing Order / Lien vers ordre existant: 2019_605213_0019, CO #002;

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

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

Specifically the licensee must:

a)Ensure that residents at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

b) Ensure that resident #004, #011 and all other 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 is reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

c)Ensure that all registered nursing staff receive training on the types of altered skin integrity, required assessments, timelines for assessments and the home's policies and procedures related to skin and wound assessments.

d) Ensure that the above training is incorporated into new staff orientation.

e) Ensure that a tracking and weekly auditing system is developed, implemented and documented for all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds to ensure that all residents exhibiting altered skin integrity are receiving the required assessments and treatments in accordance with the home's policies and procedures to ensure consistency and completion.

f) Ensure that the tracking of skin tears notes the cause and if any trends. Any skin tears involving staff will be investigated, appropriate actions taken and documented.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #002 from inspection number 2019_605213_0019 issued on May 30, 2019 with a compliance due date of July 31, 2019.

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

The licensee was ordered to 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.

The licensee failed to complete steps a) to e).

1. The licensee failed to ensure that resident #014 received a skin assessment by a member of the registered nursing staff within 24 hours upon return from hospital.

The clinical record for resident #014 was reviewed. The resident went to hospital. The resident underwent a procedure at the hospital and then returned to the home. A skin assessment was not done until 13 days after the resident returned to the home.

In separate interviews with DRC #100 and RPN #117, they reviewed the resident’s clinical record and their internal ‘risk rounds meeting’ minutes and could not locate a skin assessment that had been completed earlier than 13 days after return.

A skin assessment by a member of the registered staff was not completed for resident #014 when they returned from hospital.
(694)

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

a) The clinical record of resident #004 was reviewed. During an identified period of time, the resident had areas of altered skin integrity. Weekly skin assessments were not completed for the identified areas of altered skin integrity.

b) The clinical record of resident #011 was reviewed. During an identified period of time, the resident had areas of altered skin integrity. Weekly skin assessments were not completed for the identified areas of altered skin integrity.

RPN #106 said that documented skin assessments differed depending on the type of altered skin integrity. Registered staff were unsure what the area of altered skin integrity would be considered. The staff described the treatment and that it was provided twice a day. DRC #100 shared staff were expected to complete weekly assessments and the treatments according to the TAR.

c) The clinical record of resident #014 was reviewed. The resident had an area of altered skin integrity. A weekly wound assessment was not completed.

RPN #106, #112, #113, #117 and DRC #100 agreed that resident #004, #011 and #014's skin concerns all fit the definition of altered skin integrity and required weekly skin assessments and treatments to be provided according to the resident's TAR. RPN #117 explained they were scheduled to work as the home's wound care nurse six shifts per month. The RPN said they were directed to only keep a list of residents in the home that had skin tears or pressure areas. Residents with other skin integrity issues were not tracked. RPN #117 also said there was no system in place to ensure weekly assessments were completed on residents that were exhibiting an area of altered skin integrity.

The DRC #100 and Professional Standard Supervisor #102 confirmed education related to the skin and wound was a part of the home's annual training. The home did not provide education for registered staff about the types of impaired skin

integrity, required assessment, timelines for the assessments and the home's protocols. As of October 30, 2019, only 54 percent of registered staff had completed the home's annual training program. The home's annual training did not include training related to the types of impaired skin integrity, required assessments, timelines for the assessments or the home's protocols related to skin and wound. Professional Standards Supervisor #102 felt registered staff should already know this from their professional training.

DRC #100 said staff have access to the home's policies through the internal internet database if they wanted to review them. The policy titled, "Wound Management Program", policy number NPC D-35, effective September 2019, stated registered staff were to complete assessments as outlined in the program and complete all appropriate referrals. DRC #100 agreed the policy did not provide clear direction regarding the required assessments, timelines for the assessments or what referrals were to be completed for residents with altered skin integrity.

RPN #117 and DRC #100 reviewed the clinical records with the inspector. They acknowledged resident #004, #011, and #014 had a number of weekly assessments that were not completed.

The licensee failed to ensure that residents #004, #011 and #014 when exhibiting altered skin integrity, were reassessed at least weekly by a member of the registered staff.

The severity of this issue was a level 3 as there was actual harm/risk to the residents. The scope was level 2 as three out of three residents were affected. The home had a level 3 compliance history as there was previous non-compliance to the same subsection that included compliance order #002 from inspection 2019_605213_0019 issued May 30, 2019, with a compliance due date of July 31, 2019; and a VPC issued October 18, 2017 during inspection 2017_484646_0014. (155)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 03, 2020(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 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 January, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by SHARON PERRY (155) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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