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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Amended Public Report (A1)

Report Issue Date September 12, 2022
Inspection Number 2022_1587_0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Corporation of the County of Simcoe

Long-Term Care Home and City
Sunset Manor Home for Senior Citizens, Collingwood

Inspector who Amended
Janet Evans (#659)

Inspector who Amended Digital Signature
Janet Evans
Digitally signed by Janet Evans
Date: 2022.09.12 16:26:53 -04'00'

Additional Inspector(s)

AMENDED INSPECTION REPORT SUMMARY

- This licensee inspection report has been revised to reflect a change in wording to identified intakes #010366-22 and #010631-22 that the complaints were related to Family Council.
- The Complaint, Critical Incident System and Follow-Up inspection #2022_1587_0002 was completed on June 29, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 13-17, 22-24 and 27-29, 2022.

The following intake(s) were inspected:

- Intake # 004940-22 Follow-up regarding medication management
- Intake # 004943-22 Follow-up regarding skin and wound
- Intake # 004925-22 High Priority - Follow-up regarding responsive behaviours
- Intake # 010755-22 Complaint regarding alleged abuse of a resident
- Intake # 010428-22 Critical Incident System (CIS) related to improper care of a resident
- Intake # 010366-22 Complaint related to Family Council
- Intake # 010631-22 Complaint related to Family Council
- Intake # 009226-22 Complaint related to IPAC, orders not being followed and PASD's
- Intake # 009023-22 CIS regarding concerns related to a resident's skin and wound care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s.114.(3)	2022_773155_0001	004	#155
O. Reg. 246/22	s. 53 (4)	2022_773155_0001	001	#659

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 79/10	50(2)(b)(ii) and (iv)	2022_773155_0001 (A2)	007	#606

The following **Inspection Protocols** were used during this inspection:

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours
- Restraints/Personal Assistance Services Devices (PASD) Management
- Skin and Wound Prevention and Management

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6 (10) (b)

A resident did not have their plan of care reviewed and revised related to the use of a weighted blanket as a fall risk strategy, and the tilt function of their wheelchair for comfort and safety.

The Registered Practical Nurse (RPN) reviewed and revised the resident's plan of care to reflect the resident's current care needs.

Sources: Inspector #653's observations on June 22-23, 2022; Resident's clinical health records; Interviews with Personal Support Workers (PSWs) and RPN

Date Remedy Implemented: June 24, 2022 [653]

WRITTEN NOTIFICATION PLAN OF CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6. (7)

The licensee has failed to ensure that:

- Annual blood work was completed for resident's #006 and #009 as specified in their plan of care
- Ordered blood work was completed for resident #001 as specified in their plan of care
- The tilt wheelchair function for resident #015 was used as specified in their plan of care
- Fluids were thickened and resident #007 was awake and alert prior to providing food or fluids as specified in their plan of care

Rationale and Summary

1. Two residents were ordered to have annual blood work done. Both residents had their annual blood work done in April 2022. This same blood work was repeated a second time in April 2022, however the repeat lab work was not specified in their plan of care.

The Director of Resident Care and Universal Care Canada Incorporated, Director of Clinical Services were unsure of the process for annual blood work.

A Registered Nurse shared that the registered staff could have thought that it was missed and had it re-done.

Annual blood work done two weeks in a row for two residents had minimal impact on the residents; however they underwent repeated testing that was not necessary.

Sources: Identified resident 's Prescriber's Digiorders, Prescriber's Order Reviews, LifeLabs reports for April 2022; Entering Lab Test in Point Click Care (PCC) document, Lab Order Process document, and interviews with an RN and other staff. [#155]

2. On a specified day in March 2022, lab work was ordered for a resident. The orders were documented as processed.

The lab did not attend the home until two weeks after the order was processed but only completed a portion of the lab work. It took 20 days before the full lab tests ordered were completed. However, there was an additional lab test completed at this time, that had not been ordered by the physician.

An RN reviewed the orders on Point Click Care (PCC) for the resident's lab work and said they thought there may have been an error in the documentation of the order in PCC but they were not certain why this occurred.

The DRC was not aware of concerns related to the resident's lab work not being completed nor were they aware that an extra test had been completed.

By not having lab work completed in a timely fashion there was risk that relevant information was not available to inform the physician in their decisions to manage the resident's care. In addition, there is potential risk when tests are completed that are not ordered by a physician.

Sources: Prescriber's Digiorders, Entering Lab Test in Point Click Care (PCC) document, progress notes, Lab Order Process document, LifeLabs results, interviews with the DRC and staff. [#659]

3. A resident required two staff to provide extensive assistance to reposition them every two hours.

On a specified day in April 2022, the Occupational Therapist (OT) documented that an intervention to support postural control and prevention of skin breakdown.

Two observations showed the resident was seated upright in their mobility aid.

A PSW stated they kept the mobility aid in an upright position as otherwise it would be deemed as a restraint.

The PSSS acknowledged staff should be tilting the mobility aid to relieve pressure.

There was moderate risk to the resident of possible skin breakdown or pressure injuries when staff did not consistently utilize the PASD as specified in the plan of care.

Sources: observations; clinical health records, Use of PASDs policy #NPC SM F-70 dated April 13, 2022; Interviews with PSW, resident's family member, and the PSSS. [653]

4. A resident had been assessed as at risk of choking in March 2022.

Staff were directed to ensure that resident was awake/alert prior to administering food or fluids.

On a specified day in May 2022, a PSW said they had to stop trying to feed the resident as it was not safe. They notified the RPN.

The RPN administered medication and regular texture fluid to the resident. The resident began coughing. The PSW assisted the resident to clear the medication and fluids from the resident's mouth.

Failure to follow the resident's plan of care put the resident at increased risk for choking or aspiration.

Sources: Care plan, physician orders, March 17/22 consult note by Dr. Daniel, North Simcoe Muskoka Specialized Geriatric Services GMH Summary Action Plan transcribed March 23, 2022, home's investigation, interviews with DRC and staff.

WRITTEN NOTIFICATION BATHING

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.37.(1)

The licensee has failed to ensure residents three residents were bathed at a minimum of twice weekly by a method of their choice.

Rationale and Summary

Between May 25, 2022 to June 22, 2022:

- A resident was given five showers and a bed bath instead of their preference of a tub bath,
- A resident was given three showers, two bed baths instead of their preference of a tub bath, and it was recorded they refused a bath on two occasions, and
- A resident was recorded as refusing a bath on seven occasions and the last time they were bathed was a tub bath given on May 20, 2022.

Review of the residents' progress notes for the period of May 25, 2022 to June 22, 2022, did not explain why they were not bathed as per their preference or why they were refusing to be bathed.

Two residents not being bathed according to their preference may have made the residents feel that their preferences were not being respected. One resident may have been refusing to be

bathed because they were not being bathed as per their preference. One resident not having a bath over a four week period may have had a negative impact on their hygiene.

Sources: Resident care plans, progress notes, multidisciplinary care conference, Point of Care bathing method documentation, and interviews with a resident, Director of Resident Care , Universal Care Canada Incorporated Director of Clinical Services and other staff.
[#155]

WRITTEN NOTIFICATION HOUSEKEEPING

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 93. (2)(b)(i)

The licensee has failed to ensure that procedures were implemented for cleaning and disinfecting tubs, shower chairs and lift chairs using a low level disinfectant in accordance with evidence-based practices.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care regarding the number of residents in the home on contact precautions.

Review of the 24 Hour/Daily High Risk Report showed that there were 17 residents in the home that were positive for a specified infection. Nine of these residents lived on one resident home area.

A PSW shared that they would leave the tub disinfectant on the tub for a couple of minutes before they rinsed it off. A second PSW shared that they used wipe to wipe down the shower chair and then rinsed the chair. A third PSW shared that they would place some of the disinfectant from the tub on a towel and wipe down the shower chair and shower hose and handle. When they used the tub they would let the disinfectant sit for about 5 to 10 minutes and then rinse the tub.

Observations done of the tub rooms on two resident home areas showed that a specified Germicidal Detergent was used as the disinfectant in the tubs.

The Environmental Services Supervisor (ESS) shared that the Germicidal Detergent required a ten-minute contact time to disinfect equipment.

The Infection Prevention and Control (IPAC) lead shared that they had posted the tub cleaning protocol in the tub room within the last week and that the process for cleaning the shower chair/equipment was not fully implemented.

By not disinfecting the tub, tub lift and shower chair as per required disinfectant time there was moderate risk that infections could spread amongst residents which could impact their health and wellbeing.

Sources: Observations of tub and shower rooms on Collingwood 2 and Georgian 2 resident living areas, interviews with PSWs, ESS and IPAC Lead; Cleaning, Disinfecting, Sterilizing Resident Equipment Policy (B-40) and PSW Tubs and Tub Lifts Cleaning and Disinfection Process Draft November 19, 2021.
[#155]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *102. (9)(a) and (b).*

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection for two identified residents were monitored and recorded.

Rationale and Summary

1. A resident told inspector #155 that they had symptoms of an infection. This was immediately reported to RN/Resident Care Program Supervisor (RCPS).

The resident's physician orders showed that they were seen by the physician for for these complaints and treatment was ordered twice daily for 10 days. The resident's Medication Administration Record (MAR) showed that this was administered.

Progress notes showed that there had been no monitoring or recording of the symptoms of possible infection that the resident reported on a specified date.

The Monthly Surveillance Line List for June 2022 on home area where the resident resided did not list the resident for the presence of infection. The 24 Hour/Daily High Risk Report did not capture that the resident was on a treatment twice daily for 10 days.

The RCPS shared that when the resident complained of symptoms of an infection, a progress note should have been made regarding these symptoms. They also shared that the resident should have been placed on the June 2022 Surveillance Line List as well as the 24 Hour/Daily High Risk Report for 10 days while potential infection was being treated.

By staff not ensuring that on every shift, symptoms indicating the presence of infection for the resident were monitored and recorded, there was moderate impact and risk to resident's health as there was no follow up in relation to the potential ongoing infection.

Sources: Interview with resident, RCPS and other staff; review of resident's progress notes, Prescriber's orders, June MAR, Collingwood 2 Daily Resident 24 Hour Reports, Sunset Manor 24 Hours/Daily High Risk Reports and Infection Surveillance In Long Term Care Settings Policy (IFC C-05). [#155]

2. An identified resident had signs of dry mucous membranes and a possible oral infection.

The RPN said that they were not aware of anyone assessing the resident's mouth or mucous membranes.

There were no progress notes which included the resident's possible infection. There was no documentation on the mDaily resident 24 hours report or the specified 24 Hour/Daily High Risk Report of signs or symptoms of infection for the resident.

Registered staff were unable to locate surveillance documentation for infections on the unit. They acknowledged there was no documentation of symptoms of any specified infection for the resident over the last week.

Sources: policy Infection Surveillance in Long Term Care Settings, IFC C-05, effective December 2020, progress notes, mDaily resident 24 hr report, green binder, physician's communication log, interviews with staff. [#169]

WRITTEN NOTIFICATION NUTRITIONAL CARE AND HYDRATION PROGRAM

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 74 (2) b, c, and d

The licensee has failed to comply with their policies, procedures and processes within the nutrition / hydration program including for:
- monitoring and evaluating food intake
- making referrals to the dietitian and
- assessing resident #007 for signs of dehydration.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee is required to have a nutrition and hydration program and ensure it is complied with.

Specifically, staff did not comply with the licensee's policy Dietitian referral, NPC E-35, effective June 2021, and the Hydration Assessment and Management policy, DM E-20, effective January 2020, as well as the home's process for monitoring and evaluating food intake, which was part of the licensee's nutrition and hydration program.

Rationale and Summary

An identified resident was on medication for pain management and behaviour management.

On a specified week in June 2022, the resident was often seen sleeping and showed signs of dehydration. Staff were not always successful in being able to rouse the resident sufficiently to provide them food or fluids.

Staff were directed to complete a referral to the dietitian for things such as decreased food or fluid intake of specified amounts over a three day period, weight loss, signs of difficulty chewing, swallowing or choking It was mandatory that a nursing assessment be completed as part of the referral, which included details of the concerns and any interventions put in place pending RD assessment.

A) The home's process for monitoring food intake was the resident's food intake was documented in PointClickCare (PCC). If there was less than 50% food intake over three days then an alert should be triggered in PCC and a dietitian referral initiated.

On a specified day in June 2022, the resident's weight was recorded as a significant weight loss over a three month period.

An alert should have been sent for the resident's low food intake on five days in June 2022, when the threshold was met for a referral to the RD.

The Dietary Manager, Clinical DRC and Director of Seniors Living, UCCI, said that the home discovered the alert in PCC for low food intake had been turned off. In the absence of the alert, staff may document a resident's intake of less than 50% over three days on PCC, but this information may not be picked up or evaluated as no one was assigned to monitor this task.

Director of Seniors living, UCCI said there should have been a dietitian referral on one specified day in June 2022, related to the resident's poor nutritional intake.

According to the home's policy for referrals to the dietitian, one should have been completed for six days in June 2022, for low food intake and weight loss. There were no dietitian referrals made for four of these days.

Sources: PCC weights and vitals, POC 30 day lookback for food and fluid intake, Documentation survey report for June 2022, Dietitian referrals June 2022, progress notes, Policies: Referral to Dietitian, NPC E-35, effective June 2021, Interviews with Dietary manager, DRC, Director of Seniors Living, Dietitian and staff.

B) PSWs documented the resident's fluid intake on PCC and pull a report each night to review the resident intake. This information is provided to the RN or RPN who would follow up if residents triggered low fluid intake. If the resident had a low fluid intake for 3 days in a row then the RPN would follow up and send a referral to the RD.

On 15 of 17 days in June 2022, the residents fluid intake was below the recommended intake in their plan of care.

Over a seventeen day span in June 2022, referrals to the RD should have been made six days in June 2022, for low fluid intake, however no referral was made for two of these days.

Interventions that were implemented during this specified timeframe, were ineffective to achieve the resident's recommended fluid intake.

Documentation completed by the RN had not indicated any signs or symptoms of dehydration and there were no changes to the resident's plan of care.

Sources: POC 30 day lookback for food and fluid intake, Documentation survey report for June 2022, Dietitian referrals, progress notes, Policies: Referral to Dietitian, NPC E-35, effective June 2021, Hydration Assessment and Management DM E-20, effective January 2020. Interviews with Dietary manager, DRC, Director of Senior Living UCCI, Dietitian and staff, UCCI Director of Clinical Services

C) Over a four day period in June 2022, an identified resident showed signs of dehydration.

Two referrals were made to the RD during that week for dehydration risk. One referral, did not document any signs or symptoms of dehydration. The other referral documented use of specified medications, related to dehydration risk.

Completion of a nursing assessment was to be included as part of the dietitian referral.

An RPN said they were not aware of anyone assessing the resident's mouth and mucous membranes. They accompanied inspectors #659 and #724 and assessed the resident's mouth as dry with dry mucus membranes.

An RPN said staff were to assess the resident prior to completing the form. They reviewed two specified dietitian referrals and said the mandatory section related to signs and symptoms of dehydration had been left blank on one referral and only information related to medication administration was recorded on the second referral.

The RD said they review the referrals as part of their assessment and look to see if registered staff had assessed the resident as showing signs and symptoms of dehydration in the referral.

Not following the home's policies, procedures and processes that were part of the home's Nutrition and Hydration program may have prevented more timely RD assessments and interventions and put resident #007 at heightened risk for choking or aspiration, dehydration and weight loss.

Sources: Dietitian referrals for June 2022, progress notes, policy Hydration Assessment and Management DM E-20, effective January 2020, interviews with staff [#659]

WRITTEN NOTIFICATION MINIMIZING OF RESTRAINING

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 36 (4)

The licensee has failed to meet the requirements for inclusion of a Personal Assistance Service Device (PASD) in an identified resident's plan of care, as set out in the FLTCA, 2021.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care (MLTC) regarding an identified resident's mobility aid positioning function being disabled.

The PSSS documented they received verbal consent from the resident's SDM to use the positioning function on the resident's mobility aid.

The resident's repositioning function of the mobility aid was used as the resident was transported to the hallway.

A PSW showed the inspector a green tag at the back of the resident's mobility aid which indicated the following: "PASD Why: Comfort/ pressure relief. How: Refer to care plan". The PSW stated they would slightly reposition the resident's mobility aid during the day shift if they fell asleep in their mobility aid.

An Alternative to Restraint/PASD assessment had not been completed for the resident, and their electronic Medication Administration Record (eMAR)/ electronic Treatment Administration Record (eTAR) for June 2022, care plan, Kardex, and Point of Care (POC) tasks, did not outline information regarding PASD use. The resident's prescriber's digiorder forms and the most recent prescriber's order review also did not indicate information related to PASD use.

The float Administrator said the positioning function of the mobility aid could be used if the resident had areas of altered skin integrity and it was in the care plan to use the mobility aid for that purpose.

There was moderate risk related to the lack of assessment and clarity on the use of the identified resident's tilt wheelchair as a PASD, as staff may not have been consistently utilizing the PASD for its purpose.

Sources: Inspector observations; Resident's clinical health records, Use of PASDs policy #NPC SM F-70 dated April 13, 2022; Interviews with PSWs, and the PSSS. [653]

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s.101(4)

The licensee has failed to comply with compliance order #007 from inspection #2022_773155_0001 dated March 7, 2022, issued on April 1, 2022, with a compliance due date of April 29, 2022. The CDD was extended to May 20, 2022, at the request of the licensee.

The weekly skin and wound assessments were not completed for resident two identified residents.

As well residents three identified residents did not receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

A) Rationale and Summary:
The home's Wound Management Program, policy #NPC-D-35 SM, effective date April 2022, stated that all wounds, regardless of type must be assessed weekly.

1. An identified resident had three areas of altered skin integrity.

Documentation showed the two areas of altered skin integrity on the resident's lower limb were not re-assessed for 12 days.

Three resident's weekly skin assessments for their third area of altered skin integrity were incomplete over a 12 day period.

Sources: the home's Wound Management Program #NPC-D-35 SM effective date April 2022, resident's progress notes, Skin and Wound Evaluations V6.0, and interviews with staff. [606]

2. An identified resident had three areas of altered skin integrity. Four of the resident's weekly assessments over a four week period May – June 2022, were incomplete and missing information related to whether or not the wounds had edema, wound measurement, exudate amount, type and odour.

Sources: the home's Wound Management Program #NPC-D-35 SM effective date April 2022, resident's Skin and Wound Evaluations_V6, progress notes, care plan, and interviews with staff. [606]

3. An identified resident was at high risk for skin breakdown. The resident had six areas of altered skin integrity.

Weekly skin and wound assessments were not completed for the resident over a 12 day period for four of the areas of altered skin integrity as follows:
- the wound's induration
- a description of the wound bed;
- a description of the area of altered skin integrity;
- the assessment did not identify the presence of edema or not.

Registered Practical Nurses as well as the DRC said skin assessments should be completed weekly.

Impact or Risk:
Failure to assess the three residents' wounds weekly, may impact prescribed treatment and care which could alter healing and put the resident at further risk of harm. [606]

Sources: The home's Wound Management Program, policy #NPC-D-35 SM, effective date April 2022, resident's Skin and Wound Assessment _v6 dated and interviews with staff.

B) Rationale and Summary:

The licensee has failed to ensure an identified resident's area of altered skin integrity received immediate treatment.

The home's Wound management program, policy "NPC D-35-SM last revised April 22, 2022, directed registered staff to monitor for signs and symptoms of infection and consult with the physician for any abnormal findings.

The identified resident was at high risk for altered skin integrity. On a specified date the resident was identified with a stage III pressure ulcer.

A skin and wound assessment on a specified date identified the resident's area of altered skin integrity to have a light serosanguinous drainage and a strong odour. The resident was noted grimacing during the dressing change but denied they had pain.

A week later, the skin and wound assessment documented the resident's area of altered skin integrity had deteriorated. There was a moderate odour, redness, inflammation, and the resident had pain during the dressing change. A note was left in the physician's communication binder for assessment.

One day later, the resident's area of altered skin integrity was assessed by the physician and the consulting ET nurse. The wound had expanded, with an odour, moderate exudate and was dark red in colour. The wound was diagnosed with a wound bed infection. A new treatment was ordered and initiated.

The Physician said they were not made aware that the resident's area of altered skin integrity showed signs and symptoms of infection at the time of the assessment eight days earlier.

The RPN and DRC acknowledged the physician was not notified immediately when the resident's area of altered skin integrity was identified with signs and symptoms of infection.

Impact or Risk:
Failure to inform the physician that the resident's wound was identified with signs of infection may have contributed to the worsening of the wound due to delayed treatment and caused the resident further harm.

Sources: The home's Wound management program, policy "NPC D-35-SM last revised April 22, 2022, resident #004's progress notes, Skin and Wound Assessment _v6 dated June 7, 2022, and interviews with staff, DRC, and the physician.

[606]

COMPLIANCE ORDER [CO#001] SKIN AND WOUND CARE

NC#009 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 55(2)(b)(iv)

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 55(2)(b)(iv) of O. Reg. 246/22.

The licensee must comply with s. 55(2)(b)(iv) of O. Reg. 246/22.

Further, the licensee shall:

1. Conduct audits to ensure that skin and wound re-assessments are completed weekly, using the PCC skin and wound app, for each of resident #002, #003, #004 and #029's areas of altered skin integrity. The audits must be documented in writing and conducted weekly for a four-week period following the compliance due date of this order.
   (a) The audits conducted, at a minimum, must include and document information on the following:

   (i) Whether each section of the skin and wound re-assessment was completed;

   (ii) If a physician referral was completed as required by the home's policy;

   (iii) If daily monitoring, treatment and interventions were completed, as required;

   (iv) Whether the audit identifies that any of the items above are incomplete. Where items are identified as incomplete, the skin and wound lead should be notified for follow up.

   (v) the date and name of the person conducting each audit. A record of the audits is to be kept in the home.

2. Ensure that resident #002's plan of care includes strategies to position/re-position the resident to reduce and prevent skin breakdown and reduce and relieve pressure. Ensure that staff are made aware of these strategies and how they can implement those strategies.

Rationale and Summary

The home's Wound Management Program, policy #NPC-D-35 SM, effective date April 2022, stated that all wounds, regardless of type must be assessed weekly.

1. A resident was at high risk for skin breakdown related to their medical conditions. On a specified date in February 2022, the resident was identified with a skin tear on their left ankle.

Six Skin and Wound Assessments_V6 dated April 28 - June 9, 2022, were incomplete.

One assessment in April 2022, did not include information about evidence of infection, presence of edema, and the induration of the peri wound.

Four assessments in May 2022, did not include one or more of the following: the measurements of the wound, the condition and appearance of peri wound edges, a description of the wound bed, the size of the surrounding tissue, and the presence of odour or not

Two assessments in June 2022, the assessment did not provide information on either the presence of edema or did not include a description of the wound bed, peri wound edges, and size of the surrounding tissue.

2. An identified resident had three areas of altered skin integrity.

Documentation showed the two areas of altered skin integrity on the resident's lower limb were not re-assessed for 12 days.

Three resident's weekly skin assessments for their third area of altered skin integrity were incomplete over a 12 day period.

Sources: the home's Wound Management Program #NPC-D-35 SM effective date April 2022, resident's progress notes, Skin and Wound Evaluations V6.0, and interviews with staff. [606]

3. An identified resident had three areas of altered skin integrity. Four of the resident's weekly over a four week period May – June 2022, were incomplete and missing information related to whether or not the wounds had edema, wound measurement, exudate amount, type and odour.

Sources: the home's Wound Management Program #NPC-D-35 SM effective date April 2022, resident's Skin and Wound Evaluations_V6, progress notes, care plan, and interviews with staff. [606]

4. An identified resident was at high risk for skin breakdown. The resident had six areas of altered skin integrity.

Weekly skin and wound assessments were not completed for the resident over a 12 day period for four of the areas of altered skin integrity as follows:
- the wound's induration
- a description of the wound bed;
- a description of the area of altered skin integrity;
- the assessment did not identify the presence of edema or not.

Registered Practical Nurses as well as the DRC said skin assessments should be completed weekly.

An RPN said they were shown how to complete a skin assessment step-by-step, which covered what you needed to do to conduct an assessment such as, what kind of wound it was, the depth, the actual size and dimension, where the wound was located and if there was drainage. The registered staff would be required to put interventions in place and monitor the outcome of the wound. The registered staff would have to answer all the questions on the app.

The DRC said the home had a wound app and the expectation was for staff to complete a skin assessment by entering information in every section within the assessment.

As per above, the residents exhibited altered skin integrity, including skin breakdown, pressures, skin tears or wounds, and the licensee did not ensure that those residents were re-assessed at least weekly by a member of the registered nurse, if clinically indicated. In cases where re-assessments were done, many of them were insufficient as they did not assess for important issues related to the skin/wound.

Impact or Risk:
Failure to assess residents #002, #003, #004, and #029's wounds weekly, may impact prescribed treatment and care which could alter healing and put the resident at further risk of harm. [606]

Sources: The home's Wound Management Program, policy #NPC-D-35 SM, effective date April 2022, Skin and Wound Assessments _v6, and interviews with staff. (606)

This order must be complied with by September 12, 2022

[606]

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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

An Administrative Monetary Penalty (AMP) is being issued for failing to comply with s. 55(2)(b)(iv) of O. Reg. 246/22 under the *Fixing Long-Term Care Act, 2021* (FLTCA)

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

Notice of Administrative Monetary Penalty [AMP #001]
Related to Compliance Order (CO) # 001

Pursuant to section 158 of the FLTCA, the licensee is required to pay an administrative penalty of **$5500.00,** to be paid within 30 days of from the date of receiving an invoice (invoice to follow separately).

In accordance with s. 349(6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for:

- The licensee's failure to comply with s. 55(2)(b)(iv) of O. Reg. 246/22, which resulted in the compliance order above (s. 155), and during the three years immediately before the date of this order, the licensee failed to comply with the same requirement as it was under s. 50(2)(b)(iv) of O. Reg. 79/10 under the *Long-Term Care Homes Act, 2007* (LTCHA), which resulted in a compliance order made under s. 153 of the LTCHA (see Compliance History below).

S. 55(2)(b)(iv) of O. Reg. 246/22 falls under Item 23 of the Table in s. 349 under O. Reg. 246/22.

Compliance History

- Prior non-compliance with s. 50(2)(b)(iv) of O. Reg. 79/10 under the LTCHA, resulting in a compliance order (CO #007) in Inspection # 2022_773155_0001. The compliance order was issued on March 7, 2022.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement (s. 55(2)(b)(iv)).

Invoice with payment information will be provided under a separate mailing after service of this notice.

*Licensees must **not** pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.*

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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Health Services Appeal and Review Board
Attention Registrar
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
email: MLTC.AppealsCoordinator@ontario.ca

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