Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 16, 2021	2021_575214_0014	006701-21, 014606-21, 015271-21	Complaint

Licensee/Titulaire de permis

955464 Ontario Limited
3700 Billings Court Burlington ON L7N 3N6

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

Millennium Trail Manor
6861 Oakwood Drive Niagara Falls ON L2E 6S5

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

CATHY FEDIASH (214), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 5, 8, 9, 10, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25, and 26, 2021.

This inspection was conducted concurrently with Critical Incident System (CIS) inspection #2021_5757214_0015.

The following intakes were conducted during this complaint inspection:

-015271-21- related to prevention of abuse and neglect, skin and wound, safe and secure home, reporting and complaints;
-014606-21- related to safe and secure home;
-006701-21- related to continence care, skin and wound, nutrition, nursing and personal support services, reporting and complaints.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOCs), Nurse Practitioner (NP), Resident Assessment Instrument (RAI) Coordinator, physiotherapist (PT), Environmental Services Lead Hand (ESLH), maintenance staff, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), family members and residents.

During the course of the inspection, the inspectors reviewed relevant records, including but not limited to clinical health records, maintenance requisitions, invoices, complaint records, medication incidents, policies and procedures, and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care

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

- **8 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that two residents who exhibited altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff.

a) A resident had two alterations to their skin integrity.

A specified assessment reviewed for a period of five weeks, identified the resident had not had both of their alterations to their skin integrity reassessed weekly for four of the weeks reviewed.

It was confirmed that each area of altered skin integrity required an individual weekly reassessment and was not to be combined using one assessment tool. It was confirmed weekly reassessment for each area of altered skin integrity were to be completed and had not been.

b) A second resident had an identified alteration to their skin integrity.

A review of a specified assessment, and confirmed by staff, indicated the resident's altered skin integrity had not been reassessed for a period of three weeks.

When alterations to skin integrity are not reassessed on a weekly basis, there is a potential risk for the altered area(s) to decline, resulting in delay in assessing if current treatments are effective or ineffective.

Sources: resident progress notes and assessments, and interviews with the DOC and other staff. [s. 50. (2) (b) (iv)]

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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that medication incidents involving three residents, were reported to the resident, the resident's substitute decision-maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

a) On a specified date, a registered staff member attempted to administer medications to an identified resident, at a specified time. The resident was not prescribed any medications at this time of the day and informed the staff. No medications were administered, and the incident was determined to be a near miss.

The ADOC was made aware, who in turn notified the DOC; however, there was no place on the form for the DOC to acknowledge they had been made aware. The form listed notification to the Prescriber and Medical Director; however, this was documented as not required. The incident form had not provided a place to notify if the resident or the registered nurse in the extended class, if attending to the resident, had been made aware.

b) On a specified date, an identified resident's medication was missing.

The DOC and the prescriber of the medication had been notified. The area on the form to notify the family, Medical Director and Pharmacy were documented as not required or not applicable. The resident, their SDM, the Medical Director and the pharmacy had not been notified. The incident form had not provided a place to notify if the resident or the

registered nurse in the extended class, if attending to the resident, had been made aware.

c) On a specified date, an identified resident consumed a co-resident's medications. No identified ill effects were noted to this resident.

Under Medical Director, it was documented that the DOC had been notified. Under pharmacy notification, it was documented as not applicable. The incident form had not provided a place to notify if the resident or the registered nurse in the extended class, if attending to the resident, had been made aware.

It was confirmed a near miss was considered a medication incident. It was confirmed that all persons required to be notified of a medication incident had not been and the incident form had not contained a place to notify all persons who were required to be notified.

When all required persons are not notified, this negates the legislative requirement to notify all required persons and does not allow for those required to review trends and patterns with the goal to enhance the medication management system by reducing medication incidents and preventing harm to the resident.

Sources: residents medication incidents, and interviews with the Administrator and DOC. [s. 135. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 failed to ensure that there was a written plan of care for a resident related to their continence care.

A resident had a specified assessment conducted on admission. Their plan of care had not identified their continence care needs. Staff confirmed required interventions related to this assessment which were not in the written plan of care.

Sources: residents care plan, and interviews with PSW staff and the resident. [s. 6. (1) (a)]

2. The licensee failed to ensure that a written plan of care that set out clear directions to staff and others who provided direct care, was in place for a resident and their altered skin integrity treatments.

A resident had two alterations to their skin integrity, to an identified limb.

Two different treatments were in place, each with a specified time and day of administration.

Staff confirmed the treatment orders had not set out clear directions as they had not specified which area of the limb , they were to be applied to.

When treatment orders are not clear in their direction, this has the potential for treatment not being applied in a consistent manner; difficulty in determining if the treatment is effective; and potential for decline to the alteration in skin integrity.

Sources: residents electronic physician orders, eTAR, and interviews with Registered staff and others. [s. 6. (1) (c)]

3. The licensee failed to ensure that a treatment plan of care for a residents altered skin integrity, was based on the resident’s assessments.

The resident had an identified area of altered skin integrity. The alteration declined, over a three week period.

Since the onset of the area, specified assessments conducted on five different dates identified different treatments had been conducted.

No physician orders or treatment plan had been in place until nine weeks later, following the identified altered skin integrity.

When no plan is in place for treatments for altered skin integrity, there is a potential for inconsistent practice as there is no direction to staff which can result in the inability to assess effectiveness of treatments applied and the potential for the alteration to decline.

Sources: residents progress notes, assessments, eTAR, physician order’s, and interview with the DOC. [s. 6. (2)]

4. The licensee failed to ensure that care set out in two resident's plans of care, related to altered skin integrity treatments and interventions was provided.

a) A resident had two alterations to their skin integrity.

Two different treatments were in place, each with a specified time and day of administration.

Documentation and interviews confirmed the prescribed treatments were not provided to the resident as specified in their plan.

b) A resident had an identified area of alteration to their skin integrity.

Their care plan specified an intervention had been put in place for their altered skin integrity. Observations conducted nine weeks later, identified the intervention had not been in place.

Interviews confirmed the intervention had not been in place and was put into place, two days later, following the observations.

When the care that has been assessed for the resident with altered skin integrity is not provided, this has the potential to cause further decline and harm to the affected area(s).

Sources: resident progress notes, care plans, observations, and interviews with the DOC and other staff. [s. 6. (7)]

5. The licensee failed to ensure that a resident's plan of care had been reviewed and revised when their care needs changed in relation to interventions in place for their altered skin integrity.

A resident had an identified area of alteration to their skin integrity.

Their care plan specified an intervention had been put in place for their altered skin integrity. Observations conducted nine weeks later, identified the intervention was not in place.

It had been identified that this intervention had been removed as it had not met the needs of the resident. Interviews with staff identified it was unknown when the intervention had been removed and it was confirmed the resident's plan of care had not been reviewed and revised when their care needs changed. Following this review, it was confirmed a new intervention had now been implemented.

Sources: residents care plan, progress notes, assessments, interview and observation with the resident, and interviews with the DOC and ADOC. [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 to ensure that there is a written plan of care that sets out the planned care for the resident; clear directions to staff and others who provide direct care to the resident; is based on an assessment of the residents and their needs and preferences; is provided to the resident as specified in their plan; and to ensure that the resident is reassessed and the plan of care is reviewed and revised when their care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure their policy and the pharmacy policy in regard to medication incidents, was in compliance with and implemented in accordance with all applicable requirements under the Act.

In accordance with LTCH Act, 2007, s. 8 (1), and in reference to O. Reg. 79/10, s. 114 (2), the licensee was required to have written policies developed for the medication management system to ensure accurate storage, administration and disposal of all drugs used in the home.

In accordance with LTCH Act, 2007, s. 8 (1), and in reference to O. Reg. 79/10, s. 135 (1) (b), the licensee was required to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Both the licensee and pharmacy policies related to medication incidents and adverse drug reactions, had not included all persons who were required to be notified. It was confirmed the policies had not met the legislative requirements identified.

Sources: the licensee's Medication Incident policy, (#CN-M-03, and last revised February 25, 2020), and the pharmacy's policy, Medication Incident policy (#9-1, reviewed August 2021), and interviews with the Administrator and DOC. [s. 8. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the licensee's and pharmacy's policies, in regard to medication incidents and adverse drug reactions, is in compliance and implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that strategies were developed and implemented to respond to a resident who demonstrated responsive behaviours.

A resident had a history of specified, responsive behaviours.

On an identified date, the resident eloped and was brought back to the home. No injuries were reported.

The resident's current plan of care and an interview with staff confirmed the plan had not included strategies or interventions to manage the specified responsive behaviours.

There was potential for harm to the resident when strategies and interventions were not implemented to manage the responsive behaviours.

Sources: residents care plan, progress notes, and interview with the DOC. [s. 53. (4) (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, for each resident demonstrating responsive behahaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure electrical and non-electrical equipment, including mechanical lifts, were kept in good repair, and maintained and cleaned at a level that met manufacturer specifications.

a) Ceiling lifts, an electric bath chair and a bathtub were identified to not be in good working condition.

It was confirmed the home was not aware of some ceiling lifts and the bathtub, not being in good working condition.

The home used an electronic maintenance referral system and confirmed that policies and procedures had not been created and implemented for the use of this system.

When policies and procedures are not developed and implemented, this can result in an inconsistent approach to ensure equipment that is not in good repair is not used and reported in a timely manner for repair.

b) Review of maintenance records for mechanical lifts, over a period of four years, indicated this equipment had not been maintained at a level that met manufacturer specifications for two of the four years. It was indicated that one of the years was due to the pandemic.

The licensee's policy directed the home to set up a schedule for mechanical lifts, ensuring servicing by qualified technicians, annually.

Staff confirmed that procedures for the mechanical lifts, had not been implemented, as required.

When policies and procedures for ensuring that equipment is serviced at specific intervals, in order to keep in good repair and maintained, are not implemented, this has the potential for equipment to break down prematurely, and places residents and staff who use the equipment, at risk for harm.

Sources: the licensee’s maintenance services policy (#CE-02-02, and last revised on June 2019), maintenance requisitions, and interview with staff. [s. 90. (2) (a)]

2. The licensee failed to ensure that procedures were developed and implemented to ensure all equipment were kept in good repair.

The foot board on a resident bed was identified to be cracked in half and a second resident bed was observed to have the head and foot board in disrepair. It was confirmed that referrals reporting this equipment, had not been received.

When policies and procedures are not developed and implemented, this can result in an inconsistent approach to ensure equipment that is not in good repair is not used and reported in a timely manner for repair.

Sources: observation of two rooms, and interviews with a resident and staff. [s. 90. (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 procedures are developed and implemented to ensure that all equipment, including electrical and non-electrical equipment and mechanical lifts are kept in good repair and maintained at a level that meets manufacturer specifications, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home for two residents, that included the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

The licensee's policy indicated all complaints, verbal and written were to be recorded on the complaints log.

a) A complainant had indicated they had a concern in the first quarter of a specified year and reported this to the Administrator, in charge, at the time and had not heard back. The home had a change in management staff following this time and the complainant indicated a meeting did take place to resolve their concerns; however, they requested to know a specific outcome, as they indicated they had not been made aware.

It was confirmed that a conference had taken place and it was believed the concern had been addressed.

A review of the home’s complaint log indicated the first logged complaint/concern had been entered mid way through the year. No entries prior to this time period had been documented. It was confirmed the details of the discussion at the conference had not been documented onto the complaint log.

b) During a meeting with the home to review a resident's care need, it was indicated the resident’s family had verbalized concerns to them, regarding the care need. Staff confirmed they had spoken with family during the summer months.

A review of the home’s complaint log contained no documented entries of the verbalized concern. It was confirmed the concerns had not been documented on the complaint log.

The home had a change in management during the identified year. It was confirmed the complaint log had previously been stored in a specified electronic file, that was unable to be located for the time frame reviewed.

When there is no documented record in the home of all complaints received, that meet the identified requirements, this minimizes the home's ability to analyze patterns and trends and evaluate the effectiveness of approaches implemented.

Sources: the licensee’s complaints procedures policy (#CA-02-14, and last revised December 7, 2020), home’s complaint log, and interviews with staff. [s. 101. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that written physician orders for a resident, were maintained.

A resident had two alterations to their skin integrity. Electronic records indicated treatment had been in place.

Review of the resident's chart and interviews with staff confirmed the written physician orders were unable to be located.

Sources: residents electronic and paper chart, and an interview with staff. [s. 231. (a)]

Issued on this 22nd day of December, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	CATHY FEDIASH (214), ROSEANNE WESTERN (508)
Inspection No. / No de l’inspection :	2021_575214_0014
Log No. / No de registre :	006701-21, 014606-21, 015271-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 16, 2021
Licensee / Titulaire de permis :	955464 Ontario Limited 3700 Billings Court, Burlington, ON, L7N-3N6
LTC Home / Foyer de SLD :	Millennium Trail Manor 6861 Oakwood Drive, Niagara Falls, ON, L2E-6S5
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Cindy Harbridge

To 955464 Ontario Limited, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / No d'ordre : 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 must be compliant with s. 50 (2) (b) (iv) of O. Reg. 79/10.

Specifically, the licensee shall prepare, submit and implement a plan to ensure the identified residents, and any other residents who exhibit altered skin integrity, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The plan must include but is not limited to:
a) The person(s) responsible for identifying all residents who exhibit altered skin integrity.

b) The person(s) who will be responsible for ensuring weekly reassessments are completed.

d) The person(s) responsible for implementing training to all staff who are required to complete weekly reassessments of altered skin integrity. This training shall be documented and include the names of all staff, their designation, and date training provided. Training records shall be retained.

e) An auditing schedule to ensure that resident's who require weekly reassessment of their altered skin integrity, receive this. Auditing shall continue until no further concerns arise with the completion of the weekly reassessments. Documentation of the audits shall be retained.

Please submit the written plan for achieving compliance for inspection 2021_575214_0015 to Cathy Fediash, LTC Homes Inspector, MLTC, by email to HamiltonSAO.moh@ontario.ca by January 4, 2022.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure that two residents who exhibited altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff.

a) A resident had two alterations in their skin integrity.

A specified assessment reviewed for a period of five weeks, identified the resident had not had both of their alterations to their skin integrity reassessed weekly for four of the weeks reviewed.

It was confirmed that each area of altered skin integrity required an individual weekly reassessment and was not to be combined using one assessment tool. It was confirmed weekly reassessment for each area of altered skin integrity were to be completed and had not been.

b) A second resident had an identified alteration to their skin integrity.

A review of a specified assessment, and confirmed by staff, indicated the resident's altered skin integrity had not been reassessed for a period of three weeks.

When alterations to skin integrity are not reassessed on a weekly basis, there is a potential risk for the altered area(s) to decline, resulting in delay in assessing if current treatments are effective or ineffective.

Sources: resident progress notes and assessments, and interviews with the DOC and other staff. [s. 50. (2) (b) (iv)]

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

Severity: There was minimal risk of harm as both residents had the potential for their altered skin integrity to decline when the areas were not reassessed on a weekly basis.

Scope: The scope of the non-compliance was identified as a pattern. One other resident with altered skin integrity was reviewed during this inspection and received weekly assessments.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10 s. 50 (2) (b) (iv) and two Written Notifications (WN), and two Voluntary Plans of Correction (VPC) were issued to the home.

(214)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Apr 29, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Order / Ordre :

The licensee must be compliant with s. 135 (1) (b) of O. Reg. 79/10.

Specifically, the licensee must:

a) Ensure a procedure is in place to notify all required persons, of every medication incident and every adverse drug reaction involving residents.

b) If the licensee continues to use their current electronic form to document medication incidents and adverse drug reactions, to ensure this form contains an area to document all required persons have been notified.

c) Ensure the implementation of any new or updated forms used to document medication incidents and adverse drug reactions, through training of all staff who are required to complete these forms.

d) This training shall be documented and include the names of all staff, their designation, and date training provided. Training records shall be retained.

Grounds / Motifs :

1. The licensee failed to ensure that medication incidents involving three residents, were reported to the resident, the resident's substitute decision-maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

a) On a specified date, a registered staff member attempted to administer medications to an identified resident, at a specified time. The resident was not prescribed any medications at this time of the day and informed the staff. No medications were administered, and the incident was determined to be a near miss.

The ADOC was made aware, who in turn notified the DOC; however, there was no place on the form for the DOC to acknowledge they had been made aware. The form listed notification to the Prescriber and Medical Director; however, this was documented as not required. The incident form had not provided a place to notify if the resident or the registered nurse in the extended class, if attending to the resident, had been made aware.

b) On a specified date, an identified resident's medication was missing.

The DOC and the prescriber of the medication had been notified. The area on the form to notify the family, Medical Director and Pharmacy were documented as not required or not applicable. The resident, their SDM, the Medical Director and the pharmacy had not been notified. The incident form had not provided a place to notify if the resident or the registered nurse in the extended class, if attending to the resident, had been made aware.

c) On a specified date, an identified resident consumed a co-resident's medications. No identified ill effects were noted to this resident.

Under Medical Director, it was documented that the DOC had been notified. Under pharmacy notification, it was documented as not applicable. The incident form had not provided a place to notify if the resident or the registered nurse in the extended class, if attending to the resident, had been made aware.

It was confirmed a near miss was considered a medication incident. It was confirmed that all persons required to be notified of a medication incident had not been and the incident form had not contained a place to notify all persons who were required to be notified.

When all required persons are not notified, this negates the legislative requirement to notify all required persons and does not allow for those required to review trends and patterns with the goal to enhance the medication management system by reducing medication incidents and preventing harm to the resident.

Sources: residents medication incidents, and interviews with the Administrator and DOC. [s. 135. (1)]

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

Severity: No harm or risk was identified in relation to the three identified residents reviewed.

Scope: This non-compliance was widespread as three out of three medication incidents reviewed identified that not all required persons had been notified.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10 s. 135 (1) (b) and one Voluntary Plans of Correction (VPC) were issued to the home.

(214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 13, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16th day of December, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cathy Fediash

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