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**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 27, 2016 | 2015_301561_0022 | H-003487-15 | Resident Quality Inspection |

### Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE BRAMPTON ON L6T 4B9

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

TALL PINES LONG TERM CARE CENTRE
1001 Peter Robertson Blvd. BRAMPTON ON L6R 2Y3

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

DARIA TRZOS (561), KATHLEEN MILLAR (527), MICHELLE WARRENER (107), SAMANTHA DIPIERO (619)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): November 09, 10, 12, 13, 16-19, 23-26, 2015**

**The following complaint inspections were completed along with the RQI: 008028-14, 008772-14, 000311-15, 008383-15, 009274-15, 028334-15, 029449-15, 018028-15, 032436-15;**

**The following Critical Incident inspections were completed along with the RQI: 008707-14, 001685-15, 002842-15, 013862-15, 022131-15, 001307-15.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC), Supervisors of Care (SOC), Manager of Facility Services, Activation Supervisor, Social Worker, Registered Dietitian (RD), Family Council Spokesperson, Resident Council Spokesperson, Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), dietary staff, housekeeping aides, family members and residents.**

**During the course of the inspection, the inspectors toured the home, observed the provision of care, observed the meal service, reviewed health care records, reviewed relevant policies, procedures and practices, maintenance and housekeeping practices, and food production systems, interviewed residents, family members and staff.**

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

**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Critical Incident Response**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **20 WN(s)**
- **9 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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).**

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

The progress notes indicated that resident #037 had a wound. The Treatment Administration record (TAR) showed that the treatment for the wound had been initiated on an identified date in 2015. The health care records were reviewed and no skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound was completed when the wound was first discovered. The home's Skin and Wound Care Program, revised August 2013, instructs the registered staff to initiate a weekly wound assessment utilizing the Bates-Jensen Assessment Tool on Point Click Care (PCC). The interview with registered staff confirmed that the resident's wound should have been assessed using the Bates-Jensen Assessment Tool in PCC.

The interview withe the Wound Care Nurse and the Acting DOC confirmed that the staff were expected to assess the resident using the Bates-Jensen Wound Assessment Tool. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that resident #037 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The progress notes on an identified date in 2015 indicated that resident #037 had a wound. The TAR indicated that treatment had been initiated. The health care records were reviewed and indicated that there were no weekly skin assessments completed for the resident's wound. The weekly skin assessments using the Bates-Jensen Assessment Tool had been started few weeks later after treatment had been initiated. According to health records the resident's wound had deteriorated.

The home's policy called "Skin and Wound Program", revised August 2013, indicated that registered nursing staff were expected to do the following for residents with pressure ulcers:
"1.Upon discovery of the pressure ulcer, initiate a weekly wound assessment utilizing the Bates-Jensen Assessment Tool on PCC".

The interview with registered staff, Wound Care Nurse and the DOC confirmed that the policy was not followed and that skin assessments using the Bates-Jensen Assessment Tool should have been completed on weekly basis.
[s. 50. (2) (b) (iv)]

3. The licensee has failed to ensure that resident #056, who had multiple areas of skin breakdown, was reassessed at least weekly by a member of the registered nursing staff.

The home's program, "Skin and Wound Care Program" revised August 2013, directed staff to complete a Bates-Jensen Weekly Wound Assessment on Point Click Care for all altered skin integrity, pressure ulcers, skin tears or wounds. The on-line tool directed staff to use a separate tool for each identified area.

Resident #056 had a Bates Jensen Wound Assessment tool completed on an identified date in 2014 that identified one wound. Progress notes for the same date identified that resident had several areas of skin breakdown. An assessment of the other identified areas was not completed using the Bates-Jensen Wound Assessment tool.

Bates-Jensen Wound Assessments completed on several dates in 2014 and 2015, used one Assessment tool for all identified open areas. The on-line tool directed staff to use a separate tool for each identified area. It was unclear from the tool which area was being assessed or if the information was consistent across all of the identified areas. Not all areas of altered skin integrity were assessed weekly and were assessed using a clinically appropriate tool.

A Bates-Jensen Wound Assessment was not completed for several weeks in 2014, and the resident's wound had deteriorated, as identified in a progress note. The Acting DOC confirmed that the home did not comply with the legislation.[s. 50. (2) (b) (iv)]

4. The licensee has failed to ensure that supplies were readily available as required to treat pressure ulcers or wounds and promote healing.

Resident #056 had multiple areas of skin breakdown that required treatment. The progress notes indicated that the supplies for treatment were available at the home on two dates in 2014. The resident also required nutritional supplement to promote wound healing. The progress notes indicated that the supplement was not available in the home on three consecutive days in 2014, as required. Staff interviewed were unclear why the supplies were not available in the home at that time. [s. 50. (2) (c)]

***Additional Required Actions:***

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

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**WN #2: 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 Skin and Wound policy, program was complied with.

The home's policy called "Skin and Wound Program", revised August 2013, indicated that registered nursing staff were expected to do the following for residents with pressure ulcers:
"9. Make a referral to Enterostomal Therapist (ET) nurse or Wound Care Nurse, Nurse Practitioner and Dietitian (for stage 2-4 and unstageable ulcers only)".

The health care records and interviews with registered staff, Wound Care Nurse and the Acting DOC confirmed that the home's policy was not followed and that staff did not refer resident #037 to the Dietitian or Wound Care Nurse when resident's wound was first discovered in 2015. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the Falls Prevention and Management Program was complied with.

The home's policy called "Falls Prevention and management Program", effective April 5, 2011 and revised August 2015, indicated that the PSW's role Post-Fall is to report any changes in the resident's condition/health status to the RN/RPN. Furthermore, the home's procedure which is also included in the training "Falls in the Elderly" from RNAO best practice guidelines instructs the staff to notify the registered staff immediately when a fall occurs.

A) The resident #050 had a fall on an identified date 2014. A PSW saw the resident on the floor but did not attend to the resident immediately. The PSW notified the registered

staff of the fall after a visitor had indicated to them that the resident was injured. The PSW failed to notify the registered staff of the resident's fall immediately after they saw them on the floor. The investigation notes and the interview with the SOC confirmed that the PSW thought that the resident was just sitting on the floor. The interview with the SOC confirmed that it was the home's expectation that the PSW was required to attended to the resident when they saw them on the floor and should have pressed the call bell in the dining room to call for help. The staff failed to follow the home's procedure related to falls.

B) The investigation notes and the interview with the Administrator indicated that on an identified date in 2015, a direct care provider transferred resident #051 using a lift without the assistance of another staff member. Resident had a fall and sustained an injury. The direct care provider did not notify the registered staff immediately after the resident sustained a fall. The direct care provider left the resident on the floor and went to look for another staff member to assist with lifting the resident off the floor. Two direct care providers then transferred the resident back to bed before notifying the registered staff about the fall. The resident was transferred to the hospital and had a significant deterioration in their health condition. The Administrator confirmed that the staff member should have stayed with the resident, called the registered staff by using the call bell and should have never moved the resident. The Administrator indicated that staff are trained annually on these procedures and should have followed the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Skin and Wound policy, and the Falls Prevention and Management Program are complied with, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident in the home was protected from abuse by anyone.

On an identified date, resident #054 was abused by one of the home's direct care providers. Registered staff who witnessed the abuse failed to properly inform the registered nurse in charge in accordance with the homes policy titled "Prevention, Reporting, and Elimination of Abuse/Neglect", policy number LTC1-05.01, revised March 24, 2014. According to the written account of the events, confirmed by the Administrator, The Registered staff removed the direct care provider from the room and failed to further ensure the safety of the resident by not conducting an immediate head to toe assessment, and also failed to remove the direct care provider from the premises immediately in accordance with the home's Abuse Policy. The Administrator confirmed that the Registered staff failed to report the witnessed abuse to the charge nurse. It was confirmed by the home's Administrator that the direct care provider who abused the resident had also been previously suspected in staff to resident abuse cases but had no plan in place for additional monitoring and supervision at the time the abuse occurred. The Administrator of the home was interviewed and confirmed that the registered staff and other direct care providers involved had received abuse training annually from the home yet failed to comply with the home's policies and procedures and did not meet the legislative requirement. [s. 19. (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 residents in the home are protected from abuse by anyone, to be implemented voluntarily.***

**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system regarding the reporting of suspected abuse was complied with.

The home's policy titled "Prevention, Reporting, and Elimination of Abuse/Neglect", policy # LTC1-05.01, revised March 24, 2014, stated that "Any person who has firsthand knowledge of abuse shall immediately inform a member of the center's staff and the Director, Performance Improvement and Compliance Branch, and MOHLTC" and "An employee who has first knowledge of abuse shall immediately inform their supervisor, or if not available the registered nurse in charge."

A) On an identified date in 2015, resident #052 reported an allegation of verbal abuse to a PSW staff. A review of the residents records indicated that registered staff and the Administrator of the home began an investigation into the allegation but did not report the allegation of abuse to the Director immediately. An interview with the Acting DOC confirmed the home's policy is to report suspected abuse to the Ministry immediately, and confirmed that the home did not meet the expectation of its own policy.

B) On an identified date in 2015, a registered staff member witnessed abuse from a direct care provider to resident #054. The registered staff member failed to notify the charge nurse or any other member of the home's administration staff of the abuse immediately. The Administrator confirmed that the home failed to report this matter to the Director immediately.(619) [s. 20. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan, policy, protocol, procedure, strategy or system regarding the reporting of suspected abuse is complied with., to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices**

**Specifically failed to comply with the following:**

**s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:**
**6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the restraining of a resident by a physical device was included in a resident's plan of care.

Resident #032 was observed having a table top tray applied outside of the meal time. Upon review of the home's restraint policy it was confirmed that Personal Assistance Services Devices (PASD's) were to be removed and reapplied at least every two hours and that they were to be used to support resident's Activities of Daily Living (ADL's), in this case, for the purpose of eating. Records of the hourly checks for the PASD and restraints indicated that the PASD was not being released and reapplied at least every two hours. During an interview with PSW staff it was confirmed that the staff left the table top tray in use for the resident for the majority of the day and did not use it solely for the purpose of a PASD to support the resident's ADL's at meal times. PSWs confirmed the table top tray was being used as a restraining device. In review of the resident's chart it was determined that there was no consent, assessment, or order for the use of the table top tray as a restraint. The Acting DOC confirmed that the table top was being used as a restraint and was not being used in accordance with the homes policy and did not meet the legislative requirement. [s. 31. (2) 6.]

***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 restraining of a resident by a physical device is included in a resident's plan of care, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

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

The investigation notes and the interview with the Administrator indicated that on an identified day in 2015, a direct care provider transferred resident #051 using a lift without the assistance of another staff member. Resident had a fall, sustained an injury and was transferred to the hospital. This incident resulted in a significant change in resident's health condition.

The home's policy called "Minimal Lift Program, policy number LTC9-05.09.04, revised June 6, 2011, was reviewed and indicated that for any mechanical lifts including, total lift, sit stand lift and a ceiling lift, two staff must be present when using the lifts. The Administrator confirmed that the direct care provider did not use a safe transferring technique while transferring the resident. [s. 36.]

***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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.***

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**WN #7: 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. The licensee has failed to ensure that when resident #056's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

Resident #056 had a documented allergy to a medication resulting in the resident not being able to take narcotic pain medications. The resident was receiving as needed medication to relieve pain. The resident's pain was not always relieved by this medication; however, the resident was not assessed using a clinically appropriate assessment instrument specifically designed for pain.

The home's policy, "Pain Management Program" revised, March 2011, directed staff to complete a Pain Assessment Tool on the computerized charting system quarterly (according to the RAI-MDS schedule), when a resident exhibited a change in health status or when pain was not relieved by initial interventions, upon readmission from hospital, and to complete weekly pain assessments on residents who were on regular pain medications.

The resident did not have pain assessments using the "Pain Assessment Tool" in their electronic health record. The Acting DOC confirmed that the resident's pain was not assessed using the Pain Assessment Tool. [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 to ensure that when resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs at the observed lunch meal on November 23, 2015.

Residents (#060, #061, #001, #004, #002) had their dessert placed on their tables prior to finishing their entrees. The residents had not asked for their dessert to be provided. The PSW who placed the desserts on the tables stated that they were leaving the dining room soon so they provided the desserts with the resident's entrees. Staff confirmed the dessert should not have been placed on the table for the identified residents prior to finishing their entrees. [s. 73. (1) 8.]

2. The licensee failed to ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and

drink as comfortably and independently as possible at the observed lunch meals November 9 and 23, 2015.

A) Resident #060 had a plan of care that required staff to use specific feeding techniques and a moderate amount of verbal cues throughout the meal. The resident also required straws for fluids and soup to assist the resident with eating and drinking. At the lunch meal on November 9, 2015, the resident was observed sleeping with a mug of soup in their hand, and a straw from the soup in the resident's mouth, without staff providing verbal prompting or specific feeding techniques for approximately 20 minutes. The resident's entree was placed on the table at 1252 hours and the resident sat with a spoonful of food sleeping and did not receive verbal encouragement or specific feeding techniques for over 20 minutes when the LTC Homes Inspector inquired about the resident.
At the lunch meal on November 23, 2015, staff placed a nosey cup of soup in the resident's hand at 1246 hours; however, the resident was unable to tip the cup up enough to get the soup out of the cup; a straw had not been provided. The resident sat with the cup in their hand trying to drink without success until staff returned at 1302 hours when the PSW provided two (teaspoons) tsp of soup from the cup which the resident ate while being fed. The PSW then left the resident and the resident again sat without eating independently until a family member arrived to feed the resident their soup at 1310 hours.

B) Resident #050 had a plan of care that required one staff to provide total assistance with eating (registered staff or full time PSW) and for the provision of a nosey cup with meals. At the lunch meal on November 23, 2015, the resident was intermittently fed by a PSW; however, the resident sat unattended by staff for long periods between assistance. The resident was not assisted with their ice cream or frozen nutritional supplement and staff intermittently provided assistance with the resident's yogurt and water. The PSW intermittently assisting the resident stated that registered staff were supposed to assist the resident but did not as they had too many residents that needed assistance with eating. The Registered Dietitian confirmed the resident required full assistance with eating. The resident was not provided the level of assistance or the assistive device required in their plan of care and the resident did not consume all of their meal.

C) Resident #062 had a plan of care that required one nursing attendant for total assistance with eating. At the lunch meal on November 9, 2015, the resident sat sleeping in-front of their soup without eating and without assistance being offered. At the lunch meal on November 23, 2015, the resident was not provided assistance with their entree.

The resident was able to consume their sandwich independently; however, at 1302 hours the resident was trying to eat texture modified salad with their fingers. The resident did not receive the required level of assistance with eating. Staff assisted the resident with their dessert; however, had not provided the required level of assistance with their entree.

D) Resident #008 had a plan of care that required supervision and reminders and encouragement with eating. At the lunch meal on November 9, 2015, the resident was not provided encouragement throughout the meal and covered their meal with a napkin and did not consume it. The meal was removed without the resident consuming anything.

E) Resident #058 had a plan of care that required limited assistance for eating and constant encouragement to complete meals. At the lunch meal on November 9, 2015, the resident did not receive constant encouragement when they sat in-front of their soup and entree not eating for extended periods of time. The resident was fed by their family member at the lunch meal November 23, 2015. [s. 73. (1) 9.]

3. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance at the observed lunch meals November 9 and 23, 2015.

Resident #003 had a plan of care that required the resident to be in an upright position with a positioning aid (pillow) used during meals. On November 9, 2015, the resident was observed with their chin extended towards the ceiling while being fed. A pillow was not in place behind the resident and the resident was not in a safe position for feeding. On November 23, 2015, the resident was observed somewhat reclined in their wheelchair with their chin extended towards the ceiling while being assisted with eating. A pillow was not in place for positioning the resident. The wheelchair was placed in an upright position after the LTC Homes Inspector inquired about the resident; however, a pillow was still not used for positioning the resident during feeding. The Registered Dietitian confirmed the resident was to be in an upright position with a positioning device in place during meal service. [s. 73. (1) 10.]

4. The licensee has failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance at the observed lunch meals November 9, and 23, 2015.

A) Resident #062 had a plan of care that required total assistance with eating. On

November 9, 2015, the resident's soup and entree were placed on the table in-front of the resident prior to assistance being provided. The resident sat sleeping at the table and did not consume their soup. The resident's entree was placed on the table at 1246 hours and assistance was not provided until 1312 hours. The resident was not eating independently without the assistance.
On November 23, 2015, the resident's soup was placed on the table at 1235 hours and assistance was provided at 1247 hours. The resident sat with their soup in-front of them while the PSW assisting at the table fed the resident beside.

B) Resident #002 had a plan of care that required total assistance with eating and drinking. On November 9, 2015, the resident's soup and beverages were placed on the table for over half an hour prior to assistance being provided to the resident. On November 23, 2015, the resident's entree was placed on the table prior to assistance being provided. Staff assisted another resident at the table first and then fed resident #002 after their entree had been sitting on the table for 10 minutes.

C) Resident #063 had a plan of care that required extensive to total assistance with eating. At the lunch meal November 23, 2015, the resident's soup was placed on the table at 1235 and the resident was assisted at 1250 hours. Staff were assisting another resident at the table while the resident's soup sat on the table. [s. 73. (2) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance and to ensure that residents who required assistance with eating or drinking are only served a meal when someone is available to provide the assistance, to be implemented voluntarily.***

**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

A) Resident #048 was transferred to the hospital for suspected ingestion of a chemical substance that was left in the resident's bathroom. The home's policy called "Storage of Chemicals", policy number LTC6-06-06, and revised November 19, 2010, directs staff to ensure that all chemicals are stored in a locked room, and if chemicals were to be used on housekeeping carts, they would be stored in the locked container when not in use. In addition, the home's policy called "Poison Control", policy number LTC9-06.02, and revised February 18, 2011, directs staff that "ALL HAZARDOUS substances must be kept locked at all times". Housekeeping aides and PSWs were interviewed and confirmed that hazardous substances were expected to be locked at all times when not in use, and never to be left in the residents' room. The Acting DOC and the Manager of Facilities were interviewed and confirmed that chemical substances were expected to be locked at all times and should not be left in resident rooms or accessible to residents.(527)

B) On November 9, 2015, at 1002 hours on the Humber Court home area, chemicals were accessible to residents in an unlocked cupboard in the recreation room. One bottle of Lemon-Eze cream cleanser, which contained a WHIMS label with a toxic symbol was given to the charge nurse who confirmed that hazardous chemical were to be kept inaccessible to residents. [s. 91.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

The health care records indicated that on an identified date in 2015, resident #051 had an external appointment with a physician and returned with a new prescription to be repeated x 6. The Registered Nurse transcribed the order as a telephone order omitting "repeat x 6". The resident received the medication for only 30 days. Resident's health condition started to deteriorate and was sent to the hospital. The attending physician at the hospital had inquired about the medication. The home had started investigating and found out that the order was transcribed incorrectly and resident did not receive the medication as prescribed. Resident had a significant change in their health condition.

The health records, investigation notes and the interviews with the Acting DOC and SOC confirmed that the registered staff had transcribed the order incorrectly resulting in a significant change in resident's health condition. The licensee failed to ensure that the medication was administered to the resident as specified by the prescriber. [s. 131. (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 drugs are administered to a resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that every resident had the right to be afforded privacy in treatment and in caring for his or her personal needs.

On November 9, 2015, in the Woodhill Court home area, a resident was on the toilet of the spa room with the door to the room left open. The PSW attending the resident stated that the door was kept open so they could check on the resident every few minutes. The resident was not afforded privacy while on the toilet. [s. 3. (1) 8.]

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**WN #12: 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).**

**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 licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) The progress notes indicated that the POA raised a concern related to resident #050's undershirt being tied under the resident. The staff interviewed indicated that the undershirt was tied to the side and when resident was checked they did not notice it. The written plan of care was reviewed and indicated that the resident had behaviours of disrobing. This was also confirmed by staff. Tying the undershirt was not part of the intervention to address the behaviour. The Acting DOC confirmed that this was not part of the plan of care and that the undershirt should not have been tied.(561)

B) The resident #056's plan of care directed staff to ensure the resident's hair was washed on bath days and the resident was to receive a bed bath twice weekly. Documentation over a three month period, December 2014 to February 2015, reflected the resident had their hair washed 5 times during this time period and refused twice. The resident did not have their hair washed on 19 bath days over the three month period. Documentation did not reflect the resident refused or rationale for not washing the resident's hair during those bath days. The Acting DOC confirmed when staff documented "No" on the flow sheets the hair was not washed. PSW staff that provided care to the resident were unable to remember why the care was documented as not being provided. The Hairdresser confirmed the resident was not routinely having their hair washed through the hairdresser, only for special occasions or every few weeks prior to December 2014. The care set out in the plan of care in relation to having the resident's hair washed on bath days was not provided to the resident as specified in their

plan. [s. 6. (7)]

2. The licensee failed to ensure that the plan of care was reviewed and revised when the residents care needs changed.

Resident #055 was assessed as a high risk for falls in August 2015. The resident was assessed to be in need of interventions to prevent falls including a bed alarm as stated in the plan of care. During an observation of the resident's room on November 23, 2015, it was determined that there was no bed alarm in place. During an interview with the SOC it was determined that the bed alarm was removed because it was causing sleep disturbances to the resident and instead a chair alarm was being used effectively as a bed alarm. The SOC confirmed that this information was not updated or revised in the plan of care and confirmed that this did not meet the legislative requirement. [s. 6. (10) (b)]

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #056 had a plan of care related to pain.

Documentation in the progress notes between January and March 2015, identified the resident was having pain related to their health condition and the resident was receiving medication for the treatment of pain. The resident's written plan of care did not include pain. The Acting Director of Care confirmed pain should have been included on the resident's written plan of care. [s. 26. (3) 10.]

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**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care**

**Specifically failed to comply with the following:**

**s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #056 received preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The resident's plan of care identified that a family member would cut the resident's toenails while they were visiting. The Acting DOC confirmed that when residents or families refused to pay for foot care services families were required to cut the resident's toenails.

Resident #056 did not have their toenails routinely cut and monitored by staff. The Acting DOC stated the resident was quite independent prior to going to the hospital in 2014; however, their care needs changed after re-admission to the home. There was no evidence the resident had their toenails cut between the return from hospital in August 2014, to October 2014. The resident was seen by Foot Care as a one time service in October 2014.[s. 35. (1)]

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**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:**
**1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).**
**2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).**
**3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).**
**4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the written approach to care included the identification of behavioural triggers that resulted in responsive behaviours.

The review of the triggered MDS data in 2015, indicated an increase in responsive behaviours for resident #024. It was determined that there had been an increase in responsive behaviours from the resident during the residents second quarter in the home. On review of the resident's plan of care, behavioural interventions had been identified within the resident's care plan however; no behavioural triggers had been identified by staff. An interview with registered staff confirmed that the resident had not been referred to the BSO for further assessment in regards to identifying behavioural triggers and managing responsive behaviours. An interview with the Acting DOC confirmed that this did not meet the homes expectation for the management of responsive behaviours, nor did it meet the legislative requirement. [s. 53. (1) 1.]

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**WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council**

**Specifically failed to comply with the following:**

**s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council Meeting Minutes from January 01, 2015 until November 11, 2015 identified that not all concerns or recommendations received were responded to in writing within ten days.

Meeting minutes for October 14, 2015 included questions related to the sheers that were removed and whether new ones were being provided, possibility of more parking lot space and inquiries related to meals and snacks. These concerns were not responded to by the licensee.

Meeting minutes for November 11, 2015 included a concern related to the cigarette butts left on the ground piling up in front of the Tall Pines. This concern was not responded to by the licensee.

Interview with the Administrator confirmed that these concerns were not responded to by the licensee within 10 days. [s. 57. (2)]

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**WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the planned menu items were offered and available at the observed lunch meal on November 9, 2015, in one of the home areas.

The planned menu included bread to be offered to residents receiving the hot entree (Salisbury steak, peas, and hashbrowns or mashed potatoes). Bread and pureed bread were available for service; however, were not offered to residents at the observed meal. The Dietary Aide portioning the meal stated that the pureed bread was only available for residents receiving a pureed sandwich. None of the residents in the dining room receiving the hot meal entree were offered bread with their meal (all textures) as per the planned menu, resulting in reduced nutritional value of the meal (reduced number of grain servings, calories, fibre, B vitamins, etc.).

The planned menu included milk to be offered at meals. Only two residents were offered milk during the observed meal service. Four out of 27 residents in that dining room had a plan of care that restricted milk products. Residents who were unable to voice their preferences to staff were also not offered or provided milk with meals and their plans of care did not indicate that staff were not to offer milk. Staff were unclear why residents were not offered milk when questioned by the Inspector. At the observed lunch meal service on November 23, 2015, 16 or more residents in the same home area were offered and provided milk which most of the residents consumed.

The licensee has failed to ensure that the planned menu items were offered and available at the observed lunch meal November 23, 2015, for resident #050. The resident had a planned menu that required 250 mL of milk to be served in a nosey cup with meals. The resident was not offered the milk, as per the planned menu at the observed meal.

The nutritive value of the meals was reduced when the planned menu items were not offered at the observed lunch meals. [s. 71. (4)]

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**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
5. A medication incident or adverse drug reaction in respect of which a resident was taken to hospital.

On an identified date in 2015, resident #051 had an external appointment with a physician and returned with a prescription for a medication to be repeated x 6 after 30 days. The Registered Nurse transcribed the order as a telephone order omitting "repeat x 6". Resident's health condition started to deteriorate and resident was sent to the hospital. The medication error was discovered when the physician from the hospital inquired about the medication.
The review of the health records and investigation notes indicated that a medication incident was not reported to the Director within one business day after the occurrence. The Administrator confirmed that the home was in non-compliance with the legislation in relation to reporting of this incident. [s. 107. (3) 5.]

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**WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs were stored in an area or medication cart,
(i) that is used exclusively for drugs and drug-related supplies.

The licensee failed to ensure that staff using the double locked narcotic box was used exclusively for drugs and drug related supplies. On November 19, 2015 at 1020 hours the narcotic box located inside the medication cart used for the home area of Castlemore Court was unlocked by registered staff. It was determined that personal items that were not narcotic medications were located inside. These personal items included an envelope containing a spare key to the spa room, a thin gold coloured ring, as well as a small zippered pouch that contained a red beaded necklace. The Acting DOC confirmed that only drugs or drug related items were to be stored in this area, and confirmed that the home did not meet the legislative requirement. [s. 129. (1) (a)]

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**WN #20: 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 failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program.

A) On November 9, 2015 during the initial tour of the entire home, a total of three home areas, specifically spa tub rooms and spa shower rooms were found to have unlabeled used personal hygiene products. Registered staff confirmed that personal hygiene items should be labeled in accordance with the homes infection prevention and control policy. The Acting DOC confirmed that personal hygiene products should have been labeled and confirmed that the home did not meet the legislative requirement.(619)

B) On November 10, 2015 at 1136 hours, a Spa Room on the second floor, room 2110, had unlabeled care products. Staff confirmed all personal care items used for residents were to be labeled for each individual resident. The Spa Room contained:  two opened jars of petroleum jelly, one used men's Old Spice stick deodorant, and one used generic bottle of roll on deodorant. [s. 229. (4)]

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**Issued on this 10th day of February, 2016**

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

**Original report signed by the inspector.**

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**

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | DARIA TRZOS (561), KATHLEEN MILLAR (527), MICHELLE WARRENER (107), SAMANTHA DIPIERO (619) |
| **Inspection No. / No de l'inspection :** | 2015_301561_0022 |
| **Log No. / Registre no:** | H-003487-15 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Jan 27, 2016 |
| **Licensee / Titulaire de permis :** | THE REGIONAL MUNICIPALITY OF PEEL<br>10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9 |
| **LTC Home / Foyer de SLD :** | TALL PINES LONG TERM CARE CENTRE<br>1001 Peter Robertson Blvd., BRAMPTON, ON, L6R-2Y3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Rejane Dunn |

To THE REGIONAL MUNICIPALITY OF PEEL, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

**Order # / Ordre no :** 001

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

**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 shall prepare, submit, and implement a plan to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
The plan shall include, but is not limited to:

1. A review of all residents with altered skin integrity in the home to ensure that these residents are being assessed weekly including supporting documentation of the review
2. Mandatory education to all registered staff in relation to skin and wound program, specifically around weekly reassessment of all wounds using a clinically appropriate tool
3. Develop and implement an audit process to ensure that skin and wound policies and procedures are being complied with by staff.

The plan shall be submitted electronically to Long Term Care Homes Inspector, Daria Trzos, by February 12, 2016 to: Daria.Trzos@ontario.ca. The plan is to be complied with by: April 15, 2016.

**Grounds / Motifs :**

1. The licensee has failed to ensure that resident #056, who had multiple areas of skin breakdown, was reassessed at least weekly by a member of the registered nursing staff.

The home's program, "Skin and Wound Care Program" revised August 2013, directed staff to complete a Bates-Jensen Weekly Wound Assessment on Point Click Care for all altered skin integrity, pressure ulcers, skin tears or wounds. The on-line tool directed staff to use a separate tool for each identified area.

Resident #056 had a Bates Jensen Wound Assessment tool completed on an identified date in 2014 that identified one wound. Progress notes for the same date identified that resident had several areas of skin breakdown. An assessment of the other identified areas was not completed using the Bates-Jensen Wound Assessment tool.

Bates-Jensen Wound Assessments completed on several days in 2014 and 2015, used one Assessment tool for all identified open areas. The on-line tool directed staff to use a separate tool for each identified area. It was unclear from the tool which area was being assessed or if the information was consistent

across all of the identified areas. Not all areas of altered skin integrity were assessed weekly and were assessed using a clinically appropriate tool.

A Bates-Jensen Wound Assessment was not completed for several weeks in 2014, and the resident's wound had deteriorated, as identified in a progress note. The Acting DOC confirmed that the home did not comply with the legislation. (107)

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The progress notes on an identified date in 2015 indicated that resident #037 had a wound. The TAR indicated that treatment had been initiated. The health care records were reviewed and indicated that there were no weekly skin assessments completed for the resident's wound. The weekly skin assessments using the Bates-Jensen Assessment Tool had been started few weeks later after treatment had been initiated. According to health records the resident's wound had deteriorated.

The home's policy called "Skin and Wound Program", revised August 2013, indicated that registered nursing staff were expected to do the following for residents with pressure ulcers:
"1.Upon discovery of the pressure ulcer, initiate a weekly wound assessment utilizing the Bates-Jensen Assessment Tool on PCC".

The interview with registered staff, Wound Care Nurse and the DOC confirmed that the policy was not followed and that skin assessments using the Bates-Jensen Assessment Tool should have been completed on weekly basis.
(561)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Apr 15, 2016

## 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.

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 27th day of January, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Daria Trzos

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office