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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 10, 2018	2017_624196_0016	017636-17, 022498-17, 022500-17, 022503-17	Follow up

Licensee/Titulaire de permis

RIVERSIDE HEALTH CARE FACILITIES, INC.
110 VICTORIA AVENUE FORT FRANCES ON P9A 2B7

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

RAINYCREST
550 OSBORNE STREET FORT FRANCES ON P9A 3T2

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

LAUREN TENHUNEN (196), KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 20 - 24, 2017.

This Follow Up inspection was conducted for:

- Compliance Order (CO) #001 issued in inspection report #2017_435621_0017 regarding accommodation services - maintenance, s.15(2)(c);

- Compliance Order (CO) #001 issued in inspection report #2017_463616_0011 regarding abuse, s.19(1);

- Compliance Order (CO) #002 issued in inspection report #2017_463616_0011 regarding plan of care, s.6(7); and

- Compliance Order (CO) #003 issued in inspection report #2017_463616_0011 regarding the skin and wound care program, r.48(1)2.

Complaint inspection #2017_624196_00018 and Critical Incident System (CIS) inspection #2017_624196_0017 were inspected concurrently. As a result, findings of non-compliance related to LTCHA 2007, S.O.2007, c.8., s.6.(7) identified in the aforementioned inspection reports, will be reflected in this Follow Up report.

During the inspection, the Inspectors conducted a walk through of resident care areas, observed staff to resident interactions, observed the provision of care and services to residents, reviewed various home policies, procedures and training records, and reviewed resident health care records.

During the course of the inspection, the inspector(s) spoke with with the Administrator, the Director of Care (DOC), the Assistant Director of Nursing (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Resident Assessment Instrument (RAI) Coordinator, the Nurse Practitioner [RN (EC)], the Wound Care Lead, the Environmental Services Manager (ESM), a Therapeutic Recreationist, Administrative Receptionist, Dietary Aide, Cook, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Family Council
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During the inspection, resident #003 was identified as requiring skin and wound care treatment.

Inspector #196 reviewed resident #003's health care records, including a treatment record, which noted an area of altered skin integrity. The care plan, had a focus of altered skin integrity which identified, the specific type and location of the altered skin integrity and a type of device to prevent further injury.

The PSW binder contained a care plan focus of altered skin integrity which was last updated on a specific date in 2017; the care plan noted the location and type of altered skin integrity, and did not include the type of device to prevent further injury.

During observations on a specific date during the inspection, the device was not present on resident #003.

During an interview, PSW #126 reported to the Inspector that they had provided care to this resident, "this morning". They denied knowledge that a device was to be used; they indicated that there was no device in the resident's room. In addition, the PSW stated that resident #003 had always had an area of altered skin integrity but there had been no protective covering in place on that same morning when care was provided. They went

on to say they hardly ever read the care plan.

During the inspection, RPN #106 confirmed to the Inspector that there was no device present on resident #003. They further reported that the electronic care plan, with the focus of altered skin integrity, identified the use of a device as an intervention and that a device should have been in place.

RN #105 reported to Inspector #196 that the care plan located in the PSW binder had not been updated with the current altered skin integrity treatment for resident #003. [s. 6. (1) (c)]

2. 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.

Inspector #196 followed up on outstanding Compliance Order (CO) #002 issued during inspection #2017_463616_0011, with a compliance date of November 1, 2017. The CO required the home to:

- Prepare, submit and implement a plan for achieving compliance to ensure that for every resident in the home, staff provide care as specified in each resident's plan of care, including the planned skin and wound care for resident #014.
- Submit the plan by September 27, 2017, and fully implement the plan by November 1, 2017.

During observations made on November 21, 2017, at 1715hrs, Inspector #196 noted resident #014 had a device in place on a part of their body and there was no device on another part of their body.

During an interview, RPN #102 confirmed to the Inspector that resident #014 did not have a device in place on a part of their body.

The Inspector observed a sign above the resident's bed which identified the use of a device on two parts of the resident's body.

During an interview with RPN #102, they acknowledged the sign posted above resident #014's bed had indicated the resident was to have a device on two parts of the resident's body.

The Inspector reviewed resident #014's health care records. The care plan that was located within the PSW assignment binder, included the focus of, Activity of Daily Living, and the intervention, to have a device on two parts of the resident's body; also that the devices were to be used at all times; and specified the reason for their use. Another focus in the care plan, included the same intervention.

In an interview, PSW #126 reported to the Inspector that they did not have time to read the resident's care plan and that they were not sure if the device was to be on one part of the body or on both. In a subsequent interview, PSW #126 confirmed to the Inspector that this resident was to have the device on both parts of their body, as was indicated on the sign in the resident's room.

During an interview with the DOC, they reported to the Inspector that PSWs were responsible for reading the care plans and to be aware of interventions included in the plans of care. [s. 6. (7)]

3. As part of the follow-up to CO #003, regarding the licensee's implementation of a skin and wound care program, resident #014 was identified as requiring skin and wound care treatment.

Inspector #196 reviewed the health care records for resident #014 for information regarding skin and wound care.

On a date, RN (EC) #104 had ordered a specific treatment for area "A" on resident #014's body.

The RN (EC) had also ordered a specific treatment for a different area, "B" of resident #014's body.

On a subsequent date, the physician ordered treatment for area, "A" of resident #014's body.

The wound care flow sheet for area, "A" identified the particular treatment and the frequency of treatment and specified the days it was to be completed.

The treatment record document for area, "B" indicated a specific treatment.

During an interview with Inspector #196, RN #105 confirmed that the current care plan

identified the correct ordered treatment for both area, "A" and "B". Upon review of the wound care flow sheet for area "A", RN #105 confirmed that the MD/RN (EC) order had not been transcribed onto the wound care sheet correctly; therefore, the wrong treatment was provided to the resident on two different dates, in 2017.

During an interview with RN (EC) #104 they confirmed to the Inspector that for area, "A", the staff were to follow the most current physician or RN (EC) order.

During an interview with RN #105, they reviewed with the Inspector the treatment record document for area, "B" and confirmed that on three different dates in 2017, the incorrect treatment was provided. [s. 6. (7)]

4. A complaint was received by the Director related to the care provided to resident #005.

Inspector #625 reviewed resident #005’s care plan titled ADL Assistance, which identified that the resident required specific transfer assistance from staff and the use of a particular apparatus.

On a date during the inspection, the Inspector observed resident #005’s call bell ringing. When the Inspector approached the resident’s room, they observed Therapeutic Recreationist #127 in the room beside an ambulation device.

During interviews with Therapeutic Recreationist #127, they stated that they had rang the bell as they had wanted to bring resident #005 to a recreation program and required staff assistance to transfer the resident from their bed into their ambulation device. They stated that they had transferred the resident by themselves using a type of manual transfer; they were unaware of the resident’s plan of care identifying the resident required a particular type of staff assistance and the use of a particular apparatus and they had not received any training related to transferring residents.

Inspector #625 observed a logo posted on the wall in resident #005’s room, which identified the type of transfer the resident required.

During an interview with Inspector #625, the DOC stated that, if Therapeutic Recreationist #127 had transferred resident #005 by themselves using a manual transfer and the resident’s plan of care identified a particular type of staff assistance and the use of a particular apparatus, that care had not been provided to the resident as set out in the resident’s plan of care. [s. 6. (7)]

5. A complaint was received by the Director related to a specific type of monitoring and care provided to resident #006. The complaint indicated that resident #006 had an incident which resulted in injury, on a particular date in 2017. The complainant reported that, at the time of the incident, the specific type of monitoring was not provided. The complainant also stated that the home had asked them to provide a specific type of monitoring, including providing care to the resident, for entire shifts when the home was short staffed.

Inspector #625 reviewed the Critical Incident System (CIS) report submitted to the Director for resident #006’s incident with injury on a specific date in 2017. The report also identified that the specific type of monitoring was not provided due to lack of available staff and that another strategy was implemented.

Inspector #625 reviewed resident #006’s care plans located in the binder, last updated a particular date in 2017 and electronic care plans last updated on another date in 2017. The plans identified that staff were to provide a specific type of monitoring 24 hours per day, to complete a specific charting tool, and read the binder that contained care plans and roles/responsibilities.

(A) Failure to Provide specific type of monitoring

Inspector #625 reviewed resident #006’s electronic progress notes from an approximate three month period with a focus on the provision of a specific type of monitoring. The progress notes entered on three separate dates in a particular month in 2017, indicated that on a certain shift, the specific type of monitoring was not provided and that another strategy was implemented.

Inspector #625 reviewed staffing schedule documents which indicated:
- on a specific date, the SDM provided coverage for a period of time;
- on 11 dates, in one month, the contingency plan was used on a particular shift. The document also indicated the home used a contingency plan where one staff person would monitor both residents on a specific shift.
- on eight dates, the following month, the contingency plan was used on a particular shift; and
- on one specific date, resident #006’s SDM attended the home and provided coverage for a period of time

Inspector #625 reviewed a document signed by the home’s DOC #101, which identified strategies to follow when the contingency plan was implemented.

During an interview with Inspector #625, the Administrative Receptionist #128 indicated that they completed scheduling for the specific type of monitoring for resident #006. They stated that, when the home could not provide a staff person to monitor both resident #006 and resident #016, who both required a specific type of monitoring, the home used a contingency plan, where one staff person would monitor both residents on a a particular shift. The employee acknowledged that this had occurred on specific shifts during two months in 2017.

During an interview with the ADOC #129, they stated to Inspector #625 that each resident on one of the homes' unit, that require a specific type of monitoring, should have that type of monitoring and not a different type of monitoring. The ADOC stated that they were aware of the incident with injury that resident #006 had on a particular date and stated that the resident should have had their own staff member present to provide the specific type of monitoring.

During an interview with the DOC, they acknowledged to Inspector #625 that, on the date of resident #006’s incident with injury, the shift only had one staff person monitoring two residents, each of whom required a specific type of monitoring. The DOC also stated that resident #006’s SDM had covered some full shifts for the specific type of monitoring when the home did not have staff to provide this monitoring.

(B) Failure to Complete the Monitoring tool and Review the Binder

Inspector #625 reviewed resident #006’s monitoring tool records from an approximate three week period, in 2017. The records were not completed in entirety, correctly or consistently with required coding and/or staff member’s initials.

During an interview with Dietary Aide #130, they stated to Inspector #625 that they had started monitoring resident #006 at 1430 hours, that this was their first time providing this specific type of monitoring for this resident and that they were not familiar with resident #006’s care plans located in their binder. At 1710 hrs, 160 minutes after beginning the shift, Dietary Aide #130 stated to Inspector #196 that they were still not yet familiar with the resident’s care plans.

During an interview with PSW #120, they acknowledged that the monitoring tool had

multiple blank time increments corresponding to the columns dated for two separate dates in 2017, were present. In addition, they stated to the Inspector that staff had assisted with activities of daily living with resident #006 but had not documented the corresponding A or B code on the monitoring record to indicate the activity occurred.

During an interview with PSW #125 (who was providing a specific type of monitoring of resident #006), they stated that they had last reviewed the binder three to four weeks previous and that they were not aware of the changes to the requirements for completion of the monitoring record that occurred on a certain date, and were not specifically aware to initial beside coding for number five to eight, to code A or B, or to only use one number per time frame.

During an interview with Cook #124 (who was providing a specific type of monitoring of resident #006), they stated that they were not aware of the changes to the monitoring record including when to initial in a time frame, when to use codes A or B, or to only use one number per time frame. The Cook also stated that they had worked and provided this specific type of monitoring with the resident approximately 12 times over the last two months but had not been told to read the interventions list located in the resident's binder.

During an interview with Inspector #625, RN (EC) #104 stated that staff should have followed resident #006's plan of care with respect to completing the monitoring record including initialing as required, using only one number per square and coding for activity-related behaviours with A or B.

During an interview with Inspector #625, the DOC stated that resident #006's plan of care had not been followed with respect to completion of the monitoring record including the documentation of numbers and coding of letters A or B. [s. 6. (7)]

6. A complaint was received by the Director related to the care provided to resident #005.

Inspector #625 reviewed resident #005's care plan titled ADL Assistance which identified that the resident required the assistance of staff with a specific activity. The Inspector also reviewed the one unit's Bath Schedules (Days and Evenings) which indicated resident #005 was scheduled to receive a bath on a particular shift on two specific days per week.

Inspector #625 reviewed resident #005's PSW Flow Sheets for a specific month in 2017, which identified that staff were to, "Use a code of 8 if activity did not occur." The Inspector identified that staff had documented bathing did not occur during the evening shift on on of the scheduled dates in 2017. There was no documentation to indicate that resident #005 received or was offered a bath on three other dates in 2017. The last documentation related to resident #005's bath was on a particular shift on a date in 2017.

During interviews with resident #005, they stated to the Inspector that they had not received a bath on a specific date in 2017, and had been informed by staff working that date, that they could not provide the resident with a bath as they were, "short handed".

During an interview with Inspector #625, the Administrative Receptionist #128 stated that, during the a specific shift on a specific date in 2017, the one unit had been short two PSWs from 1430 hours to 2230 hours and one PSW from 1830 hrs to 2030 hrs.

During an interview with PSW #116, they stated to the Inspector that they worked the specific shift on a specific date in 2017, and the one unit was short staffed. The PSW stated that, because of the staffing constraints, multiple baths were missed including resident #005's baths. The PSW stated that they would usually pass on missed baths to the next shift but had not done so that evening.

During an interview with Inspector #625, the DOC stated that they had provided the Registered Nurses with a memo related to the provision of baths to residents on weekends when the home was short staffed. The DOC stated that PSWs would need to make a decision as to which resident would have a tub bath and which would be offered a bed bath using Tena, "bathing gloves" (if the resident was agreeable). The DOC stated that, if a resident missed a bath, it should be rescheduled as soon as possible and that staff should make sure the resident received a bath. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Inspector #196 followed up on outstanding Compliance Order (CO) #001 issued during inspection #2017_435621_0017, with a compliance date of September 29, 2017. The licensee was ordered to ensure that:

1) Required repairs to three specific resident rooms included, but not limited to, drywall repairs, painting, repair or replacement of wall, door and corner guard protectors, repair or replacement of damaged flooring, sinks and room accessories, were addressed.
2) An auditing process was developed and implemented at regular intervals for each resident room in the home, to identify all maintenance issues outstanding.
3) A corrective action plan was developed and implemented for all resident rooms in the home to address maintenance issues identified from resident and family requests or complaints, maintenance requests from home's staff, as well as issues identified from maintenance audit reports.

The licensee had failed to comply with CO #001 and non-compliance was identified pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) as follows:
1) Related to part three of the order, the home failed to develop and implement a corrective action plan for all resident rooms in the home to address maintenance issues identified from resident and family requests or complaints, maintenance requests from home's staff, as well as issues identified from maintenance audit reports.

Inspector #196 reviewed the auditing process that had been developed and implemented that identified all maintenance issues for each resident room. The audit tool identified specific areas within each resident room that were in disrepair and noted additional areas of concerns in need of repair.

During an interview with the Environmental Services Manager (ESM), they reported to the Inspector that residents and families, could talk to home staff and they could place a phone call on their behalf to the maintenance department and leave a voice mail message with maintenance concerns. In addition, they stated that residents or family members could go to the front desk to report maintenance issues and a complaint form could be completed by the front desk staff or whomever may get the information and the ESM would contact the complainant. The ESM went on to say that home staff were to leave a voice mail message for the maintenance department and this message would be placed in a log book in the maintenance shop. In addition, the ESM reported that the home had a computer program that allowed, "maintenance connection" requests to be entered online, but not all staff had been trained and therefore a phone call/voice mail was the best way to make a maintenance request.

During an interview with Administrative Receptionist #128, they indicated to the Inspector that the complaint forms were no longer used by the home, since at least early 2017, when the previous Administrator #108 had discontinued their use.

During an interview with DOC #101, they reported to the Inspector that a meeting had been held with the ESM, the Chief Financial Officer (CFO) and themselves, regarding a corrective plan for the maintenance concerns identified in the audit. They went on to report that the ESM should have developed the corrective action plan.

During an interview with the Administrator, they reported to the Inspector that the ESM was to develop the corrective action plan for the maintenance audit reports of all the resident rooms, and to address maintenance issues identified from resident and family requests or complaints, and maintenance requests from home's staff.

During an interview with the ESM, they reported to the Inspector that a corrective action plan had not yet been developed or implemented to address the disrepair in resident rooms as identified in the maintenance audit reports. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following interdisciplinary programs were developed and implemented in the home: A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Inspector #196 followed up on outstanding Compliance Order (CO) #003 issued during Inspection #2017_463616_0011 with a compliance date of October 11, 2017. The CO required the home to:

"Ensure that an interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions is developed and implemented in the home."

During this inspection, DOC #101 provided a document titled, "Skin and Wound Care Program" to Inspector #196. The document had a water mark, "DRAFT" on it and

according to the DOC, the program had been implemented within the home.

Inspector #196 reviewed the, "Skin and Wound Care Program" document which identified the policy, definitions, purpose and goals, procedures to follow for multidisciplinary staff members, evaluation of the program itself, and staff training and education.

During an interview with DOC #101, they reported to the Inspector that the licensee’s skin and wound care program training was conducted by RN #103. They went on to report that:
- 61% of the registered staff had completed the training; and
- 77% of the PSWs had completed the training.

During the inspection, several staff interviews were conducted to determine whether the staff had received training in the licensee’s skin and wound care program.

- PSW #126 reported that they could not recall receiving training in the skin and wound program, nothing in the previous month, or online in the past year;
- RPN #132 reported that they were not familiar with a skin and wound care package and stated that they thought a Braden scale was not longer done as previous;
- RPN #133 reported that they could not recall RN #103 providing training in skin and wound care recently, nor had any training in the skin and wound program in the past year;
- RN #131 reported on a particular date during the inspection, they were the registered staff member completing the wound care and treatments for both of the homes' units and they started employment at the home on a particular date in 2017. In addition, they stated that for training on the licensee’s skin and wound program, they had gone with a senior staff member and were shown supplies and physician’s orders. They also reported that if they needed the policies and procedures for skin and wound care they would ask another staff member for them as they were unsure of where they were located; and
- RN #105 reported to the Inspector that they had been given a paper copy of the home’s skin and wound care program written program to review but had not yet completed their review. [s. 48. (1) 2.]

2. As part of the follow up inspection, to CO #003 regarding the skin and wound care program, Inspector #196 reviewed the health care records of resident #001.

Resident #001 had two treatment record documents in the TAR (Treatment Administration Record) binder, one for an area of altered skin integrity on a location of their body, and one dated two weeks later, for a different area of altered skin integrity on another location of their body. The RN (EC) order dated a specific dated identified a certain treatment was to be provided to one of the areas of their body.

During an interview with RN #105, they reported to the Inspector that resident #001 returned from a location other than the home, on a particular date in 2017. Upon return from the other location, new orders for treatment were required. They confirmed that there were no treatment orders from the RN (EC) or physician for the area of altered skin intergrity on either areas of the residents body. Further review of the health care record determined that neither a Braden scale or a head to toe skin assessment completed by the PSW staff on the resident's bath days, were done since the resident returned from a location other than the home.

The skin and wound care program, as provided by the DOC was reviewed. Within the program, it indicated that a Braden scale was to be completed by the registered staff upon a resident's return from a location other than the home. In addition, the program indicated that a physician order for treatment recommendations was to be obtained.

During an interview with RN (EC), they reported to the Inspector that they were unaware of any current altered skin integrity on a part of the resident's body and nursing staff had not informed them of any concerns. In addition, they confirmed to the Inspector that a new order for treatment would need to be ordered upon return from a location other than the home.

During an interview with the DOC, they confirmed to the Inspector that staff were to follow the skin and wound program, although the program was in a draft form. [s. 48. (1) 2.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with 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 all residents were protected from abuse by anyone and shall ensure that residents were not neglected by the licensee or staff.

Inspector #196 followed up on outstanding Compliance Order (CO) #001 issued during inspection #2017_463616_0011 with a compliance date of September 27, 2017. The CO required the home to:

"Ensure that residents are protected from abuse by anyone, specifically that the care plan including techniques and interventions to prevent, minimize or respond to the demonstrated physically responsive behaviours of resident #016 are implemented."

Inspector #196 reviewed the binder with information regarding resident #016. The care plan dated on a specific date included the focus and included numerous interventions to prevent, minimize or respond to the responsive behaviours of resident #016. In addition, noted, that all staff members that provided specific monitoring must read the binder with the care plans and roles and responsibilities.

During an interview, RN #107 reported that resident #016 was inside their room with the door closed. In addition, they reported this was the first time they had been asked to do this specific monitoring for this resident; they had started this monitoring at 1515 hrs that same day. When asked, RN #107 denied that they had read the information in the binder, or the care plan, but had received a report from the staff that had provided care earlier in that day.

During an interview, the DOC reported to Inspector #196 that staff were to read the care plan at the start of the shift prior to providing specific monitoring for resident #016. [s. 19. (1)]

2. Please see WN #1, paragraph 4, for record review information.

The care plan under a specific focus indicated a specific type of monitoring as an intervention, and under another focus of the plan, this specific type of monitoring was to occur at all times.

During the inspection, Inspector #625 reviewed the staffing schedule documents, regarding the specific type of monitoring, which included:

- A document that stated the contingency plan for a specific shift and outlined what the plan was to entail

- A spreadsheet which identified that during eight shifts in a particular month in 2017, that the contingency plan was used;

- Emails from the Administrative Receptionist staff #128 dated on two separate dates in 2017, that identified the contingency plan was used during the shifts on two dates in one particular month in 2017;

- A document which identified that, on shifts on four separate dates during a particular month, the contingency plan was used; and

- Inspector #625 reviewed a document signed by the home's DOC #101 which identified strategies to follow when the contingency plan was implemented.

During an interview with Inspector #625, the Administrative Receptionist #128 stated that they completed scheduling for the staffing for the specific type of monitoring for resident #006. The stated that, when the home could not provide staffing for the specific type of monitoring for both resident #006 and resident #016, who both required specific type of monitoring, the home used a contingency plan where one staff person would monitor both residents on a specific shift. The employee acknowledged that this had occurred on specific shifts during two months in 2017.

During an interview with the ADOC #129, they stated to Inspector #625 that each resident on the one of the homes' unit, that require a specific type of monitoring, should have that type of monitoring and not a different type of monitoring.

During an interview with the DOC, they confirmed to Inspector #196 that the contingency plan did not follow the current plan of care for resident #016. [s. 19. (1)]

3. During an interview with DOC #101, they reported to Inspector #196 that resident #016's responsive behaviours had remained unchanged and they would continue on a specific type of monitoring. They indicated that the behaviours included particular actions. In addition, they added that the resident did not have a Substitute Decision Maker (SDM) to act on their behalf and that a letter had been sent to an agency to assist on a particular date in summer 2017. They also reported that an application had been completed through an agency for admission to a specialized facility on a particular date in summer 2017. In addition, the DOC reported that a second application was completed approximately one week later, as information had been incomplete on the first application.

Inspector #196 reviewed the resident's hard copy of their chart. The physician's order dated on a particular date, identified further paper work completed for referral for treatment.

During a subsequent interview with DOC #101, they reported to the Inspector that they had not heard back regarding the application for admission to the specialized facility. The DOC then proceeded to send an email during the interview with the Inspector to the agency intake person at the specialized facility to inquire about the application status.

During discussion with the DOC, they reported that on a particular date, another incident, in which resident #016 had demonstrated responsive behaviour towards another resident, had occurred. They went on to say that the specific type of monitoring provided by staff, had been unable to redirect resident #016. They added that there had been no changes in the residents' plan of care in relation to this specific incident and that all strategies had been in place at that time. They stated there were no other referrals to other resources and they were not sure of the last time two named consultants had provided advice. They reported that there had not been a special meeting in response to the incident which occurred on a specific date. [s. 19. (1)]

Additional Required Actions:

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

Issued on this 16th day of January, 2018

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

Original report signed by the inspector.

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196), KATHERINE BARCA (625)
Inspection No. / No de l'inspection :	2017_624196_0016
Log No. / No de registre :	017636-17, 022498-17, 022500-17, 022503-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 10, 2018
Licensee / Titulaire de permis :	RIVERSIDE HEALTH CARE FACILITIES, INC. 110 VICTORIA AVENUE, FORT FRANCES, ON, P9A-2B7
LTC Home / Foyer de SLD :	RAINYCREST 550 OSBORNE STREET, FORT FRANCES, ON, P9A-3T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marva Griffiths

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To RIVERSIDE HEALTH CARE FACILITIES, INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_463616_0011, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall:

a) Ensure skin and wound care is provided to resident #014, and to all residents in the home, as specified in their plans of care;
b) Ensure that:
1.) resident #005 is provided with bathing and transferring specific to their designated plan of care,
2.) resident #006 is provided with the interventions specified within their plan of care to manage their responsive behaviours,
3.) resident #004 is provided with transferring techniques, as specified in their respective plan of care, and
c) Ensure that all resident care, set out in the plan of care, is provided to the resident as specified in the plan.

Grounds / Motifs :

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.

Inspector #196 followed up on outstanding Compliance Order (CO) #002 issued during inspection #2017_463616_0011, with a compliance date of November 1, 2017. The CO required the home to:

- Prepare, submit and implement a plan for achieving compliance to ensure that for every resident in the home, staff provide care as specified in each resident's plan of care, including the planned skin and wound care for resident #014.

- Submit the plan by September 27, 2017, and fully implement the plan by November 1, 2017.

During observations made on November 21, 2017, at 1715hrs, Inspector #196 noted resident #014 had a device in place on a part of their body and there was no device on another part of their body.

During an interview, RPN #102 confirmed to the Inspector that resident #014 did not have a device in place on a part of their body.

The Inspector observed a sign above the resident's bed which identified the use of a device on two parts of the resident's body.

During an interview with RPN #102, they acknowledged the sign posted above resident #014's bed had indicated the resident was to have a device on two parts of the resident's body.

The Inspector reviewed resident #014's health care records. The care plan that was located within the PSW assignment binder, included the focus of, Activity of Daily Living, and the intervention, to have a device on two parts of the resident's body; also that the devices were to be used at all times; and specified the reason for their use. Another focus in the care plan, included the same intervention.

In an interview, PSW #126 reported to the Inspector that they did not have time to read the resident's care plan and that they were not sure if the device was to be on one part of the body or on both. In a subsequent interview, PSW #126 confirmed to the Inspector that this resident was to have the device on both parts of their body, as was indicated on the sign in the resident's room.

During an interview with the DOC, they reported to the Inspector that PSWs were responsible for reading the care plans and to be aware of interventions included in the plans of care. [s. 6. (7)] (196)

2. A complaint was received by the Director related to a specific type of monitoring and care provided to resident #006. The complaint indicated that resident #006 had an incident which resulted in injury, on a particular date in 2017. The complainant reported that, at the time of the incident, the specific type of monitoring was not provided. The complainant also stated that the home had

asked them to provide a specific type of monitoring, including providing care to the resident, for entire shifts when the home was short staffed.

Inspector #625 reviewed the Critical Incident System (CIS) report submitted to the Director for resident #006's incident with injury on a specific date in 2017. The report also identified that the specific type of monitoring was not provided due to lack of available staff and that another strategy was implemented.

Inspector #625 reviewed resident #006's care plans located in the binder, last updated a particular date in 2017 and electronic care plans last updated on another date in 2017. The plans identified that staff were to provide a specific type of monitoring 24 hours per day, to complete a specific charting tool, and read the binder that contained care plans and roles/responsibilities.

(A) Failure to Provide specific type of monitoring

Inspector #625 reviewed resident #006's electronic progress notes from an approximate three month period with a focus on the provision of a specific type of monitoring. The progress notes entered on three separate dates in a particular month in 2017, indicated that on a certain shift, the specific type of monitoring was not provided and that another strategy was implemented.

Inspector #625 reviewed staffing schedule documents which indicated:
- on a specific date, the SDM provided coverage for a period of time;
- on 11 dates, in one month, the contingency plan was used on a particular shift. The document also indicated the home used a contingency plan where one staff person would monitor both residents on a specific shift.
- on eight dates, the following month, the contingency plan was used on a particular shift; and
- on one specific date, resident #006's SDM attended the home and provided coverage for a period of time

Inspector #625 reviewed a document signed by the home's DOC #101, which identified strategies to follow when the contingency plan was implemented.

During an interview with Inspector #625, the Administrative Receptionist #128 indicated that they completed scheduling for the specific type of monitoring for resident #006. They stated that, when the home could not provide a staff person to monitor both resident #006 and resident #016, who both required a specific

type of monitoring, the home used a contingency plan, where one staff person would monitor both residents on a a particular shift. The employee acknowledged that this had occurred on specific shifts during two months in 2017.

During an interview with the ADOC #129, they stated to Inspector #625 that each resident on one of the homes' unit, that require a specific type of monitoring, should have that type of monitoring and not a different type of monitoring. The ADOC stated that they were aware of the incident with injury that resident #006 had on a particular date and stated that the resident should have had their own staff member present to provide the specific type of monitoring.

During an interview with the DOC, they acknowledged to Inspector #625 that, on the date of resident #006's incident with injury, the shift only had one staff person monitoring two residents, each of whom required a specific type of monitoring. The DOC also stated that resident #006's SDM had covered some full shifts for the specific type of monitoring when the home did not have staff to provide this monitoring.

(B) Failure to Complete the Monitoring tool and Review the Binder

Inspector #625 reviewed resident #006's monitoring tool records from an approximate three week period, in 2017. The records were not completed in entirety, correctly or consistently with required coding and/or staff member's initials.

During an interview with Dietary Aide #130, they stated to Inspector #625 that they had started monitoring resident #006 at 1430 hours, that this was their first time providing this specific type of monitoring for this resident and that they were not familiar with resident #006's care plans located in their binder. At 1710 hrs, 160 minutes after beginning the shift, Dietary Aide #130 stated to Inspector #196 that they were still not yet familiar with the resident's care plans.

During an interview with PSW #120, they acknowledged that the monitoring tool had multiple blank time increments corresponding to the columns dated for two separate dates in 2017, were present. In addition, they stated to the Inspector that staff had assisted with activities of daily living with resident #006 but had not documented the corresponding A or B code on the monitoring record to indicate

the activity occurred.

During an interview with PSW #125 (who was providing a specific type of monitoring of resident #006), they stated that they had last reviewed the binder three to four weeks previous and that they were not aware of the changes to the requirements for completion of the monitoring record that occurred on a certain date, and were not specifically aware to initial beside coding for number five to eight, to code A or B, or to only use one number per time frame.

During an interview with Cook #124 (who was providing a specific type of monitoring of resident #006), they stated that they were not aware of the changes to the monitoring record including when to initial in a time frame, when to use codes A or B, or to only use one number per time frame. The Cook also stated that they had worked and provided this specific type of monitoring with the resident approximately 12 times over the last two months but had not been told to read the interventions list located in the resident's binder.

During an interview with Inspector #625, RN (EC) #104 stated that staff should have followed resident #006's plan of care with respect to completing the monitoring record including initialing as required, using only one number per square and coding for activity-related behaviours with A or B.

During an interview with Inspector #625, the DOC stated that resident #006's plan of care had not been followed with respect to completion of the monitoring record including the documentation of numbers and coding of letters A or B. [s. 6. (7)] (196)

3. A complaint was received by the Director related to the care provided to resident #005.

Inspector #625 reviewed resident #005's care plan titled ADL Assistance, which identified that the resident required specific transfer assistance from staff and the use of a particular apparatus.

On a date during the inspection, the Inspector observed resident #005's call bell ringing. When the Inspector approached the resident's room, they observed Therapeutic Recreationist #127 in the room beside an ambulation device.

During interviews with Therapeutic Recreationist #127, they stated that they had rang the bell as they had wanted to bring resident #005 to a recreation program and required staff assistance to transfer the resident from their bed into their ambulation device. They stated that they had transferred the resident by themselves using a type of manual transfer; they were unaware of the resident's plan of care identifying the resident required a particular type of staff assistance and the use of a particular apparatus and they had not received any training related to transferring residents.

Inspector #625 observed a logo posted on the wall in resident #005's room, which identified the type of transfer the resident required.

During an interview with Inspector #625, the DOC stated that, if Therapeutic Recreationist #127 had transferred resident #005 by themselves using a manual transfer and the resident's plan of care identified a particular type of staff assistance and the use of a particular apparatus, that care had not been provided to the resident as set out in the resident's plan of care. [s. 6. (7)] (196)

4. As part of the follow-up to CO #003, regarding the licensee's implementation of a skin and wound care program, resident #014 was identified as requiring skin and wound care treatment.

Inspector #196 reviewed the health care records for resident #014 for information regarding skin and wound care.

On a date, RN (EC) #104 had ordered a specific treatment for area "A" on resident #014's body.

The RN (EC) had also ordered a specific treatment for a different area, "B" of resident #014's body.

On a subsequent date, the physician ordered treatment for area, "A" of resident #014's body.

The wound care flow sheet for area, "A" identified the particular treatment and the frequency of treatment and specified the days it was to be completed.

The treatment record document for area, "B" indicated a specific treatment.

During an interview with Inspector #196, RN #105 confirmed that the current care plan identified the correct ordered treatment for both area, "A" and "B". Upon review of the wound care flow sheet for area "A", RN #105 confirmed that the MD/RN (EC) order had not been transcribed onto the wound care sheet correctly; therefore, the wrong treatment was provided to the resident on two different dates, in 2017.

During an interview with RN (EC) #104 they confirmed to the Inspector that for area, "A", the staff were to follow the most current physician or RN (EC) order.

During an interview with RN #105, they reviewed with the Inspector the treatment record document for area, "B" and confirmed that on three different dates in 2017, the incorrect treatment was provided. [s. 6. (7)] (196)

5. A complaint was received by the Director related to the care provided to resident #005.

Inspector #625 reviewed resident #005's care plan titled ADL Assistance which identified that the resident required the assistance of staff with a specific activity. The Inspector also reviewed the one unit's Bath Schedules (Days and Evenings) which indicated resident #005 was scheduled to receive a bath on a particular shift on two specific days per week.

Inspector #625 reviewed resident #005's PSW Flow Sheets for a specific month in 2017, which identified that staff were to, "Use a code of 8 if activity did not occur." The Inspector identified that staff had documented bathing did not occur during the evening shift on on of the scheduled dates in 2017. There was no documentation to indicate that resident #005 received or was offered a bath on three other dates in 2017. The last documentation related to resident #005's bath was on a particular shift on a date in 2017.

During interviews with resident #005, they stated to the Inspector that they had not received a bath on a specific date in 2017, and had been informed by staff working that date, that they could not provide the resident with a bath as they were, "short handed".

During an interview with Inspector #625, the Administrative Receptionist #128 stated that, during the a specific shift on a specific date in 2017, the one unit had been short two PSWs from 1430 hours to 2230 hours and one PSW from 1830

hrs to 2030 hrs.

During an interview with PSW #116, they stated to the Inspector that they worked the specific shift on a specific date in 2017, and the one unit was short staffed. The PSW stated that, because of the staffing constraints, multiple baths were missed including resident #005's baths. The PSW stated that they would usually pass on missed baths to the next shift but had not done so that evening.

During an interview with Inspector #625, the DOC stated that they had provided the Registered Nurses with a memo related to the provision of baths to residents on weekends when the home was short staffed. The DOC stated that PSWs would need to make a decision as to which resident would have a tub bath and which would be offered a bed bath using Tena, "bathing gloves" (if the resident was agreeable). The DOC stated that, if a resident missed a bath, it should be rescheduled as soon as possible and that staff should make sure the resident received a bath. [s. 6. (7)]

The decision to issue this Director Referral, and re-issue a CO was based on the licensee's ongoing noncompliance with this section of the legislation, the scope was determined to be a pattern, with the potential for actual harm to residents. Pursuant to the LTCHA 2007, S.O.2007, c.8, s.6(7) non-compliance was determined.

The licensee has a history of non-compliance in this area of the legislation as follows:
- a CO issued in inspection #2017_463616_0011, July 17, 2017;
- a Director Referral and CO issued in inspection #2017_435621_0011, March 31, 2017;
- a VPC issued in inspection #2017_395613_0001, January 9, 2017;
- a CO issued in inspection #2016_463616_0026, November 14, 2016;
- a WN issued in inspection #2016_320612_0018, June 16, 2016; and
- a CO issued in inspection #2016_339617_0021, May 30, 2016. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_435621_0017, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee is ordered to:

a) Develop and implement a corrective action plan to address the disrepair in resident rooms as identified in the maintenance audit reports; and
b) Develop and implement a consistent process to address maintenance issues identified from resident, and family requests or complaints and maintenance requests from the home's staff.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Inspector #196 followed up on outstanding Compliance Order (CO) #001 issued during inspection #2017_435621_0017, with a compliance date of September 29, 2017. The licensee was ordered to ensure that:

1) Required repairs to three specific resident rooms included, but not limited to, drywall repairs, painting, repair or replacement of wall, door and corner guard protectors, repair or replacement of damaged flooring, sinks and room accessories, were addressed.
2) An auditing process was developed and implemented at regular intervals for

each resident room in the home, to identify all maintenance issues outstanding.
3) A corrective action plan was developed and implemented for all resident rooms in the home to address maintenance issues identified from resident and family requests or complaints, maintenance requests from home's staff, as well as issues identified from maintenance audit reports.

The licensee had failed to comply with CO #001 and non-compliance was identified pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) as follows:
1) Related to part three of the order, the home failed to develop and implement a corrective action plan for all resident rooms in the home to address maintenance issues identified from resident and family requests or complaints, maintenance requests from home's staff, as well as issues identified from maintenance audit reports.

Inspector #196 reviewed the auditing process that had been developed and implemented that identified all maintenance issues for each resident room. The audit tool identified specific areas within each resident room that were in disrepair and noted additional areas of concerns in need of repair.

During an interview with the Environmental Services Manager (ESM), they reported to the Inspector that residents and families, could talk to home staff and they could place a phone call on their behalf to the maintenance department and leave a voice mail message with maintenance concerns. In addition, they stated that residents or family members could go to the front desk to report maintenance issues and a complaint form could be completed by the front desk staff or whomever may get the information and the ESM would contact the complainant. The ESM went on to say that home staff were to leave a voice mail message for the maintenance department and this message would be placed in a log book in the maintenance shop. In addition, the ESM reported that the home had a computer program that allowed, "maintenance connection" requests to be entered online, but not all staff had been trained and therefore a phone call/voice mail was the best way to make a maintenance request.

During an interview with Administrative Receptionist #128, they indicated to the Inspector that the complaint forms were no longer used by the home, since at least early 2017, when the previous Administrator #108 had discontinued their use.

During an interview with DOC #101, they reported to the Inspector that a

meeting had been held with the ESM, the Chief Financial Officer (CFO) and themselves, regarding a corrective plan for the maintenance concerns identified in the audit. They went on to report that the ESM should have developed the corrective action plan.

During an interview with the Administrator, they reported to the Inspector that the ESM was to develop the corrective action plan for the maintenance audit reports of all the resident rooms, and to address maintenance issues identified from resident and family requests or complaints, and maintenance requests from home's staff.

During an interview with the ESM, they reported to the Inspector that a corrective action plan had not yet been developed or implemented to address the disrepair in resident rooms as identified in the maintenance audit reports. [s. 15. (2) (c)]

The decision to re-issue a CO was based upon the licensee's ongoing noncompliance with this section of the legislation, was based on the scope, which was determined to be a pattern, with a minimum risk of harm to residents pursuant to LTCHA 2007, S.O. 2007, c.8, s. 15.(2)(c).

The licensee has a history of noncompliance in this area of the legislation as follows:
- a CO issued in inspection #2017_435621_0017, May 29, 2017; and
- a VPC issued in inspection #2016_264609_0019, issued July 19, 2017.

(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_463616_0011, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that an interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions is developed and implemented in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that the following interdisciplinary programs were developed and implemented in the home: A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Inspector #196 followed up on outstanding Compliance Order (CO) #003 issued during Inspection #2017_463616_0011 with a compliance date of October 11, 2017. The CO required the home to:

"Ensure that an interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions is developed and implemented in the home."

During this inspection, DOC #101 provided a document titled, "Skin and Wound Care Program" to Inspector #196. The document had a water mark, "DRAFT" on it and according to the DOC, the program had been implemented within the home.

Inspector #196 reviewed the, "Skin and Wound Care Program" document which identified the policy, definitions, purpose and goals, procedures to follow for multidisciplinary staff members, evaluation of the program itself, and staff training and education.

During an interview with DOC #101, they reported to the Inspector that the licensee's skin and wound care program training was conducted by RN #103. They went on to report that:
- 61% of the registered staff had completed the training; and
- 77% of the PSWs had completed the training.

During the inspection, several staff interviews were conducted to determine whether the staff had received training in the licensee's skin and wound care program.

- PSW #126 reported that they could not recall receiving training in the skin and wound program, nothing in the previous month, or online in the past year;
- RPN #132 reported that they were not familiar with a skin and wound care package and stated that they thought a Braden scale was not longer done as previous;
- RPN #133 reported that they could not recall RN #103 providing training in skin and wound care recently, nor had any training in the skin and wound program in the past year;
- RN #131 reported on a particular date during the inspection, they were the registered staff member completing the wound care and treatments for both of the homes' units and they started employment at the home on a particular date in 2017. In addition, they stated that for training on the licensee's skin and wound program, they had gone with a senior staff member and were shown supplies and physician's orders. They also reported that if they needed the

policies and procedures for skin and wound care they would ask another staff member for them as they were unsure of where they were located; and
- RN #105 reported to the Inspector that they had been given a paper copy of the home's skin and wound care program written program to review but had not yet completed their review. [s. 48. (1) 2.] (196)

2. As part of the follow up inspection, to CO #003 regarding the skin and wound care program, Inspector #196 reviewed the health care records of resident #001.

Resident #001 had two treatment record documents in the TAR (Treatment Administration Record) binder, one for an area of altered skin integrity on a location of their body, and one dated two weeks later, for a different area of altered skin integrity on another location of their body. The RN (EC) order dated a specific dated identified a certain treatment was to be provided to one of the areas of their body.

During an interview with RN #105, they reported to the Inspector that resident #001 returned from a location other than the home, on a particular date in 2017. Upon return from the other location, new orders for treatment were required. They confirmed that there were no treatment orders from the RN (EC) or physician for the area of altered skin intergrity on either areas of the residents body. Further review of the health care record determined that neither a Braden scale or a head to toe skin assessment completed by the PSW staff on the resident's bath days, were done since the resident returned from a location other than the home.

The skin and wound care program, as provided by the DOC was reviewed. Within the program, it indicated that a Braden scale was to be completed by the registered staff upon a resident's return from a location other than the home. In addition, the program indicated that a physician order for treatment recommendations was to be obtained.

During an interview with RN (EC), they reported to the Inspector that they were unaware of any current altered skin integrity on a part of the resident's body and nursing staff had not informed them of any concerns. In addition, they confirmed to the Inspector that a new order for treatment would need to be ordered upon return from a location other than the home.

During an interview with the DOC, they confirmed to the Inspector that staff were

to follow the skin and wound program, although the program was in a draft form. [s. 48. (1) 2.]

The decision to re-issued this Compliance Order (CO) was based upon the licensee's ongoing noncompliance with this section of legislation, the scope which was a pattern, and the severity which was determined to be a potential for actual harm to residents pursuant to O. Reg. 79/10, r.48.(1)2.

The licensee has a history of noncompliance in this area of the legislation as follows:
- a CO was issued in inspection #2017_463616_0011, July 17, 2017. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_463616_0011, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that residents are protected from abuse by anyone. The licensee is specifically ordered to ensure the care plan, including techniques and interventions to prevent, minimize or respond to the demonstrated physically responsive behaviours of resident #016, are implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone and shall ensure that residents were not neglected by the licensee or staff.

Inspector #196 followed up on outstanding Compliance Order (CO) #001 issued during inspection #2017_463616_0011 with a compliance date of September 27, 2017. The CO required the home to:

"Ensure that residents are protected from abuse by anyone, specifically that the care plan including techniques and interventions to prevent, minimize or respond to the demonstrated physically responsive behaviours of resident #016 are implemented."

Inspector #196 reviewed the binder with information regarding resident #016. The care plan dated on a specific date included the a focus and included numerous interventions to prevent, minimize or respond to the responsive behaviours of resident #016. In addition, noted, that all staff members that provided specific monitoring must read the binder with the care plans and roles and responsibilities.

During an interview, RN #107 reported that resident #016 was inside their room with the door closed. In addition, they reported this was the first time they had been asked to do this specific monitoring for this resident; they had started this monitoring at 1515 hrs that same day. When asked, RN #107 denied that they had read the information in the binder, or the care plan, but had received a report from the staff that had provided care earlier in that day.

During an interview, the DOC reported to Inspector #196 that staff were to read the care plan at the start of the shift prior to providing specific monitoring for resident #016. [s. 19. (1)] (196)

2. Please see WN #1, paragraph 4, for record review information.

The care plan under a specific focus indicated a specific type of monitoring as an intervention, and under another focus of the plan, this specific type of monitoring was to occur at all times.

During the inspection, Inspector #625 reviewed the staffing schedule documents, regarding the specific type of monitoring, which included:

- A document that stated the contingency plan for a specific shift and outlined what the plan was to entail

- A spreadsheet which identified that during eight shifts in a particular month in 2017, that the contingency plan was used;

- Emails from the Administrative Receptionist staff #128 dated on two separate dates in 2017, that identified the contingency plan was used during the shifts on two dates in one particular month in 2017;

- A document which identified that, on shifts on four separate dates during a particular month, the contingency plan was used; and

- Inspector #625 reviewed a document signed by the home's DOC #101 which identified strategies to follow when the contingency plan was implemented.

During an interview with Inspector #625, the Administrative Receptionist #128 stated that they completed scheduling for the staffing for the specific type of

monitoring for resident #006. The stated that, when the home could not provide staffing for the specific type of monitoring for both resident #006 and resident #016, who both required specific type of monitoring, the home used a contingency plan where one staff person would monitor both residents on a specific shift. The employee acknowledged that this had occurred on specific shifts during two months in 2017.

During an interview with the ADOC #129, they stated to Inspector #625 that each resident on the one of the homes' unit, that require a specific type of monitoring, should have that type of monitoring and not a different type of monitoring.

During an interview with the DOC, they confirmed to Inspector #196 that the contingency plan did not follow the current plan of care for resident #016. [s. 19. (1)] (196)

3. During an interview with DOC #101, they reported to Inspector #196 that resident #016's responsive behaviours had remained unchanged and they would continue on a specific type of monitoring. They indicated that the behaviours included particular actions. In addition, they added that the resident did not have a Substitute Decision Maker (SDM) to act on their behalf and that a letter had been sent to an agency to assist on a particular date in summer 2017. They also reported that an application had been completed through an agency for admission to a specialized facility on a particular date in summer 2017. In addition, the DOC reported that a second application was completed approximately one week later, as information had been incomplete on the first application.

Inspector #196 reviewed the resident's hard copy of their chart. The physician's order dated on a particular date, identified further paper work completed for referral for treatment.

During a subsequent interview with DOC #101, they reported to the Inspector that they had not heard back regarding the application for admission to the specialized facility. The DOC then proceeded to send an email during the interview with the Inspector to the agency intake person at the specialized facility to inquire about the application status.

During discussion with the DOC, they reported that on a particular date, another

incident, in which resident #016 had demonstrated responsive behaviour towards another resident, had occurred. They went on to say that the specific type of monitoring provided by staff, had been unable to redirect resident #016. They added that there had been no changes in the residents' plan of care in relation to this specific incident and that all strategies had been in place at that time. They stated there were no other referrals to other resources and they were not sure of the last time two named consultants had provided advice. They reported that there had not been a special meeting in response to the incident which occurred on a specific date. [s. 19. (1)]

The decision to re-issue this Compliance Order (CO) was based on the licensee's ongoing noncompliance with this section of legislation, although the scope was isolated, there was a potential for actual harm to residents.

The licensee has a history of noncompliance in this area of the legislation as follows:
- a CO issued in inspection #2017_463616_0011, July 17, 2017;
- a VPC issued in inspection #2017_435621_0016, May 29, 2017;
- a VPC issued in inspection #2017_395613_0001, January 9, 2017;
- a CO issued in inspection #2016_463616_0026, November 14, 2016;
- a WN issued in inspection #2016_264609_0019, July 19, 2016; and
- a CO issued in inspection #2016_320612_0018, June 20, 2016. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 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 10th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur :	Lauren Tenhunen
Service Area Office / Bureau régional de services :	Sudbury Service Area Office