Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 02, 2017;	2017_418615_0013 (A1)	032785-16	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

The Village at St.Clair
1800 Talbot Road WINDSOR ON 000 000

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

HELENE DESABRAIS (615) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): May 9 and 11, 2017.

The following intake was completed during this inspection:

032785-16/IL-48006-LO related to alleged improper care of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), one Assistant Director of Care (ADOC), one Registered Practical Nurse-Resident Assessment Instrument Coordinator (RPN-RAI Coordinator), one Registered Practical Nurse (RPN) and three Personal Support Workers (PSWs).

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Pain

Skin and Wound Care

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

- **3 WN(s)**
- **0 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	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 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 :

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

A review of a complaint report stated that a resident had a skin condition and included pictures corroborating this statement.

A review of the resident's care plan, on a specific date, stated the skin condition, the monitoring, interventions and communicating skin concerns to the Registered Team Lead so that proper interventions could be put into place.

A review of the Personal Support Workers flow sheet titled "skin concern tracking tool and skin assessment concerns" for a specific month had no documentation on the resident's worsening skin condition.

A review of the physician's order, related to the resident, and the resident's Treatment Administration Record (TAR) for the a specific month stated interventions for the affected area and to alert the physician if the skin condition

worsens.

A review of the resident's Minimum Data Set (MDS) quarterly assessment, on a specific date, had no documentation of a skin condition present and no documented evidence of a skin assessment found for the affected area since the resident's admission.

A review of the resident's clinical record had no documented evidence of a skin and wound assessment being completed.

During an interview, a PSW, a RPN and a RPN RAI Coordinator, stated that the resident has a recurring skin condition since the resident's admission. They said that the treatment was in the resident's TAR, care plan and when there was a change in the resident's skin condition, it was to be documented and reported to the Registered Nurse for a skin assessment.

During an interview, the DOC stated that the resident's affected area was not assessed. The DOC said that there should have been a skin assessment for the resident on admission, since the resident's Power of Attorney had mentioned that the resident had a recurrent skin condition and a treatment administered daily. The first skin assessment was completed the same day the complainant informed the home. The DOC shared that the home's expectation was that residents with skin problems, lesions or wounds should be assessed by a registered nurse with the "wound assessment tool". [s. 50. (2) (b) (i)]

2. A review of another resident's Minimum Data Set (MDS) admission assessment, on a specific date, stated a skin and wound concern with specific interventions.

A review of the resident's care plan stated the potential for skin integrity issues, the monitoring, interventions and communicating skin concerns to the Nurse if the skin condition worsens.

A review of the physician's order, related to the resident, and the resident's Treatment Administration Record (TAR) for a specific month stated interventions for the affected area related to the resident's skin condition.

A review of the resident's Treatment Administration Record (TAR) showed that staff were administering a treatment as prescribed for the skin condition.

A review of the Personal Support Workers flow sheet titled “skin concern tracking tool and skin assessment concerns” had no documentation on the resident’s worsening skin condition.

Observation of the resident, on a specific date, found the resident in their room with a skin condition on an area of the body.

A review of the resident's clinical record had no documented evidence of a skin and wound assessment being completed weekly.

During an interview, a RPN and a PSW stated that the resident had a skin condition when admitted to the home and no skin and wound assessment was completed, and now, was exhibiting a worsening skin condition.

During an interview, a RPN RAI Coordinator acknowledged that the resident had a skin condition and that a skin and wound assessment was not completed on admission and other specific dates. The RPN RAI Coordinator stated that the skin assessments were not done all the time and that the home’s expectation is that skin and wound assessment be completed weekly. [s. 50. (2) (b) (iv)]

3. A review of another resident's Minimum Data Set (MDS) admission assessment, on a specific date, stated a skin and wound concern with specific interventions.

A review of the resident's care plan stated the potential for skin integrity issues, the monitoring, interventions and communicating skin concerns to the Nurse if the skin condition increased.

A review of the physician's order, related to that resident, stated the skin condition and interventions for the affected area of the skin condition.

During an interview, the resident stated that a skin condition was in a specific area "because staff don’t clean it good enough”.

A review of the resident's clinical record had no documented evidence of a skin and wound assessment being completed weekly.

A review of the home's policy "Skin and Wound Care Program" stated "The PSW will: 1. Document skin integrity over the entire body on spa days utilizing appropriate documentation, 2. Report altered skin integrity to the registered team

members. The registered team member will conduct a head-to-toe assessment and document that assessment: within 24 hours of move in, develop interventions that address risk items identified and implement inter-professional plan of care to prevent skin breakdown, administered a PRN, Skin Assessment will be performed when there is a change in skin integrity, complete a Quarterly Skin Assessment, complete the wound assessment of the areas reported and weekly thereafter".

During an interview, two PSWs stated that the resident has a skin condition to a specific area and that interventions were in place. One PSW stated that PSWs inform the registered nurse, “Nurses know, we all know”.

During an interview, an RPN stated that the resident has a skin condition to a specific area and that weekly skin assessment should be completed. One skin assessment was completed on a specific date and no weekly assessments were completed for the resident.

Interview with the DOC and a ADOC stated that residents with skin problems should be assessed weekly with the PAINAD assessment in Point Click Care (PCC) if there was a skin problem.

The licensee failed to ensure that a resident's skin was assessed by a member of the registered nursing staff, using a clinically appropriate assessment that is specifically designed for skin and wound assessment and that two residents' skin concerns were reassessed at least weekly by a member of the registered nursing staff.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be a widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's pain that was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A review of a complaint report, on a specific date, indicated that a resident was having pain in a specific area, the nurse was notified and no pain assessment was completed or pain medication offered for the resident.

The current care plan for the resident stated the resident had different specific pain, monitoring and interventions.

A review of the physician's current order indicated that the resident was prescribed an analgesic regularly and another pain relief medication when needed and to notify the physician if increased or persistent pain occurred.

A review of the resident's Minimum Data Set (MDS) quarterly assessment, on a specific date, stated "Pain symptoms: mild pain less than daily and, analgesics

used daily in the last seven days".

A review of the resident's clinical record showed that registered staff were documenting the resident's pain using a pain scale, however no pain assessment was completed or the frequency the resident was administered medication for pain when needed.

Observation, on a specific date, the resident was sitting in their room and was asked if they had pain in a specific area and was able to answer "pain yes".

A review of the Home's "Pain Management Program" policy stated "Recognizing that the degree of pain is always as the resident states it, Schlegel Villages team members will use clinically-appropriate pain assessment tools to meet the resident's needs and preferences for pain management" and "The registered team will: Complete and document a pain assessment, with history of unexpressed pain-what has helped before-information from family/SDM, when report from resident, family, team member volunteers that pain is present. Determine (if able to) the type of pain (chronic, acute, nociceptive and or neuropatic). Conduct a Pain Assessment (at a minimum of weekly) when: a schedule pain medication does not relieve the pain, pain remains regardless of the support strategies. Observe, understand, support and reflect on the care plan daily with the neighbourhood team to address each individual resident's pain".

A review of the resident's clinical records found no documented evidence of a pain assessment completed since the resident's admission.

During an interview, a PSW stated that the resident has pain, sometimes to a specific area and that the resident can answer when asked about the pain. The PSW shared that another PSW had "better luck with the resident", and stated that the resident did have pain to a different area in the past. The PSW shared that resident's pain would be documented in the shift change report or the family would report it.

During an interview, an RPN said that the resident has facial expressions for demonstrating pain to a specific area but never complained about pain in the the area the care plan refers to. Review of the resident's current care plan, with the RPN indicated that the resident's pain to that area was not recurrent, that it should not be in the care plan and that there was no focus for pain. The RPN stated that they knew the resident had pain in a specific area, and had given the resident an

analgesic in the past for the pain.

During an interview, the DOC stated that no pain assessments were completed for the resident and that there should have been a pain assessment (PAINAD) for the resident on admission, since the resident's family had mentioned that the resident had specific pain in two areas.

A review of the resident's clinical record, with the DOC, indicated that the resident had one pain assessment completed when it was recommended by the Behavioural Support of Ontario (BSO) staff because pain was identified during transfers and during care.

The DOC shared that the home's expectation is that residents expressing pain should be assessed weekly with the PAINAD assessment. [s. 52. (2)]

2. The current care plan for another resident stated the resident had specific pain, monitoring and interventions and refer to the physician if any concerns.

A review of the physician's current order indicated that the resident was prescribed an analgesic regularly and another pain relief medication when needed.

A review of the Minimum Data Set (MDS) admission assessment, on a specific date, stated "Pain symptoms: moderate pain daily. Pain site. Medication: analgesic used daily in the last seven days".

A review of the resident's clinical record showed that registered staff were documenting the resident's pain using a pain scale, however no pain assessment was completed or the frequency the resident was administered medication for pain when needed.

A review of the resident's clinical records found no documented evidence of a pain assessment completed since the resident's admission.

During an interview a PSW, stated that the resident usually has pain to a specific area and will ask for analgesics and that the PSWs report it to the registered nurse.

During an interview, an RPN reviewed the daily communication sheet "24 hours report" and stated that the home did not complete weekly pain assessments "Only when they show symptoms, but I would still complete them weekly".

During an interview, a RPN RAI Coordinator said that the resident has pain to three different areas. The RPN RAI Coordinator stated that pain assessments were completed quarterly, as well as a weekly basis for residents that are scheduled on pain medications, “the resident had pain medications and no pain assessments were completed". The RPN RAI Coordinator shared that the home’s expectation was that the resident would have a weekly pain assessment. [s. 52. (2)]

3. A review of another resident's Minimum Data Set (MDS) admission assessment indicated, in section J, “Pain symptoms: moderate pain daily. Pain Site: other. Medication: analgesic used daily in the last seven days”.

The current care plan for the resident stated the resident had different specific pain, monitoring and interventions and to "notify physician if interventions are unsuccessful or if current complaint is a significant change from neighbours past experience of pain”.

A review of the physician’s current order indicated that the resident was prescribed an analgesic regularly, another analgesic and other pain relief medications when needed.

A review of the resident's clinical record showed that registered staff were documenting the resident's pain using a pain scale, however no pain assessment was completed or the frequency the resident was administered medication for pain when needed.

During an interview, the resident said that they were in excruciating pain in one area of the body and that "the medication is not really working and the doctor does not know what to do for me and pushing on narcotics”.

During an interview, a PSW stated that the resident had excruciating pain to a specific area during care every day, that PSWs inform the registered nurse, “Nurses know, we all know”.

During an interview, a PSW stated that the resident "has pain everywhere", that PSWs note the pain and report it to registered nurse.

During an interview, an RPN said that the resident expressed pain all over, all the time. The RPN stated that pain assessments were completed until a specific date,

but nothing after that date.

During an interview, the DOC and a ADOC shared that the home used a scale for pain but no assessment and that the PAINAD assessment in PCC should have been completed. Both stated that the physician did try different medications and interventions for the resident. The DOC stated that "the pain assessments were done weekly in the past but the home changed the policy and now they (registered staff) are just not doing them".

The DOC stated that the home's expectation was that the resident would have a weekly pain assessment.

The licensee has failed to ensure that the three residents' pain was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be a widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 52. (2)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The home has failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

A review of a complaint report, on a specific date, indicated alleged improper care from the home's staff to a resident. The complainant also forwarded to the Ministry of Health and Long Term Care (MOHLTC) a copy of the complaint (e-mail), sent to the home on a specific date, regarding concerns for the care of a resident.The complainant's e-mail explained in detail that the resident was improperly cared for and that it resulted in the resident developing a worsening skin condition. The complainant also forwarded two pictures of the resident's skin condition to the MOHLTC.

On a specific date, the home submitted the complainant's complaint (email) to the MOHLTC but no critical incident report to the Director.

During an interview on a specific date, the DOC stated that after reviewing the complaint, and acknowledging improper care to the resident, no critical incident report was completed and forwarded to the Director.

The licensee failed to immediately report the suspicion and the information of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident to the Director.

The severity was determined to be a level 1 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on May 21, 2015, as Written Notification (WN) on a Critical Incident Inspection #2015_256517_0015. [s. 24. (1) 1.]

Issued on this 2 day of August 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
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Division des foyers de soins de longue durée
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : HELENE DESABRAIS (615) - (A1)

Inspection No. / No de l'inspection : 2017_418615_0013 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 032785-16 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Aug 02, 2017;(A1)

Licensee / Titulaire de permis : Schlegel Villages Inc
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

LTC Home / Foyer de SLD : The Village at St.Clair
1800 Talbot Road, WINDSOR, ON, 000-000

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Julie D'Alessandro

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

To Schlegel Villages 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)

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee shall ensure that all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

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

A review of a complaint report stated that a resident had a skin condition and included pictures corroborating this statement.

A review of the resident's care plan, on a specific date, stated the skin condition, the monitoring, interventions and communicating skin concerns to the Registered Team Lead so that proper interventions could be put into place.

A review of the Personal Support Workers flow sheet titled “skin concern tracking tool and skin assessment concerns” for a specific month had no documentation on the resident’s worsening skin condition.

A review of the physician's order, related to the resident, and the resident’s Treatment Administration Record (TAR) for the a specific month stated interventions for the affected area and to alert the physician if the skin condition worsens.

A review of the resident's Minimum Data Set (MDS) quarterly assessment, on a specific date, had no documentation of a skin condition present and no documented evidence of a skin assessment found for the affected area since the resident’s admission.

A review of the resident's clinical record had no documented evidence of a skin and wound assessment being completed.

During an interview, a PSW, a RPN and a RPN RAI Coordinator, stated that the resident has a recurring skin condition since the resident's admission. They said that the treatment was in the resident's TAR, care plan and when there was a change in the resident's skin condition, it was to be documented and reported to the Registered Nurse for a skin assessment.

During an interview, the DOC stated that the resident's affected area was not assessed. The DOC said that there should have been a skin assessment for the resident on admission, since the resident's Power of Attorney had mentioned that the resident had a recurrent skin condition and a treatment administered daily. The first skin assessment was completed the same day the complainant informed the home. The DOC shared that the home's expectation was that residents with skin problems, lesions or wounds should be assessed by a registered nurse with the "wound assessment tool". [s. 50. (2) (b) (i)]

(615)

2. A review of another resident's Minimum Data Set (MDS) admission assessment, on a specific date, stated a skin and wound concern with specific interventions.

A review of the resident's care plan stated the potential for skin integrity issues, the monitoring, interventions and communicating skin concerns to the Nurse if the skin condition worsens.

A review of the physician's order, related to that resident, stated the skin condition and interventions for the affected area of the skin condition.

During an interview, the resident stated that a skin condition was in a specific area "because staff don't clean it good enough".

A review of the resident's clinical record had no documented evidence of a skin and wound assessment being completed weekly.

A review of the home's policy "Skin and Wound Care Program" stated "The PSW will: 1. Document skin integrity over the entire body on spa days utilizing appropriate documentation, 2. Report altered skin integrity to the registered team members. The

registered team member will conduct a head-to-toe assessment and document that assessment: within 24 hours of move in, develop interventions that address risk items identified and implement inter-professional plan of care to prevent skin breakdown, administered a PRN, Skin Assessment will be performed when there is a change in skin integrity, complete a Quarterly Skin Assessment, complete the wound assessment of the areas reported and weekly thereafter".

During an interview, two PSWs stated that the resident has a skin condition to a specific area and that interventions were in place. One PSW stated that PSWs inform the registered nurse, “Nurses know, we all know”.

During an interview, an RPN stated that the resident has a skin condition to a specific area and that weekly skin assessment should be completed. One skin assessment was completed on a specific date and no weekly assessments were completed for the resident.

Interview with the DOC and a ADOC stated that residents with skin problems should be assessed weekly with the PAINAD assessment in Point Click Care (PCC) if there was a skin problem.

The licensee failed to ensure that a resident's skin was assessed by a member of the registered nursing staff, using a clinically appropriate assessment that is specifically designed for skin and wound assessment and that two residents' skin concerns were reassessed at least weekly by a member of the registered nursing staff.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be a widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 50. (2) (b) (iv)]

(615)

3. A review of another resident's Minimum Data Set (MDS) admission assessment, on a specific date, stated a skin and wound concern with specific interventions.

A review of the resident's care plan stated the potential for skin integrity issues, the monitoring, interventions and communicating skin concerns to the Nurse if the skin condition worsens.

A review of the physician's order, related to the resident, and the resident's Treatment Administration Record (TAR) for a specific month stated interventions for the affected area related to the resident's skin condition.

A review of the resident's Treatment Administration Record (TAR) showed that staff were administering a treatment as prescribed for the skin condition.

A review of the Personal Support Workers flow sheet titled "skin concern tracking tool and skin assessment concerns" had no documentation on the resident's worsening skin condition.

Observation of the resident, on a specific date, found the resident in their room with a skin condition on an area of the body.

A review of the resident's clinical record had no documented evidence of a skin and wound assessment being completed weekly.

During an interview, a RPN and a PSW stated that the resident had a skin condition when admitted to the home and no skin and wound assessment was completed, and now, was exhibiting a worsening skin condition.

During an interview, a RPN RAI Coordinator acknowledged that the resident had a skin condition and that a skin and wound assessment was not completed on admission and other specific dates. The RPN RAI Coordinator stated that the skin assessments were not done all the time and that the home's expectation is that skin and wound assessment be completed weekly. [s. 50. (2) (b) (iv)]
(615)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 :

Aug 31, 2017(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all residents exhibiting pain are assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident's pain that was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A review of a resident's Minimum Data Set (MDS) admission assessment indicated, in section J, "Pain symptoms: moderate pain daily. Pain Site: other. Medication: analgesic used daily in the last seven days".

The current care plan for the resident stated the resident had different specific pain,

monitoring and interventions and to "notify physician if interventions are unsuccessful or if current complaint is a significant change from neighbours past experience of pain”.

A review of the physician’s current order indicated that the resident was prescribed an analgesic regularly, another analgesic and other pain relief medications when needed.

A review of the resident's clinical record showed that registered staff were documenting the resident's pain using a pain scale, however no pain assessment was completed or the frequency the resident was administered medication for pain when needed.

During an interview, the resident said that they were in excruciating pain in one area of the body and that "the medication is not really working and the doctor does not know what to do for me and pushing on narcotics”.

During an interview, a PSW stated that the resident had excruciating pain to a specific area during care every day, that PSWs inform the registered nurse, “Nurses know, we all know”.

During an interview, a PSW stated that the resident "has pain everywhere", that PSWs note the pain and report it to registered nurse.

During an interview, an RPN said that the resident expressed pain all over, all the time. The RPN stated that pain assessments were completed until a specific date, but nothing after that date.

During an interview, the DOC and a ADOC shared that the home used a scale for pain but no assessment and that the PAINAD assessment in PCC should have been completed. Both stated that the physician did try different medications and interventions for the resident. The DOC stated that “the pain assessments were done weekly in the past but the home changed the policy and now they (registered staff) are just not doing them”.

The DOC stated that the home’s expectation was that the resident would have a weekly pain assessment.

The licensee has failed to ensure that the three residents' pain was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be a widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 52. (2)]

(615)

2. The current care plan for another resident stated the resident had specific pain, monitoring and interventions and refer to the physician if any concerns.

A review of the physician's current order indicated that the resident was prescribed an analgesic regularly and another pain relief medication when needed.

A review of the Minimum Data Set (MDS) admission assessment, on a specific date, stated "Pain symptoms: moderate pain daily. Pain site. Medication: analgesic used daily in the last seven days".

A review of the resident's clinical record showed that registered staff were documenting the resident's pain using a pain scale, however no pain assessment was completed or the frequency the resident was administered medication for pain when needed.

A review of the resident's clinical records found no documented evidence of a pain assessment completed since the resident's admission.

During an interview a PSW, stated that the resident usually has pain to a specific area and will ask for analgesics and that the PSWs report it to the registered nurse.

During an interview, an RPN reviewed the daily communication sheet "24 hours report" and stated that the home did not complete weekly pain assessments "Only when they show symptoms, but I would still complete them weekly".

During an interview, a RPN RAI Coordinator said that the resident has pain to three different areas. The RPN RAI Coordinator stated that pain assessments were completed quarterly, as well as a weekly basis for residents that are scheduled on pain medications, "the resident had pain medications and no pain assessments were completed". The RPN RAI Coordinator shared that the home's expectation was that the resident would have a weekly pain assessment. [s. 52. (2)]

(615)

3. A review of a complaint report, on a specific date, indicated that a resident was

having pain in a specific area, the nurse was notified and no pain assessment was completed or pain medication offered for the resident.

The current care plan for the resident stated the resident had different specific pain, monitoring and interventions.

A review of the physician's current order indicated that the resident was prescribed an analgesic regularly and another pain relief medication when needed and to notify the physician if increased or persistent pain occurred.

A review of the resident's Minimum Data Set (MDS) quarterly assessment, on a specific date, stated "Pain symptoms: mild pain less than daily and, analgesics used daily in the last seven days".

A review of the resident's clinical record showed that registered staff were documenting the resident's pain using a pain scale, however no pain assessment was completed or the frequency the resident was administered medication for pain when needed.

Observation, on a specific date, the resident was sitting in their room and was asked if they had pain in a specific area and was able to answer "pain yes".

A review of the Home's "Pain Management Program" policy stated "Recognizing that the degree of pain is always as the resident states it, Schlegel Villages team members will use clinically-appropriate pain assessment tools to meet the resident's needs and preferences for pain management" and "The registered team will: Complete and document a pain assessment, with history of unexpressed pain-what has helped before-information from family/SDM, when report from resident, family, team member volunteers that pain is present. Determine (if able to) the type of pain (chronic, acute, nociceptive and or neuropatic). Conduct a Pain Assessment (at a minimum of weekly) when: a schedule pain medication does not relieve the pain, pain remains regardless of the support strategies. Observe, understand, support and reflect on the care plan daily with the neighbourhood team to address each individual resident's pain".

A review of the resident's clinical records found no documented evidence of a pain assessment completed since the resident's admission.

During an interview, a PSW stated that the resident has pain, sometimes to a specific area and that the resident can answer when asked about the pain. The PSW shared that another PSW had "better luck with the resident", and stated that the resident did have pain to a different area in the past. The PSW shared that resident's pain would be documented in the shift change report or the family would report it.

During an interview, an RPN said that the resident has facial expressions for demonstrating pain to a specific area but never complained about pain in the the area the care plan refers to. Review of the resident's current care plan, with the RPN indicated that the resident's pain to that area was not recurrent, that it should not be in the care plan and that there was no focus for pain. The RPN stated that they knew the resident had pain in a specific area, and had given the resident an analgesic in the past for the pain.

During an interview, the DOC stated that no pain assessments were completed for the resident and that there should have been a pain assessment (PAINAD) for the resident on admission, since the resident's family had mentioned that the resident had specific pain in two areas.

A review of the resident's clinical record, with the DOC, indicated that the resident had one pain assessment completed when it was recommended by the Behavioural Support of Ontario (BSO) staff because pain was identified during transfers and during care.

The DOC shared that the home's expectation is that residents expressing pain should be assessed weekly with the PAINAD assessment. [s. 52. (2)]

(615)

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Aug 31, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère 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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
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 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

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

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection 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

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

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

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

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

Directeur
a/s Coordinateur des appels
Inspection 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

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

Issued on this 2 day of August 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : HELENE DESABRAIS

Service Area Office /
Bureau régional de services : London