Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY-JEAN SCHIENBEIN (158)
Inspection No. / No de l'inspection :	2013_140158_0013
Log No. / Registre no:	S-000233-13, S-000072-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 28, 2013
Licensee / Titulaire de permis :	WIKWEMIKONG NURSING HOME LIMITED 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
LTC Home / Foyer de SLD :	WIKWEMIKONG NURSING HOME 2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ELIZABETH COOPER

To WIKWEMIKONG NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # /
Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee is required to ensure that the home is equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times.

Grounds / Motifs :

1. A Compliance Order was issued in the Follow Up Inspection # 2010_154_1856_08Nov102644. The Compliance Order was re-issued in Inspection # 2011_188_1856_11Mar100511. (158)

2. The licensee did not ensure that the resident-staff communication and response system could be easily seen, accessed and used by residents.
On June 12, 2013 at 10:30hr, the Inspector observed that three residents who were resting in their beds and one resident who was sitting in their chair, did not have access to their call bells. The call bells were observed to be hanging behind the head board, on the floor and not within the resident's reach.
On June 13, 2013 at 09:50hr, the Inspector observed that two residents were asleep in their beds and two residents were sitting in their chairs. Their call bells were observed to be hanging behind the head board, on the floor, in the waste basket and hanging behind the mattress and not accessible to the resident at all times.
On June 13, 2013, the Inspector observed that three residents were asleep in their beds at 13:20hr. Their call bells were observed hanging behind the head board, on the floor, and in the waste basket and not accessible to the resident at all times .
The resident-staff communication and response system was not easily accessed by residents. (158)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 03, 2013

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2013_099188_0006, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for developing and implementing a pain management program to identify pain in residents and manage pain. The plan shall include time frames for development and implementation and identify the staff member(s) responsible for implementation. Further, the written description of the program, shall include goals and objectives, relevant policies, procedures and protocols and provide for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The licensee shall prepare, submit and implement a plan for developing and implementing a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

The plans shall be submitted in writing to Kelly-Jean Schienbein, Long Term Care
Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5 or Fax at 705.564.3133. This plan must be submitted by July 05, 2013 and fully implemented by August 30, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that the skin and wound care program is implemented in the home. On June 13, 2013, the Inspector reviewed the home's "Skin Care and Wound Management" policy which identifies that a multi-disciplinary team meets quarterly to monitor the Skin Care and Wound Management program. Staff # 100 and staff # 101 identified that there is no one "in Charge" or looking at wounds at this time. The interim DOC/Administrator identified that the former DOC/Administrator was the lead and had reviewed all the wounds in the home. The interim DOC/Administrator added that the wound care program has yet to be looked at and may need to be revamped. Although requested, the DOC/Administrator was unable to find and show the Inspector past records of multi-disciplinary team meetings held.
The policy also provides direction regarding weekly head to toe assessments and weekly assessments of altered skin, including wounds by the Skin Care and Wound Management nurse. Three residents' health care records were reviewed and there were no resident head to toe assessments found completed. Staff # 100 and staff # 101 identified that skin assessments are not routinely done and

that there is no "wound care" nurse. The Inspector noted that the quarterly and annual RAI/MDS assessments, which monitor and evaluate the interventions and reviews a resident's plan of care have not been completed for 23/50 residents. Assessments, including wound assessments for three residents were signed as completed, however, n/a (not applicable) is documented. There was no evaluation or indication that the interventions or the plan of care is effective. The licensee failed to ensure that the skin and wound care program was implemented in the home.
(158)

2. The licensee failed to ensure that the skin and wound care program is implemented in the home. On June 13, 2013, the Inspector reviewed the home's "Skin Care and Wound Management" policy, which identifies a wound treatment protocol for skin tears, stage one wounds and stage two wounds. The protocol identifies that the medical directive used to treat the wound is written on the physician's order sheet. Resident # 02 acquired a wound. It was identified in the progress notes that a medical directive was used to treat resident # 02 wound. The physician's order sheets were reviewed and the Inspector noted that there was no medical directive written for resident # 02 wound treatment.
The licensee failed to ensure that its wound protocol for a resident's wound was implemented in the home. (158)

3. On June 13, 2013, Inspector spoke with the home's Administrator/Director of Care who identified that no formal pain management program is currently developed and implemented within the home. The licensee failed to ensure that a pain management program to identify pain in residents and manage pain is developed and implemented in the home. (158)

4. The licensee did not ensure that a pain management program was developed or implemented in the home which identifies and manages pain in residents. It was noted by the Inspector that the RAI/MDS assessment was incomplete and there was no evaluation of pain in resident # 02's RAI/MDS assessment. The licensee failed to ensure that monitoring of the resident's responses to and the effectiveness of the pain management strategies were completed. A pain management program was not developed or implemented in the home which identifies and manages pain in residents, including resident # 02. (158)

5. The licensee failed to ensure that a pain management program which, at a

minimum, provides for (1) communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired, (2) strategies to manage pain, (3) comfort care measures and (4) monitoring of residents' responses to, and the effectiveness of, the pain management strategies. Inspector reviewed resident # 01's health care record, including the progress notes and medication administration records which indicated that resident # 01 has daily pain which is treated primarily with pharmacological interventions. Inspector was able to locate the admission pain assessment for this resident, however, a current pain assessment has not been completed. Inspector spoke with staff #100 who confirmed that although a pain assessment tool is available in the home, no assessment has been completed for resident # 01. The licensee failed to ensure that when a resident's pain is not relieved by initial interventions that the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.
It was also noted by the Inspector that the RAI/MDS assessment was incomplete and therefore the home failed to evaluate resident # 01 pain and monitor the resident's responses to and the effectiveness of the pain management strategies. A pain management program was not developed or implemented in the home which identifies and manages pain in residents, including resident # 01. (158)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee is required to ensure that a sufficient amount of appropriate dressing supplies are available in the home for the treatment of resident # 04 wound and the wounds of any other resident in the home experiencing altered skin integrity.

Grounds / Motifs :

1. Resident # 04 has a pressure ulcer. The physician ordered that a medicated powder be applied to resident # 04 wound twice a week. A review of resident # 04's Medication Administration Record (MAR) and progress notes by the Inspector show that the medicated powder was not available in the home and therefore not applied as ordered by the physician. The licensee failed to ensure that the required supplies to treat resident # 04 pressure ulcer were available at the home as required. (158)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 03, 2013

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 or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 28th day of June, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : KELLY-JEAN SCHIENBEIN

Service Area Office / Bureau régional de services : Sudbury Service Area Office

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 28, 2013	2013_140158_0013	S-000233-13, S-000072-13	Follow up

Licensee/Titulaire de permis

WIKWEMIKONG NURSING HOME LIMITED
2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0

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

WIKWEMIKONG NURSING HOME
2281 Wikwemikong Way, P.O. Box 114, Wikwemikong, ON, P0P-2J0

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 12, 13 , 14, 2013

Log #: S-000233-13, S-000072-13 were reviewed during this Follow-Up Inspection.

During the course of the inspection, the inspector(s) spoke with the interim Administrator/Director of Care, Registered Nursing Staff, Personal Support Workers and residents

During the course of the inspection, the inspector(s) conducted a walk through of various resident care areas, observed staff to resident interactions, reviewed health care records of residents and reviewed various policies and procedures within the home.

The following Inspection Protocols were used during this inspection:
Pain

Resident Charges

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident-staff communication and response system could be easily seen, accessed and used by residents. On June 12, 2013 at 10:30hr, the Inspector observed that three residents who were resting in their beds and one resident who was sitting in their chair, did not have access to their call bells. The call bells were observed to be hanging behind the head board, on the floor and not within the resident's reach. On June 13, 2013 at 09:50hr, the Inspector observed that two residents were asleep in their beds and two residents were sitting in their chairs. Their call bells were observed to be hanging behind the head board, on the floor, in the waste basket and hanging behind the mattress and not accessible to the resident at all times. On June 13, 2013, the Inspector observed that three residents were asleep in their beds at 13:20hr. Their call bells were observed hanging behind the head board, on the floor, in the waste basket and not accessible to the resident at all times. The resident-staff communication and response system was not easily accessed by residents. [s. 17. (1) (a)]

2. A Compliance Order was issued in the Follow Up Inspection # 2010_154_1856_08Nov102644. The Compliance Order was re-issued in Inspection # 2011_188_1856_11Mar1005111. [s. 17. (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 O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the skin and wound care program is implemented in the home. On June 13, 2013, the Inspector reviewed the home's "Skin Care and Wound Management" policy, which identifies a wound treatment protocol for skin tears, stage one wounds and stage two wounds. The protocol identifies that the medical directive used to treat the wound is written on the physician's order sheet. Resident # 02 acquired a wound. It was identified in the progress notes that a medical directive was used to treat resident # 02 wound. The physician's order sheets were reviewed and the Inspector noted that there was no medical directive written for resident # 02 wound treatment.
The licensee failed to ensure that its wound protocol for a resident's wound was implemented in the home. [s. 48. (1) 2.]

2. The licensee failed to ensure that the skin and wound care program is implemented in the home. On June 13, 2013, the Inspector reviewed the home's "Skin Care and Wound Management" policy which identifies that a multi-disciplinary team meets quarterly to monitor the Skin Care and Wound Management program. Staff # 100 and staff # 101 identified that there is no one "in Charge" or looking at wounds at this time. The interim DOC/Administrator identified that the former DOC/Administrator was the lead and had reviewed all the wounds in the home. The interim DOC/Administrator added that the wound care program has yet to be looked at and may need to be revamped. Although requested, the DOC/Administrator was unable to find and show the Inspector past records of multi-disciplinary team meetings held.
The policy also provides direction regarding weekly head to toe assessments and weekly assessments of altered skin, including wounds by the Skin Care and Wound Management nurse. Three residents' health care records were reviewed and there were no resident head to toe assessments found completed. Staff # 100 and staff # 101 identified that skin assessments are not routinely done and that there is no "wound care" nurse. The Inspector noted that the quarterly and annual RAI/MDS assessments, which monitor and evaluate the interventions and reviews a resident's plan of care have not been completed for 23/50 residents. Assessments, including wound assessments for three residents were signed as completed, however, n/a (not applicable) is documented. There was no evaluation or indication that the interventions or the plan of care is effective.
The licensee failed to ensure that the skin and wound care program was implemented in the home. [s. 48. (1) 2.]

3. The licensee failed to ensure that a pain management program which, at a

minimum, provides for (1) communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired, (2) strategies to manage pain, (3) comfort care measures and (4) monitoring of residents' responses to, and the effectiveness of, the pain management strategies. Inspector reviewed resident # 01's health care record, including the progress notes and medication administration records which indicated that resident # 01 has daily pain which is treated primarily with pharmacological interventions. Inspector was able to locate the admission pain assessment for this resident, however, a current pain assessment has not been completed. Inspector spoke with staff #100 who confirmed that although a pain assessment tool is available in the home, no assessment has been completed for resident # 01. The licensee failed to ensure that when a resident's pain is not relieved by initial interventions that the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.
It was also noted by the Inspector that the RAI/MDS assessment was incomplete and therefore the home failed to evaluate resident # 01 pain and monitor the resident's responses to and the effectiveness of the pain management strategies. A pain management program was not developed or implemented in the home which identifies and manages pain in residents, including resident # 01. [s. 48. (1) 4.]

4. The licensee did not ensure that a pain management program was developed or implemented in the home which identifies and manages pain in residents. It was noted by the Inspector that the RAI/MDS assessment was incomplete and there was no evaluation of pain in resident # 02's RAI/MDS assessment. The licensee failed to ensure that monitoring of the resident's responses to and the effectiveness of the pain management strategies were completed. A pain management program was not developed or implemented in the home which identifies and manages pain in residents, including resident # 02. [s. 48. (1) 4.]

5. On June 13, 2013, Inspector spoke with the home's Administrator/Director of Care who identified that no formal pain management program is currently developed and implemented within the home. The licensee failed to ensure that a pain management program to identify pain in residents and manage pain is developed and implemented in the home. [s. 48. (1) 4.]

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. 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, (c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Resident # 04 has a pressure ulcer. The physician ordered that a medicated powder be applied to resident # 04 wound twice a week. A review of resident # 04's Medication Administration Record (MAR) and progress notes by the Inspector show that the medicated powder was not available in the home and therefore not applied as per physician's order. The licensee failed to ensure that the required supplies to treat resident # 04 pressure ulcer were available at the home as required. [s. 50. (2) (c)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

1. The home did not ensure that resident # 01 plan of care set out clear directions for the staff and others who provide direct care to the resident. The Inspector reviewed resident # 01's health care record. Inspector noted that resident # 01 progress notes and medication administration records indicate that this resident has ongoing daily pain. Resident # 01 plan of care does not identify pain as a problem nor provide interventions to manage the pain. [s. 6. (1) (c)]

2. The licensee did not ensure that the plan of care set out clear directions for the staff and others who provide direct care to the resident.
Staff # 100 identified that resident # 03 receives daily analgesia for pain related to a previous injury and chronic pain. The resident confirmed that they have daily pain which worsens at night. Resident # 03 plan of care identifies that resident # 03 has chronic pain, however it only identifies a pharmaceutical intervention and fails to provide the staff with clear direction to manage the resident's ongoing pain as related to the resident's increase pain level at night. [s. 6. (1) (c)]

3. Resident # 04 has a pressure ulcer. The resident's plan of care identifies interventions such as, turn and reposition with skin care q2hr, ensure the mattress is inflated and check q shift and PRN.
The Inspector observed that resident # 04 was not turned every 2 hours and that the mattress was soft. The home failed to ensure that the care set out in the plan of care provided to resident # 04 as specified in the plan. [s. 6. (7)]

4. The Inspector noted that there were no resident plans of care readily available to the front line staff. Although the PSWs have access to Point of Care and a "kardex", the information on the "kardex" is not as clear, is missing information and at times conflicts with the interventions found on the resident's plan of care. The home failed to ensure that staff and others who provide direct care to a resident have convenient and immediate access to the plan of care. [s. 6. (8)]

5. Resident # 04 was diagnosed with a wound infection. A change of condition assessment was not completed. The annual MDS assessment completed after the onset of the infection did not acknowledge the wound infection nor assess or evaluate interventions related to the wound care. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the plans of care for resident # 01 and resident # 03 set out clear directions for the staff and others who provide direct care to the resident; that the care set out in the plan of care is provided to resident # 04 as specified in the plan and that resident plans of care are readily available to the front line staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. Inspector reviewed resident # 01's health care record. Inspector noted progress notes and medication administration records indicate this resident continues to have ongoing pain treated primarily with pharmacological interventions. Inspector was able to locate the admission pain assessment for this resident, however, there has been no current pain assessments completed. Inspector spoke with staff #100 who confirmed that although a pain assessment tool is available in the home no assessment has been completed for resident # 01. The licensee failed to ensure that when a resident's pain is not relieved by initial interventions that the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

2. The licensee failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. It was identified in resident # 02 RAI/MDS assessment and in the progress notes, that resident # 02 has daily pain and receives analgesia daily to manage this pain. The Inspector was not able to locate a pain assessment using a clinically appropriate assessment instrument. The Inspector spoke with staff #100 who confirmed that although a pain assessment tool is available in the home, no assessment has been completed for resident # 02. The Inspector questioned Staff # 101 about pain assessments and then staff # 101 showed the Inspector a new assessment instrument for pain assessment, which was signed by the physician on May 8, 2013. Staff # 102 and staff # 103 were unaware of the new pain assessment instrument . [s. 52. (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 ensuring that resident # 01 and resident 02 pain is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #6: 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 home did not ensure that its written medication protocols and policies were implemented.
The home has a protocol which identifies that two Registered staff are to count narcotics together and immediately sign the narcotic record.
The Inspector noted that the physician ordered a narcotic three times a day to manage resident # 01's pain.
The Inspector noted that there are 14 instances where only one Registered staff signed the narcotic record for resident # 01's narcotic. [s. 114. (3) (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 ensuring that the home's written medication protocols and policies, specifically, counting narcotics are implemented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges

The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:

1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,

i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and

ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.

2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.

3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.

4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.

5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.

6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.

7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.

8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

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1. The licensee did not ensure that residents are not charged for goods and services paid for by the Government of Canada, the Government of Ontario, including a Local health Integration Network, or a municipal government in Ontario
The Inspector reviewed Resident # 05 file in the business office and noted that there was no admission agreement identifying the resident's consent for any charges. It was also noted by the Inspector that resident # 05 was charged for supplies which are available through programs operated by the Ministry of Health and Long-term Care. [s. 245. 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 ensuring that residents are not charged for goods and services which are paid by the Government of Canada, the Government of Ontario, including a Local health Integration Network, or a municipal government in Ontario, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee did not ensure that a staffing mix that is consistent with residents' assessed care and safety needs was provided. The home's staffing schedules and staffing plan, which were reviewed by the Inspector identifies that there is a specific schedule and staffing plan for the PSWs.
Changes to this schedule/staffing plan are documented in a communication book. The Inspector reviewed this book and changes to this staffing plan were observed. The management was provided with the details on June 14, 2013. [s. 31. (3)]

2. The licensee did not ensure that their staffing plan included a back-up plan for nursing and personal care staffing which includes 24/7 RN coverage that addresses situations when staff cannot come to work. The staffing schedule for the Registered Nurses was reviewed by the Inspector. It was noted that a RN called in sick for a night shift and the home had difficulty finding a replacement. The (a) DOC/administrator identified that they would have to work as the RN if a replacement was not found. The Inspector noted that there was no written back-up plan when the scheduled staff do not come to work. [s. 31. (3)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for goods and services other than accommodation, residents are only charged if provided for under an agreement.
The licensee charged a resident for goods and services without a signed written agreement between the licensee and the resident or a person authorized to enter into an agreement on behalf of the resident. [s. 91. (1) 3.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

COMPLIED/NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2013_099188_0014	158

Issued on this 22nd day of July, 2013

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