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
Apr 29, 2022	2022_773155_0001 (A2)	016890-21, 016891-21, 016892-21, 016893-21, 016894-21, 016895-21, 018529-21, 019825-21, 020841-21, 001608-22	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

Amended by JANET GROUX (606) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

2022_773155_0001 – We are extending the CDD for only 2 of the orders in this report (CO #4 and #7) to May 20, 2022.

Issued on this 29th day of April, 2022 (A2)

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 JANET GROUX (606) - (A2)

Amended 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): January 24-28, January 31-February 4 and February 7 to 11, 2022.

The following intakes were completed during this critical incident system inspection:

Log # 020841-21 related to a resident injury from unknown cause.;

Log # 018529-21 related to an allegation of improper/ incompetent treatment of a resident that resulted in a risk of harm to the resident;

Log # 001608-22 related to an allegation of resident to resident abuse;

Log # 019825-21 follow up to compliance order #001 from inspection 2021_796754_0029 related to medications not being administered in accordance with the directions for use specified by the prescriber;

Log # 016890-21 follow up to compliance order #002 from inspection 2021_739694_0022 related to every alleged, suspected or witnessed incident of abuse or neglect of a resident that is reported, is immediately investigated;

Log # 016891-21 follow up to compliance order #003 from inspection 2021_739694_0022 related to reporting alleged or suspected abuse, neglect, and improper treatment of a resident to the Director;

Log # 016893-21 follow up to compliance order #004 from inspection 2021_739694_0022 related to ensuring residents were assessed and using safe and appropriate equipment, specifically wheelchairs, based on their needs and conditions;

Log # 016894-21 follow up to compliance order #005 from inspection 2021_739694_0022 related to ensuring wound assessments were done weekly and that residents received immediate treatment to wounds;

Log # 016895-21 follow up to compliance order #006 from inspection

2021_739694_0022 related to ensuring that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument; and

Log # 016892-21 follow up to compliance order #008 from inspection 2021_739694_0022 related to ensuring 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.

NOTE: A written notification and compliance order related to O.Reg. 79/10. s.135 (2) was identified in a concurrent inspection #2022_773155_0002 (Log 001635-22) and issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DOC), Administrative Assistant, Infection Prevention Control Lead, Medical Director, Acting Resident Care Program Supervisor (ARCPS), Director of Operations-Universal Care Canada Incorporated (UCCI), Director of Clinical UCCI, Maintenance Supervisor, Housekeepers, Screeners, Simcoe Muskoka District Health Unit-Public Health Inspector, Registered Nurses (RN), Registered Practical Nurses (RPN), RPN Wound Care Nurse, Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspectors observed resident and staff interactions, infection prevention and control practices, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
12 WN(s)
5 VPC(s)
7 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
O.Reg 79/10 s. 30. (1)	CO #004	2021_739694_0022	758
O.Reg 79/10 s. 52. (2)	CO #006	2021_739694_0022	758

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with Compliance Order (CO) #002 from inspection 2021_739694_0022 served on October 6, 2021, with a compliance due date of January 14, 2022.

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident that was reported, was immediately investigated.

A resident told to the home that they were a victim of physical abuse by another resident. Three days later the police were notified by another resident and family requested an internal investigation to be completed. The home initiated the investigation four days after the resident reported that they were a victim of physical abuse.

According to the home's Zero Tolerance of Abuse and Neglect Policy (ADM F-10, August 2021), staff must immediately investigate all reports of abuse and neglect. Investigations include a head-to-toe physical assessment of the victim if physical abuse was alleged, and this is to be documented.

The DOC acknowledged that no assessments were documented, and no notes were available to support that an immediate investigation was conducted. Failure of the home to immediately investigate the alleged physical abuse delayed the home's ability to address the resident's safety concerns, which may have put them at further risk of harm.

Sources: CIS report, resident's progress notes, Zero Tolerance of Abuse and Neglect Policy (ADM F-10), interview with DOC and other staff. [s. 23. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The following is further evidence to support the order issued on October 7, 2021, during inspection 2021_739694_0022 to be complied by January 14, 2022.

Pursuant to s. 152 (2), the licensee is vicariously liable for staff who fail to immediately report the neglect of a resident by the staff that resulted in harm or a risk of harm to the resident.

A resident told a PSW that they did not receive care. Two staff noted that the resident had not received care. The incident was not immediately reported to the Director, as the home first submitted the Critical Incident (CI) report the following day.

By not immediately reporting the incident to the Director, the Director was unable to respond to the incident in a timely manner.

Sources: CIS report, the home's investigation notes, resident's clinical health records; Interviews with PSWs, RPN and RN. [s. 24. (1)]

2. The licensee failed to comply with Compliance Order (CO) #003 from inspection 2021_739694_0022 served on October 6, 2021, with a compliance due date of January 14, 2022.

The licensee failed to ensure that anyone who had reasonable grounds to suspect that abuse of a resident, that resulted in harm or risk of harm to the resident, was immediately reported to the Director.

A critical incident was submitted to the Director four days after a resident had alleged they were a victim of physical abuse by another resident.

A complete investigation was not conducted immediately, and there was no documentation whether the resident was or was not harmed by this incident.

Staff was interviewed and acknowledged a head-to-toe physical and pain assessment was not conducted.

The Administrator stated the incident was not reported because there was no injury to the resident, however, there was no assessment documented or investigation notes to support this.

Inspector #705751 interviewed the Director of Care and Director of Operations with UCCI. The incident was reported to the Director 20 days after the allegation of physical abuse was made by the resident.

Failure of the home to immediately report the alleged abuse could have delayed the Director's ability to respond to the incident in a timely manner.

Sources: CIS reports, resident's progress notes, Zero Tolerance of Abuse and Neglect Policy (ADM F-10), interview with Administrator and other staff. [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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 failed to comply with Compliance Order (CO) #008 from inspection 2021_739694_0022 served on October 6, 2021, with a compliance due date of January 14, 2022.

The licensee failed to ensure that when resident #032 had their foley catheter changed, there was no documentation as to the size of the catheter removed, the size of catheter inserted, the amount and colour of urine return, and how the procedure was tolerated by the resident.

Resident #032's progress notes showed that their foley catheter was not changed on the scheduled day as it had been changed two days prior. There was no documentation that the foley catheter was changed two days prior.

Director of Resident Care #101 was not able to determine when the foley catheter was removed or reinserted. This was to be documented in resident #032's progress notes as per the homes policy.

Failure to document when the resident's foley catheter was removed and when the foley catheter was reinserted put the resident as risk for potential complications such as infections or urine retention.

Sources: #032's progress notes, treatment administration records, interview with Director of Resident Care #101, and Urinary Catheterization-Insertion and Removal Policy (NPC SM E-65 dated October 20, 2021). [s. 30. (2)]

2. The licensee failed to ensure that when resident #001 had their foley catheter changed, that there was documentation as to the size of the catheter removed, the size of catheter inserted, the amount and colour of urine return, and how the procedure was tolerated by the resident.

Resident #001's treatment administration record showed that an RPN signed that they changed resident #001's foley catheter. Resident #001's progress notes showed no documentation regarding removal of a foley catheter or insertion of a new foley catheter.

Director of Resident Care #101 was not able to find any notes in the resident record regarding the removal and reinsertion of resident #001's foley catheter. This was to be documented in resident #001's progress notes as per the homes policy.

Failure to document resident #001's catheter removal and reinsertion, characteristics about the amount and colour of urine on return and how the procedure was tolerated put the resident at potential risk of possible infection.

Sources: #001's progress notes, treatment administration record, interview with Director of Resident Care #101, and Urinary Catheterization-Insertion and Removal Policy (NPC SM E-65 dated October 20, 2021). [s. 30. (2)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the written protocols for hypoglycemia were implemented.

The home's policy Management of Diabetic Residents (NPC E-60) dated August 2021, stated that the hypoglycemia protocol should be initiated for any resident with a blood glucose less than 4 mmol/L. The physician was to be notified of all hypoglycemic episodes. For a resident that was conscious and able to swallow, if blood glucose was 2.8 to 3.9 mmol/L then 175 millilitres of juice or pop (not sugar free) or instaGlucose 15 grams was to be given and repeat blood glucose in 15 minutes. If blood glucose was less than 2.8 mmol/L then 250 millilitres of juice or pop (not sugar free) or InstaGlucose 31 grams was to be given and to repeat blood glucose in 15 minutes.
Once the hypoglycemia had been reversed the resident should have the usual meal or snack that was due at that time of the day to prevent repeated hypoglycemia. If a meal was more that one hour away, a snack including 15 grams of carbohydrate and a protein source should be consumed (crackers and peanut butter or cheese, or a sandwich with protein). The hypoglycemic event was to be documented in risk management and a medication incident form completed

a) Resident #030 was administered the wrong insulin on an identified date. The on-call physician was notified and ordered that the resident was to have their blood sugar rechecked in an hour and to follow the facility protocol for hypoglycemia.

Resident #030's hypoglycemia event on the identified date where their blood sugar fell to less than 4 mmol/L was not treated as per the hypoglycemia protocol.

b) Resident #001 had specific nutritional requirements and their care plan and medication administration record identified an individualized plan in the event of a hypoglycemic event.

Over a twenty day period, resident #001 had nine recorded blood sugars of less then 4 mmol/L indicating they were having a hypoglycemic event. Six of the nine hypoglycemic events were untreated, one was treated but the individualized hypoglycemic plan was not followed, one was treated but then given insulin, and one episode was not treated and insulin was administered.

c) Resident #027's blood sugar recorded on an identified date was less than 4 mmol/L indicating that they were having a hypoglycemic event. The event was not treated and they were administered insulin.

Director of Resident Care #101 acknowledged that the registered staff did not follow the hypoglycemia protocol for resident #030, #001 and #027 which includes holding all insulin if blood glucose is less than 4 mmol/L and notifying the physician.

Director of Clinical Services from Universal Care Canada Incorporated acknowledged that the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, was not followed for the incidents for where the residents blood sugars dropped below 2.8 mmol/L.

By staff not following the home's policy related to hypoglycemia and administering insulin to residents when their blood glucose was less than 4.0 mmol/L put the residents at high risk of a severe hypoglycemic event.

Sources: resident #001, #027, #030 medication administration records and

progress notes; Management of Diabetic Residents policy (NPC E-60) dated August 2021; Hypoglycemia management policy (NPC SM F-65) dated September 2021; Minister's Directive Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia Ministry of Long-Term Care April 15, 2020; interviews with Director of Resident Care #101, Medical Director and other staff. [s. 114. (3) (a)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 004

WN #5: 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 failed to comply with Compliance Order (CO) #001 from inspection 2021_796754_0029 served on December 6, 2021, with a compliance due date of December 30, 2021.

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

The Medication Incident Reports (MIR) documented that one resident was given the wrong medication and two residents were not administered their medication as prescribed.

Review of the Medisystem Medication Incident Report summary for the period of December 31, 2021 to January 24, 2022 showed that there had been 470 medication incidents—one wrong medication administered; two medications not administered, nineteen missing signatures, one delivery incident and 447 medications given at the wrong time.

The Director of Resident Care #101 acknowledged these medications errors and was aware that these medications had not been administered as prescribed.

One of the three residents had negative health effects when not administered their medication as specified by the prescriber.

Sources: Medication incident reports, resident’s progress notes, physician orders and medication administration records, Medication Administration Skills policy (NPC SM E-50 effective November 2021) and interview with DOC. [s. 131. (2)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 005

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the home's infection prevention and control (IPAC) program in relation to resident hand hygiene practices.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act. On March 22, 2020, Directive #3 was issued and revised on December 24, 2021, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7 by the Chief Medical Officer of Health (CMOH) of Ontario. An urgent requirement was made for LTC Homes to implement measures to protect residents, staff and visitors, including adherence to appropriate hand hygiene practices.

The home's hand hygiene policy stated that residents should be encouraged to perform hand hygiene before and after meals and snacks.

A) Two residents were observed to be in their rooms on droplet and contact precautions because they were considered a high risk contact of a COVID positive staff. Staff assisted the residents up from their beds to a chair and provided them with their lunch meal without offering hand hygiene to either resident.

B) On three different dates, observations made during the morning and afternoon snack carts, on three resident living areas showed that staff members did not provide or encourage residents with hand hygiene before they received their snacks.

A PSW shared that residents were to be offered hand hygiene before meals but they were not aware that it was to be done before offering snacks and/or beverages from the nourishment cart.

Review of the Hand Hygiene Program Policy (IPC B-45) effective December 2020 states that alcohol base hand rub (ABHR) will be made available at the entrances to dining rooms and residents encouraged to perform hand hygiene before and after meals and snacks.

Failure of the home's staff to follow expectations to encourage and/or assist resident's with hand hygiene increased the risk of infection transmission and could have put residents at risk of harm.

Sources: observation of meal service, observations of the snack service, the home's hand hygiene policy #IPC-B-45, effective date December 2020, and interviews with the home's IPAC Lead, and other staff. [s. 229. (4)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, when the resident exhibited altered skin integrity.

The following is further evidence to support the order issued on October 7, 2021, during inspection 2021_739694_0022 to be complied by January 14, 2022.

A resident told a PSW that they did not receive care. Two staff noted that the resident had not received care. An RPN documented in the progress notes that skin breakdown was noted, however, they did not complete a skin assessment.

By not completing a skin assessment for the new skin breakdown, there was potential for staff to not identify visible changes in the skin, and not be able to develop appropriate strategies to prevent further skin breakdown.

Sources: CIS report, the home’s investigation notes, resident’s clinical health records; Interviews with PSW and RPN. [s. 50. (2) (b) (i)]

2. The licensee failed to comply with Compliance Order (CO) #005 from inspection 2021_739694_0022 served on October 6, 2021, with a compliance due

date of January 14, 2022.

The licensee has failed to ensure that resident #029 received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection for their wounds.

Resident #029 had wounds.

i) The resident’s pain was to be assessed weekly and at each dressing change. During the weekly wound assessment it was documented that the resident experienced pain during the dressing change. The resident’s pain was not assessed and there were no records of any immediate interventions provided to relieve the resident's pain until their 1200 hrs scheduled dose of medication was administered.

The home's wound management program documented that staff were to monitor for signs and symptoms of infection and consult with the physician for any abnormal symptoms.

ii) The resident asked the physician to assess their wound. The physician’s note on the same day, documented that the wound was deteriorating and showed signs of infection. The resident’s dressing was changed two days prior, but there was no documentation at that time of any signs or symptoms of infection or any notification of the physician.

These gaps in implementing immediate interventions to relieve or reduce resident #029's pain and prevent infection of their wound resulted in the wound worsening and pain.

Sources: resident #029's progress notes, electronic treatment administration record (eTAR), electronic medication administration record (eMAR), wound assessments, the home's wound management policy #NPC D-35, last revised September 2020, and interviews with the home's Wound Care Nurse, DOC, and other staff. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure that resident #004 received immediate treatment and interventions to promote healing of their wounds.

Resident #004 had multiple wounds.

The physician's progress note on an identified date indicated that the resident had a wound that was worsening and ordered a change in the treatment.

There was no physician notification related to the changes to the wound.

This gap in implementing immediate interventions to promote resident #004's wound healing resulted in the deterioration of their wound.

Sources: resident #004's progress notes, eTAR, wound assessments, and interviews with the DOC, the physician and other staff. [s. 50. (2) (b) (ii)]

4. The licensee has failed to ensure resident #003 received immediate treatment and interventions to promote healing of their wound.

Resident #003 had a wound. The resident's eTAR documented the area should be assessed weekly and the physician notified of complex and non-healing areas.

The weekly wound assessment done on an identified date showed that that the wound was getting worse and that the treatment was ineffective.

A review of the wound photographs done showed the area was getting worse compared to previous photographs.

There was no notification of the Wound Care Nurse until seven days later and the physician was not notified until nine days later. Nine days after the wound was noted to be deteriorating the external Wound Care Nurse's notes showed that that the wound was larger and changed the treatment.

This gap in implementing immediate interventions to promote resident #003's healing of the wound resulted in the deterioration of the area.

Sources: resident #003's progress notes, wound assessments, eTAR, photographs of the altered skin integrity, wound care nurse's consult notes, nurse-physician communication forms and interviews with the DOC, the home's Wound Care Nurse , the physician and other staff. [s. 50. (2) (b) (ii)]

5. The licensee has failed to ensure that resident #001's skin tear was reassessed

at least weekly by a member of the registered nursing staff.

Resident #001 had a skin tear. On an identified date it was noted that area had become worse and treatment was changed.

The resident's electronic treatment administration record (eTAR) documented that the area was to be assessed weekly. There was no documentation of assessments for two weeks.

This gap in weekly assessments increased the risk that appropriate interventions were not implemented in a timely manner if the wound started to deteriorate.

Sources: resident #001's progress notes, care plan, eTAR, wound assessments and interviews with the DOC and other staff. [s. 50. (2) (b) (iv)]

6. The licensee has failed to ensure that resident #029's wounds were reassessed at least weekly by a member of the registered nursing staff.

Resident #029 had wounds. The resident's eTAR documented the wounds were to be assessed weekly and pictures taken and uploaded to the resident's electronic file.

There were no weekly assessments completed for a specific week. On an identified date, the assessments did not include measurements and documented incorrectly the stage of the wound. On a specific date, the wound assessments did not include the type of the wound and there were no measurements.

Additionally, there were no pictures taken of the wound for twenty days.

Sources: resident #029's progress notes, care plan, electronic treatment record (eTAR), assessments and interviews with the DOC and other staff. [s. 50. (2) (b) (iv)]

7. The licensee has failed to ensure that resident #004's wounds were reassessed at least weekly by a member of the registered nursing staff.

Resident #004 had wounds. The resident had assessments initiated, but the assessments were incomplete.

These gaps in the completion of wound assessments increased the risk that appropriate interventions were not implemented to treat the wounds when they started deteriorating.

Sources: resident #004's progress notes, eTAR, wound assessments, the home's weekly wound tracking tool and audits, and interviews with the DOC , the physician and other staff.

As part of the compliance order the licensee was asked to develop an audit tool for skin and wound to include and document the treatment in place and the effectiveness of the treatment for all stage III and greater pressure ulcers, and any deteriorating wounds or skin conditions, and the actions taken in regard to the audit results.

The home's skin and wound audit did not include the treatment in place for any of the altered skin integrity areas that were audited.

i) Over a one week period, the home’s weekly audits documented that resident #029’s weekly wound assessments were completed on a specific date, but the assessments were not created until six days later. There was no documentation of the actions taken regarding this audit. During a second one week period, the home’s weekly audits documented there were no measurements included in resident #029’s assessments completed on a specified date; the audit documented that the gaps identified would be followed up during the previous week.

ii) Over a one week period, the home’s weekly audits for pressure ulcers identified that a physician's order was not in place for: resident #004’s treatment of wounds; and for resident #003’s wound. During two subsequent weeks, the home’s weekly audits identified that the physician’s order for resident #003’s treatment for their woundwas not in place. The actions required had no date and it was documented that the gaps would be reviewed with the DRC and the Wound Care Nurse.

Sources: the home’s weekly wounds audits, and interviews with the home’s Wound care Nurse, the DOC and other staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 007

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to the failure to maintain infection prevention and control measures specified in Directive #3 regarding Personal Protective Equipment (PPE) use when dealing with a suspected COVID-19 resident case.

As per the version of Directive #3 in effect on December 24, 2021, as issued by the Chief Medical Officer of Health, long-term care homes are required to follow COVID-19 Directive #5 for hospitals within the meaning of the Public Hospitals Act and Long-Term Care Homes within the meaning of the Long-Term Care Homes Act, 2007.

As per the version of Directive #5 in effect on December 22, 2021, as an interim precaution in light of the uncertainty around the mechanisms of transmission of the COVID-19 Omicron variant of concern (B.1.1.529), required precautions for all health care workers providing direct care to or interacting with a suspected, probable (i.e. placed in precautions as high risk contact, in an outbreak zone of the facility or recently transferred from a facility in outbreak) or confirmed cases of

COVID-19 are a fit-tested, seal checked N95 respirator (or approved equivalent), eye protection (goggles or face shield), gown and gloves.

Resident #026 was was placed on droplet/ contact precautions, and a COVID-19 PCR test was completed. Three PSWs did not wear a fit-tested, seal checked N95 respirator (or approved equivalent), when they entered resident #026's room to provide care and assist the resident.

An agency RPN did not wear a fit-tested, seal checked N95 respirator (or approved equivalent), when they entered resident #026's room to administer medications. After exiting the room, the RPN did not doff their KN95 mask, nor disinfect their goggles.

By not wearing the required mask and by incorrectly doffing PPE when dealing with a suspected COVID-19 resident case, there was an actual risk of COVID-19 transmission.

Sources: Directive #3 (version effective as of December 24, 2021), Directive #5 (version effective as of December 22, 2021), resident #026's clinical health records; Inspector #653's observations; Interviews with Agency RPN #131, IPAC Lead #102, and other staff. [s. 5.]

2. Sixteen residents residing on a resident home area were placed in droplet contact isolation precautions as they were considered a high risk contact of a staff member that worked, and then tested positive for Covid-19.

Observations showed that a staff member did not wear a fit-tested, seal-checked N95 respirator when interacting with resident #041 in their room. Additionally, on the same day, a second staff member did not wear a fit-tested, seal-checked N95 respirator when interacting with resident #042 in their room and being in close contact with the resident. (758)

A staff member was observed going into resident #007's room. Resident #007 was on droplet contact precautions because they were a high risk contact to a staff that had tested positive for COVID-19. The staff member wore a KN95 mask and not a fit-tested, seal checked N95 respirator.

The Infection and Prevention Lead shared that they were aware of Directive #5 and they believed that the direction from public health was that the KN95 masks

were adequate. A Public Health Inspector shared that they did not direct the home as to the type of masks to use but that the sixteen residents were to be on droplet contact precautions as they were considered to have had high risk exposure due to the staff member testing positive.

A PSW was observed feeding resident #045 in their room. Resident #045 was noted to be on droplet contact precautions. The PSW was wearing a KN95 mask and not a fit-tested, seal checked N95 respirator. An RPN was observed going into resident #045's room wearing a KN95 mask and not a fit-tested, seal checked N95 respirator.

By not wearing the required mask and by incorrectly doffing PPE when dealing with a suspected COVID-19 resident case, there was potential risk of COVID-19 transmission.

Sources: Observations of droplet contact precautions and PPE use, resident #041 and #042's plans of care, Directive #3 (version effective as of December 24, 2021), Directive #5 (version effective as of December 22, 2021); Interviews with IPAC Lead, Public Health Inspector and other staff. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan, as it related to continence care, bathing, bed mobility, and application of topical lotion and cream.

A resident required two staff assistance for continence care, bathing, and bed mobility. A specific lotion was be applied to their scalp during their scheduled bath, and a cream to applied to a skin condition twice daily.

On on identified shift, the resident did not receive their scheduled sponge bath, continence care, assistance with turning and repositioning, and their topical lotion and cream, due to a last-minute staffing change and a mix-up in the resident assignment.

At the beginning of the following shift, the resident told the PSW that they did not get care done. The PSW and RPN noted that care had not been provided.

Sources: CIS report, the home’s investigation notes, resident’s clinical health records; Interviews with PSWs, Agency PSW, RPN, RN, DOC, Administrator, and Director of Clinical UCCI . [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #10: 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 has failed to ensure that the policy and procedures included in the required Pain Management Program were complied with, for resident #024 and resident #021.

O. Reg. 79/10, s. 48 (1) (4) requires an organized program of pain management to identify pain in residents and manage pain.

O. Reg. 79/10, s. 52 (1) (1) requires that the program includes communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

a) A resident was diagnosed with a fracture. The resident had cognitive impairment and was unable to rate their pain on a scale of 0 to 10.

On seven days, registered staff administered as needed Acetaminophen for pain, as per the medical directive, to the resident without completing a non-cognitive resident pain assessment tool and scoring the resident accordingly.

Sources: CIS report, MDS assessment, progress notes, eMAR, pain level summary, pain assessments, medical imaging report, “Pain Management Program” policy #NPC D-15 effective September 2019; Interviews with ARCPS, RN, DOC, and UCCI.

b) Another resident had cognitive impairment and they were unable to rate their pain on a scale of 0 to 10.

On four days, registered staff administered as needed Acetaminophen for pain, as per the medical directive, to the resident who complained of pain, without completing a non-cognitive resident pain assessment tool and scoring the resident accordingly.

By not completing the appropriate pain assessment tool, staff were unable to assess the severity of the residents pain and monitor and evaluate their pain effectively.

Sources: MDS assessment, progress notes, eMAR, pain level summary, pain assessments, “Pain Management Program” policy #NPC D-15 effective September 2019; Interviews with RPN, Agency RPN, DOC, and UCCI. [s. 8. (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 plan, policy, protocol, procedure, strategy or system that is required is complied with, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident's substitute decision-maker's (SDM) was notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse that had resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

A resident alleged that they were a victim of physical abuse from another resident. There was no documentation whether the resident was or was not harmed from this incident, and there was no documentation indicating the SDM was notified.

The DOC acknowledged that the SDM was not immediately notified.

Failure of the home to immediately report the alleged abuse to the SDM impeded on the SDM's ability to make informed decisions and advocate for the resident's safety.

Sources: CIS report, resident's progress notes, Zero Tolerance of Abuse and Neglect Policy (ADM F-10), interview with Staff #109, DOC, the resident and other staff. [s. 97. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

WN #12: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

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 failed to ensure that every medication incident involving a resident was reported to the Medical Director, the prescriber of the drug, and the resident's attending physician.

A resident was administered the wrong type of medication on an specific day. The physician on call was notified at the time of the incident and provided orders.

The Medical Director who was the prescriber of the drug and also the resident's attending physician was not notified of this medication incident.

Not informing the Medical Director, the prescriber of the drug and the attending physician of this medication incident could have put the resident at risk as they were not seen for any follow up.

Sources: Medication incident report, Nurse Physician Communication form, Risk Management Report, interviews with DOC and Medical Director. [s. 135. (1)]

2. The licensee failed to ensure that all medication incidents were reviewed and analyzed and corrective action taken as necessary.

a) On a specific date an RPN administered the wrong medication to a resident.

The RPN immediately reported the error to the Director of Resident Care who was working as the RN at the time of the incident.

Review of the Medication Incident Report did not include an analysis and what corrective action was taken to prevent recurrence.

By not analyzing this medication incident there was possible risk to residents as it was unknown if corrective actions were needed to prevent recurrence.

Sources: Medication incident report, interview with RPN and Director of Resident Care.

b) The licensee has failed to ensure that a medication incident involving a resident was documented, reviewed and analyzed and corrective actions were taken as necessary.

The home’s policy Manual for Medisystem serviced homes, Medication incident management Responsibilities, stated that upon discovery of a medication incident, including near misses, staff must immediately provide appropriate resident care and implement corrective action to mitigate further harm to the resident. The staff were to report the incident immediately to the Director of Resident Care and document an incident report prior to finishing their shift.

A resident's progress note on a specific date, documented that during the shift, an agency nurse attempted to give the wrong medications to the resident. The PSW assisted the nurse to give the right medications to the resident. The resident was upset and worried about the ability of the agency staff to provide care to the residents.

There was no documentation of an incident report. The incident was not reviewed and analyzed and there was no corrective action taken to mitigate the risk of harm to the resident.

The home's current DRC said that a medication incident was not submitted and

the pharmacy provider was not notified about the incident.

By not reviewing and analyzing the medication incident and not taking corrective actions to address it, put residents at actual risk of harm associated with medication errors.

Sources: resident's clinical records, the home's policy Manual for Medisystem serviced homes, and interviews with the DRC, the home's pharmacy consultant and other staff. [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 every medication incident involving a resident and every adverse drug reaction is (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and b)reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider; and that the licensee shall ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed; corrective action is taken as necessary; and a written record is kept of everything required, to be implemented voluntarily.

Issued on this 29th day of April, 2022 (A2)

[redacted]

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 JANET GROUX (606) - (A2)
Inspection No. / No de l'inspection :	2022_773155_0001 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	016890-21, 016891-21, 016892-21, 016893-21, 016894-21, 016895-21, 018529-21, 019825-21, 020841-21, 001608-22 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 29, 2022(A2)
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 :	Astrida Kalnins

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:

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: 001

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

Linked to Existing Order / Lien vers ordre existant: 2021_739694_0022, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with s. 23. (1) of the LTCHA.

Specifically the licensee must:

a) Ensure that all incidents of alleged, suspected or witnessed abuse or neglect are investigated immediately.

Grounds / Motifs :

1. The licensee failed to comply with Compliance Order (CO) #002 from inspection 2021_739694_0022 served on October 6, 2021, with a compliance due date of January 14, 2022.

The licensee failed to ensure that every alleged, suspected or witnessed incident of

abuse of a resident that was reported, was immediately investigated.

A resident told to the home that they were a victim of physical abuse by another resident. Three days later the police were notified by another resident and family requested an internal investigation to be completed. The home initiated the investigation four days after the resident reported that they were a victim of physical abuse.

According to the home's Zero Tolerance of Abuse and Neglect Policy (ADM F-10, August 2021), staff must immediately investigate all reports of abuse and neglect. Investigations include a head-to-toe physical assessment of the victim if physical abuse was alleged, and this is to be documented.

The DOC acknowledged that no assessments were documented, and no notes were available to support that an immediate investigation was conducted. Failure of the home to immediately investigate the alleged physical abuse delayed the home's ability to address the resident's safety concerns, which may have put them at further risk of harm.

Sources: CIS report, resident's progress notes, Zero Tolerance of Abuse and Neglect Policy (ADM F-10), interview with DOC and other staff. [s. 23. (1) (a)]

An order was made by taking the following factors into account:

Severity: There was minimal harm because resident #034's allegation of physical abuse was not investigated immediately.

Scope: Out of three incidents reviewed, one allegation of physical abuse was not investigated immediately, demonstrating an isolated incident of non-compliance.

Compliance History: The licensee continues to be in non-compliance with s. 23. (1) of the LTCHA, resulting in a compliance order (CO) being re-issued. CO#002 was issued on October 6, 2021 (inspection #2021_739694_0022) with a compliance due date of January 14, 2022. In the past 36 months, 30 other COs were issued to different sections of the legislation. (705751)

Apr 04, 2022

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

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: 2021_739694_0022, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with s. 24.(1) of the LTCHA.

Specifically the licensee must:

a) Ensure that all alleged, suspected, or witnessed incidents of improper care, abuse or neglect of a resident are immediately reported to the Director. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

Grounds / Motifs :

1. The licensee failed to comply with Compliance Order (CO) #003 from inspection 2021_739694_0022 served on October 6, 2021, with a compliance due date of January 14, 2022.

The licensee failed to ensure that anyone who had reasonable grounds to suspect

that abuse of a resident, that resulted in harm or risk of harm to the resident, was immediately reported to the Director.

A critical incident was submitted to the Director four days after a resident had alleged they were a victim of physical abuse by another resident.

A complete investigation was not conducted immediately, and there was no documentation whether the resident was or was not harmed by this incident.

Staff was interviewed and acknowledged a head-to-toe physical and pain assessment was not conducted.

The Administrator stated the incident was not reported because there was no injury to the resident, however, there was no assessment documented or investigation notes to support this.

Inspector #705751 interviewed the Director of Care and Director of Operations with UCCI. The incident was reported to the Director 20 days after the allegation of physical abuse was made by the resident.

Failure of the home to immediately report the alleged abuse could have delayed the Director's ability to respond to the incident in a timely manner.

Sources: CIS reports, resident's progress notes, Zero Tolerance of Abuse and Neglect Policy (ADM F-10), interview with Administrator and other staff. [s. 24. (1)]

An order was made by taking the following factors into account:

Severity: There was minimal risk because resident #034's allegation of physical abuse was not immediately reported to the Director.

Scope: Out of three incidents reviewed, one incident was not immediately reported to the director, demonstrating an isolated incident of non-compliance.

Compliance History: The licensee continues to be in non-compliance with s. 24. (1) of the LTCHA, resulting in a compliance order (CO) being re-issued. This subsection was issued as a Written Notification (WN) on March 10, 2020, during inspection

#2020_739694_0004, a Compliance Order (CO) on July 10, 2019, during inspection #2019_773155_0010, with a compliance due date (CDD) of August 30, 2019, a CO on May 27, 2021, during inspection #2021_739694_0018, with a CDD of June 17, 2021, and a CO on October 7, 2021, during inspection #2021_739694_0022 with a CDD of January 14, 2022. In the past 36 months, 27 other COs were issued to different sections of the legislation. (705751)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 04, 2022

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: 003

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

Linked to Existing Order / Lien vers ordre existant: 2021_739694_0022, CO #008;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with s. 30.(2) of O.Reg. 79/10.

Specifically the licensee must:

a) Ensure that when resident #001 and #032 have their foley catheter changed that the following are documented in the resident's record:
i) time and date of insertion and/or removal,
ii) catheter type and size,
iii) characteristics and amount of urine obtained,
iv) the amount, colour of urine return; and
v) how the procedure was tolerated by the resident.

b) Ensure that resident #001 and #032 have their foley catheters changed as per their physicians order.

Grounds / Motifs :

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

1. The licensee failed to comply with Compliance Order (CO) #008 from inspection 2021_739694_0022 served on October 6, 2021, with a compliance due date of January 14, 2022.

The licensee failed to ensure that when resident #032 had their foley catheter changed, there was no documentation as to the size of the catheter removed, the size of catheter inserted, the amount and colour of urine return, and how the procedure was tolerated by the resident.

Resident #032’s progress notes showed that their foley catheter was not changed on the scheduled day as it had been changed two days prior. There was no documentation that the foley catheter was changed two days prior.

Director of Resident Care #101 was not able to determine when the foley catheter was removed or reinserted. This was to be documented in resident #032's progress notes as per the homes policy.

Failure to document when the resident's foley catheter was removed and when the foley catheter was reinserted put the resident as risk for potential complications such as infections or urine retention.

Sources: #032’s progress notes, treatment administration records, interview with Director of Resident Care #101, and Urinary Catheterization-Insertion and Removal Policy (NPC SM E-65 dated October 20, 2021). (155)

2. The licensee failed to ensure that when resident #001 had their foley catheter changed, that there was documentation as to the size of the catheter removed, the size of catheter inserted, the amount and colour of urine return, and how the procedure was tolerated by the resident.

Resident #001's treatment administration record showed that an RPN signed that they changed resident #001's foley catheter. Resident #001's progress notes showed no documentation regarding removal of a foley catheter or insertion of a new foley catheter.

Director of Resident Care #101 was not able to find any notes in the resident record regarding the removal and reinsertion of resident #001's foley catheter. This was to be documented in resident #001's progress notes as per the homes policy.

Failure to document resident #001's catheter removal and reinsertion, characteristics about the amount and colour of urine on return and how the procedure was tolerated put the resident at potential risk of possible infection.

Sources: #001's progress notes, treatment administration record, interview with Director of Resident Care #101, and Urinary Catheterization-Insertion and Removal Policy (NPC SM E-65 dated October 20, 2021).

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to resident #001 and #032 when there was no documentation regarding their foley catheter change.

Scope: Two of the three residents reviewed, did not have their foley catheter change documented as per the home's policy, demonstrating a pattern of non-compliance.

Compliance History: The licensee continues to be in non-compliance with s. 30.(2) of O.Reg. 79/10., resulting in a compliance order (CO) being re-issued. CO#008 was issued on October 6, 2021 (inspection #2021_739694_0022) with a compliance due date of January 14, 2022,. In the past 36 months, 29 other COs were issued to different sections of the legislation. (155)

Apr 04, 2022

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

This order must be complied with by /
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Order(s) of the Inspector

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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: 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Order / Ordre :

The licensee must be compliant with s. 114. (3) of O. Reg. 79/10.

Specifically the licensee must:

a) Ensure that when a residents' blood glucose level is less than 4 mmol/L that insulin is not administered to the resident unless specifically ordered by the physician.

b) Ensure that the resident's physician is notified when a resident's blood glucose level is less than 4 mmol/L unless prescribed otherwise.

c) Ensure that the Hypoglycemia Management policy (NPC SM F-65) is implemented in the home.

d) Ensure that all registered staff are educated on the home's hypoglycemia protocol. A record of the education provided along with the names and date of the staff completing the education are to be kept available in the home.

e) Ensure that when resident #001 has a blood glucose level of less than 4 mmmol/L that their individualized plan for treatment, related to diet restrictions, is followed.

Grounds / Motifs :

1. The licensee failed to ensure that the written protocols for hypoglycemia were implemented.

The home's policy Management of Diabetic Residents (NPC E-60) dated August 2021, stated that the hypoglycemia protocol should be initiated for any resident with a blood glucose less than 4 mmol/L. The physician was to be notified of all hypoglycemic episodes. For a resident that was conscious and able to swallow, if blood glucose was 2.8 to 3.9 mmol/L then 175 millilitres of juice or pop (not sugar free) or instaGlucose 15 grams was to be given and repeat blood glucose in 15 minutes. If blood glucose was less than 2.8 mmol/L then 250 millilitres of juice or pop (not sugar free) or InstaGlucose 31 grams was to be given and to repeat blood glucose in 15 minutes.
Once the hypoglycemia had been reversed the resident should have the usual meal or snack that was due at that time of the day to prevent repeated hypoglycemia. If a

meal was more that one hour away, a snack including 15 grams of carbohydrate and a protein source should be consumed (crackers and peanut butter or cheese, or a sandwich with protein). The hypoglycemic event was to be documented in risk management and a medication incident form completed

a) Resident #030 was administered the wrong insulin on an identified date. The on-call physician was notified and ordered that the resident was to have their blood sugar rechecked in an hour and to follow the facility protocol for hypoglycemia.

Resident #030's hypoglycemia event on the identified date where their blood sugar fell to less than 4 mmol/L was not treated as per the hypoglycemia protocol.

b) Resident #001 had specific nutritional requirements and their care plan and medication administration record identified an individualized plan in the event of a hypoglycemic event.

Over a twenty day period, resident #001 had nine recorded blood sugars of less then 4 mmol/L indicating they were having a hypoglycemic event. Six of the nine hypoglycemic events were untreated, one was treated but the individualized hypoglycemic plan was not followed, one was treated but then given insulin, and one episode was not treated and insulin was administered.

c) Resident #027's blood sugar recorded on an identified date was less than 4 mmol/L indicating that they were having a hypoglycemic event. The event was not treated and they were administered insulin.

Director of Resident Care #101 acknowledged that the registered staff did not follow the hypoglycemia protocol for resident #030, #001 and #027 which includes holding all insulin if blood glucose is less than 4 mmol/L and notifying the physician.

Director of Clinical Services from Universal Care Canada Incorporated acknowledged that the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, was not followed for the incidents for where the residents blood sugars dropped below 2.8 mmol/L.

By staff not following the home's policy related to hypoglycemia and administering insulin to residents when their blood glucose was less than 4.0 mmol/L put the

residents at high risk of a severe hypoglycemic event.

Sources: resident #001, #027, #030 medication administration records and progress notes; Management of Diabetic Residents policy (NPC E-60) dated August 2021; Hypoglycemia management policy (NPC SM F-65) dated September 2021; Minister's Directive Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia Ministry of Long-Term Care April 15, 2020; interviews with Director of Resident Care #101, Medical Director and other staff. [s. 114. (3) (a)]

An order was made by taking the following factors into account:

Severity: There was actual risk to residents when residents with a blood glucose less than 4 mmol/L were administered insulin or when the residents were identified as having a blood glucose less thatn 4 mmol/L (hypoglycemic event) and no actions were taken.

Scope: Three of the three residents reviewed had hypoglycemic events and were not treated according to the hypoglycemic protocol, demonstrating widespread non-compliance.

Compliance History: Nine written notifications (WN), 44 voluntary plans of corrections (VPC), and 31 compliance orders were issued to the home related to different sections of the legislation in the past 36 months.
(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 20, 2022(A2)

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: 005

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

Linked to Existing Order / Lien vers ordre existant: 2021_796754_0029, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must comply with s.131.(2) of O. Reg. 79/10.

Specifically the licensee must:

a) Ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

b) Ensure that when drugs are not administered to the residents in accordance with the directions for use specified by the prescriber that a medication incident report is completed. The medication incident report must include an analysis of the incident and corrective actions taken to prevent reoccurrence.

Grounds / Motifs :

1. The licensee failed to comply with Compliance Order (CO) #001 from inspection 2021_796754_0029 served on December 6, 2021, with a compliance due date of December 30, 2021.

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

The Medication Incident Reports (MIR) documented that one resident was given the wrong medication and two residents were not administered their medication as

prescribed.

Review of the Medisystem Medication Incident Report summary for the period of December 31, 2021 to January 24, 2022 showed that there had been 470 medication incidents—one wrong medication administered; two medications not administered, nineteen missing signatures, one delivery incident and 447 medications given at the wrong time.

The Director of Resident Care #101 acknowledged these medications errors and was aware that these medications had not been administered as prescribed.

One of the three residents had negative health effects when not administered their medication as specified by the prescriber.

Sources: Medication incident reports, resident's progress notes, physician orders and medication administration records, Medication Administration Skills policy (NPC SM E-50 effective November 2021) and interview with DOC.

An order was made by taking the following factors into account:

Severity: There was actual harm to resident #030 when they were administered medication s not in accordance with the directions for use specified by the prescriber.

Scope: Three out of three residents reviewed had medications not administered in accordance with the directions for use specified by the prescriber, demonstrating widespread non-compliance.

Compliance History: The licensee continues to be in non-compliance with s. 131.(2) of O. Reg. 79/10, resulting in a compliance order (CO) being re-issued. CO#001 was issued on December 6, 2021 (inspection #2021_796754_0029) with a compliance due date of December 30, 2021; on October 7, 2021 (inspection #2021_739694_0022) and on May 27, 2021 (inspection #2021_739694_0018) . In the past 36 months, 27 other COs were issued to different sections of the legislation. (155)

Apr 01, 2022(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

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Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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Order # / No d'ordre: 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must comply with s. 229. (4) of O. Reg. 79/10.

Specifically the licensee shall:

a) Ensure that residents are encouraged and offered to perform hand hygiene before and after meals and snacks.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the home's infection prevention and control (IPAC) program in relation to resident hand hygiene practices.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act. On March 22, 2020, Directive #3 was issued and revised on December 24, 2021, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7 by the Chief Medical Officer of Health (CMOH) of Ontario. An urgent requirement was made for LTC Homes to implement measures to protect residents, staff and visitors, including adherence to appropriate hand hygiene practices.

The home's hand hygiene policy stated that residents should be encouraged to perform hand hygiene before and after meals and snacks.

A) Two residents were observed to be in their rooms on droplet and contact

precautions because they were considered a high risk contact of a COVID positive staff. Staff assisted the residents up from their beds to a chair and provided them with their lunch meal without offering hand hygiene to either resident.

B) On three different dates, observations made during the morning and afternoon snack carts, on three resident living areas showed that staff members did not provide or encourage residents with hand hygiene before they received their snacks.

A PSW shared that residents were to be offered hand hygiene before meals but they were not aware that it was to be done before offering snacks and/or beverages from the nourishment cart.

Review of the Hand Hygiene Program Policy (IPC B-45) effective December 2020 states that alcohol base hand rub (ABHR) will be made available at the entrances to dining rooms and residents encouraged to perform hand hygiene before and after meals and snacks.

Failure of the home's staff to follow expectations to encourage and/or assist resident's with hand hygiene increased the risk of infection transmission and could have put residents at risk of harm.

Sources: observation of meal service, observations of the snack service, the home's hand hygiene policy #IPC-B-45, effective date December 2020, and interviews with the home's IPAC Lead, and other staff. [s. 229. (4)]
An order was made by taking the following factors into account:

Severity: There was minimal risk of harm when residents were not offered or encouraged to perform hand hygiene before meals or snack service.

Scope: Thirty-five out of forty residents observed were not offered hand hygiene demonstrating widespread non-compliance.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. s. 229.(4) and and one voluntary plan of correction (VPC) to the same section was issued. (155)

Apr 04, 2022

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

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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: 007

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

Linked to Existing Order / Lien vers ordre existant: 2021_739694_0022, CO #005;

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 :

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 must comply with s.50. (2) of O. Reg. 79/10.

Specifically the licensee must:

a) Ensure resident #001, #004 , and #029, receive at a minimum weekly assessment of their wounds and altered skin conditions.

b) Ensure that resident #003, #004 and #029 receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

c) Ensure that skin and wound care treatments, assessments and monitoring of stage lll and greater pressure ulcers, and any deteriorating wounds or skin conditions are completed according to the home's wound management policy.

d) Ensure that a weekly auditing process is fully implemented to include at a minimum all stage III and greater pressure ulcers, and any deteriorating wounds or skin conditions. This auditing process should include, the date of the audit, the name of the manager or designate conducting the audit, the residents who have been audited, the wounds being assessed, including their stage or type, the treatment in place and the effectiveness of treatment, the results of the audit and what actions were taken in regards to the audit results. The actions taken should be completed within the week in which the audit is completed. The written copy of the audit must be kept available in the home.

Grounds / Motifs :

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

1. The licensee failed to comply with Compliance Order (CO) #005 from inspection 2021_739694_0022 served on October 6, 2021, with a compliance due date of January 14, 2022.

The licensee has failed to ensure that resident #029 received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection for their wounds.

Resident #029 had wounds.

i) The resident’s pain was to be assessed weekly and at each dressing change. During the weekly wound assessment it was documented that the resident experienced pain during the dressing change. The resident’s pain was not assessed and there were no records of any immediate interventions provided to relieve the resident's pain until their 1200 hrs scheduled dose of medication was administered.

The home's wound management program documented that staff were to monitor for signs and symptoms of infection and consult with the physician for any abnormal symptoms.

ii) The resident asked the physician to assess their wound. The physician’s note on the same day, documented that the wound was deteriorating and showed signs of infection. The resident’s dressing was changed two days prior, but there was no documentation at that time of any signs or symptoms of infection or any notification of the physician.

These gaps in implementing immediate interventions to relieve or reduce resident #029's pain and prevent infection of their wound resulted in the wound worsening and pain.

Sources: resident #029's progress notes, electronic treatment administration record (eTAR), electronic medication administration record (eMAR), wound assessments, the home's wound management policy #NPC D-35, last revised September 2020, and interviews with the home's Wound Care Nurse, DOC, and other staff. [s. 50. (2) (b) (ii)]
(758)

2. The licensee has failed to ensure that resident #004 received immediate treatment and interventions to promote healing of their wounds.

Resident #004 had multiple wounds.

The physician's progress note on an identified date indicated that the resident had a wound that was worsening and ordered a change in the treatment.

There was no physician notification related to the changes to the wound.

This gap in implementing immediate interventions to promote resident #004's wound healing resulted in the deterioration of their wound.

Sources: resident #004's progress notes, eTAR, wound assessments, and interviews with the DOC, the physician and other staff. [s. 50. (2) (b) (ii)] (758)

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

3. The licensee has failed to ensure resident #003 received immediate treatment and interventions to promote healing of their wound.

Resident #003 had a wound. The resident's eTAR documented the area should be assessed weekly and the physician notified of complex and non-healing areas.

The weekly wound assessment done on an identified date showed that that the wound was getting worse and that the treatment was ineffective.

A review of the wound photographs done showed the area was getting worse compared to previous photographs.

There was no notification of the Wound Care Nurse until seven days later and the physician was not notified until nine days later. Nine days after the wound was noted to be deteriorating the external Wound Care Nurse's notes showed that that the wound was larger and changed the treatment.

This gap in implementing immediate interventions to promote resident #003's healing of the wound resulted in the deterioration of the area.

Sources: resident #003's progress notes, wound assessments, eTAR, photographs of the altered skin integrity, wound care nurse's consult notes, nurse-physician communication forms and interviews with the DOC, the home's Wound Care Nurse , the physician and other staff. [s. 50. (2) (b) (ii)] (758)

4. The licensee has failed to ensure that resident #001's skin tear was reassessed at least weekly by a member of the registered nursing staff.

Resident #001 had a skin tear. On an identified date it was noted that area had become worse and treatment was changed.

The resident's electronic treatment administration record (eTAR) documented that the area was to be assessed weekly. There was no documentation of assessments for two weeks.

This gap in weekly assessments increased the risk that appropriate interventions were not implemented in a timely manner if the wound started to deteriorate.

Sources: resident #001's progress notes, care plan, eTAR, wound assessments and interviews with the DOC and other staff. [s. 50. (2) (b) (iv)] (758)

5. The licensee has failed to ensure that resident #029's wounds were reassessed at least weekly by a member of the registered nursing staff.

Resident #029 had wounds. The resident's eTAR documented the wounds were to be assessed weekly and pictures taken and uploaded to the resident's electronic file.

There were no weekly assessments completed for a specific week. On an identified date, the assessments did not include measurements and documented incorrectly the stage of the wound. On a specific date, the wound assessments did not include the type of the wound and there were no measurements.

Additionally, there were no pictures taken of the wound for twenty days.

Sources: resident #029's progress notes, care plan, electronic treatment record (eTAR), assessments and interviews with the DOC and other staff. [s. 50. (2) (b) (iv)] (758)

6. The licensee has failed to ensure that resident #004's wounds were reassessed at least weekly by a member of the registered nursing staff.

Resident #004 had wounds. The resident had assessments initiated, but the

assessments were incomplete.

These gaps in the completion of wound assessments increased the risk that appropriate interventions were not implemented to treat the wounds when they started deteriorating.

Sources: resident #004's progress notes, eTAR, wound assessments, the home's weekly wound tracking tool and audits, and interviews with the DOC , the physician and other staff.

As part of the compliance order the licensee was asked to develop an audit tool for skin and wound to include and document the treatment in place and the effectiveness of the treatment for all stage III and greater pressure ulcers, and any deteriorating wounds or skin conditions, and the actions taken in regard to the audit results.

The home's skin and wound audit did not include the treatment in place for any of the altered skin integrity areas that were audited.

i) Over a one week period, the home's weekly audits documented that resident #029's weekly wound assessments were completed on a specific date, but the assessments were not created until six days later. There was no documentation of the actions taken regarding this audit. During a second one week period, the home's weekly audits documented there were no measurements included in resident #029's assessments completed on a specified date; the audit documented that the gaps identified would be followed up during the previous week.

ii) Over a one week period, the home's weekly audits for pressure ulcers identified that a physician's order was not in place for: resident #004's treatment of wounds; and for resident #003's wound. During two subsequent weeks, the home's weekly audits identified that the physician's order for resident #003's treatment for their woundwas not in place. The actions required had no date and it was documented that the gaps would be reviewed with the DRC and the Wound Care Nurse.

Sources: the home's weekly wounds audits, and interviews with the home's Wound care Nurse, the DOC and other staff. [s. 50. (2) (b) (iv)]

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

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to three residents that did not receive weekly assessments of their altered skin integrity, and skin and wound treatments as required.

Scope: Widespread as three out of three residents did not receive assessments or treatment they were prescribed.

Compliance History: This subsection was issued as a Written Notification (WN) on May 30, 2019, during inspection #2019_605213_0019, and on July 10, 2019, during inspection #2019_773155_0010. A Compliance Order (CO) a CO was issued on November 18, 2020, during inspection #2020_773155_0019, with a Compliance due date (CDD) of December 7, 2020. A CO was issued on January 28, 2020, during inspection #2019_773155_0016, with a CDD of compliance due date of April 3, 2020. A CO was issued on May 30, 2019, during inspection #2019_605213_0019, with a CDD of July 31, 2019. A CO and Director Referral (DR) was also issued on September 8, 2020, during inspection #2020_739694_0020, with a CDD of September 22, 2020, a CO/DR was issued on May 27, 2021, during inspection #2021_739694_0018, with a CDD of June 17, 2021, and a CO was issued on October 7, 2021 during inspection #2021_739694_0022 with a CDD of January 14, 2022. (758)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 20, 2022(A2)

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

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

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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 29th day of April, 2022 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by JANET GROUX (606) - (A2)

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