Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

London Service Area Office
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130, avenue Dufferin 4ème étage
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 04, 2020	2019_778563_0041 (A2)	021955-19	Complaint

Licensee/Titulaire de permis

Sharon Farms & Enterprises Limited
108 Jensen Road LONDON ON N5V 5A4

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

Earls Court Village
1390 Highbury Avenue North LONDON ON N5Y 0B6

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

Amended by MELANIE NORTHEY (563) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

The Inspection Report has been amended to accommodate a request from the licensee to extend the compliance due date to July 31, 2020 for CO #001.

Issued on this 4 th day of May, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Amended by MELANIE NORTHEY (563) - (A2)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 27 and 28, December 3, 4, 5, 6, 9 and 10, 2019

During the course of the inspection, the inspector(s) spoke with the complainant, Responsive Health Management Nurse Consultant, the Director of Care, the Assistant Director of Care, the Staff Development Coordinator, the Clinical Practice Coordinator, the Registered Dietitian, Registered Nursing Staff, Personal Support Workers and a resident.

The inspector also made observations of the resident and care provided. Relevant policies and procedures, as well as education records, clinical records and plans of care for the identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

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

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

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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; O. Reg. 79/10, s. 50 (2).
(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).
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).
(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).

Findings/Faits saillants :

The licensee has failed to shall ensure that three residents 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, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required, were assessed by a registered dietitian who was a member of the staff of the home,

were reassessed at least weekly by a member of the registered nursing staff if clinically indicated and the equipment, supplies, devices and positioning aids were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

The Ministry of Health and Long Term Care Complaint Information Report documented an anonymous complaint regarding the skin and wound program at Earls Court Village. The complainant reported concerns related to wound treatments and worsening wounds for multiple residents. Specifically, three residents had worsening wounds with significant negative outcomes for the residents involved.

Ontario Regulation (O. Reg.) 79/10, s. 50 (3) states, altered skin integrity means potential or actual disruption of epidermal or dermal tissue.

The Assistant Director of Care (ADOC) stated moving forward the weekly completion of wound assessments would be audited and management would follow up with the registered staff involved. The ADOC stated there was an audit of the skin and wound assessments to ensure completion. The audit was completed by a Registered Nurse (RN) and a Registered Practical Nurse (RPN) at the end of the day on Wednesdays. Weekly wound assessments were routinely completed on Wednesdays by the RN and RPN . The ADOC stated there were a few knowledge gaps identified with registered staff, and the assessments were missing the basic information related to location and type of wound. The ADOC stated it was the small details that were required in the statistics related to wound monitoring and auditing. The information documented as part of the wound assessments were consistently inaccurate for the three residents and created an inaccurate picture of the wounds captured as part of the Point Click Care (PCC) audit.

The Skin & Wound Evaluation - V6.0 was the clinically appropriate assessment instrument that was specifically designed for skin and wound assessment used at Earls Court Village. The three residents were reassessed at least weekly by a member of the registered nursing staff and each of the five wounds were deteriorating over the course of several months. One of the three residents also developed an additional pressure ulcer during the course of the inspection.

The Skin & Wound Evaluation - V6.0 created a PUSH score. The Pressure Ulcer Scale for Healing (PUSH) tool measures three parameters that were considered

most indicative of healing: wound size (greatest length x greatest width = wound surface area), exudate amount (estimate as light, moderate or heavy after removal of the dressing), and tissue type (closed/resurfaced, epithelial tissue, granulation tissue, slough, necrotic tissue). The ADOC stated the home did not use the PUSH score, but because the information imputed was consistently incorrect, the value for the PUSH would also be wrong. Many assessments document “none” related to “dressing appearance” and sometimes the registered staff were choosing “missing”, sometimes “none”, and other times it was not completed. Also, “Pain” was documented “Cognitively Impaired – Yes” with no other assessment details documented. The ADOC stated the registered staff did not understand that when pain was identified, the resident was to be assessed and provided medications for pain and the assessment needed to reflect in the plan of care. The ADOC stated if the wound had evidence of infection, the registered staff were to follow up with the physician, possibly swab the wound and start the resident on antibiotics. The ADOC had found the registered staff required more education and needed to understand what the root cause was and what the preventative measures were. Additional care interventions were listed under the treatment section of the evaluation. The evaluations differed each week regarding the additional care interventions provided for the three residents. The ADOC stated the nurse would re-evaluate the interventions in place and reference the care plan and they were not referring to the current plan of care to assess whether interventions were still appropriate and document them as part of the wound assessment. The ADOC shared that the registered staff were choosing from a drop-down menu whether a wound was stable, healing, stalled or deteriorated and verified many assessments for multiple residents were inaccurate related to wound status. Many wound assessments document that the area was a stage IV, then some say Moisture Associated Skin Damage (MASD) for the same wound. The ADOC stated the nurse was also choosing the type of wound. The ADOC verified that when they evaluated the skin and wound program, they were able to study the assessments and soon realized the registered staff needed more education on using the skin and wound application.

The Skin and Wound audit was recently completed and documented multiple areas of altered skin integrity for multiple residents on each of the four resident care areas at Earls Court Village. Wounds varied from abrasions to unstageable pressure ulcers.

The "Impaired Skin Integrity" algorithm instructed the registered staff to enter the wound order in the electronic Treatment Administration Record (eTAR) and

Medical Directive (MD) for "Weekly Skin and Wound Assessment Q Wed: (location and type of wound)", refer to the Registered Dietitian (refer to Physio if necessary) and update the plan of care to include the treatment order in the MD and eTAR. The ADOC stated it was an expectation to document in the eTAR when a wound assessment was completed for both the scheduled weekly assessment and when the wound assessment was completed as needed (PRN). The ADOC stated the treatment order related to a wound would be in the eTAR and under the orders tab in PCC. There would also be the treatment protocol order and weekly wound assessment order in the eTAR and it was primarily the unit supervisor’s responsibility to create the treatment order in the eTAR. It was also the Assistance Director of Care also creates eTAR wound orders in PCC. For one of the resident's, there was no treatment order for their wound upon return from hospital.

The Registered Dietitian (RD) stated a RD referral should be completed if a wound was progressively deteriorating and for the three residents, a RD referral was not sent when there was a progressive deterioration of their wounds. The RD explained they were not a current member of the skin and wound team and have not been asked to join the team since it was assembled by the ADOC and shared they would expect to be a member of the skin and wound team. The RD verified they were a part of the annual skin and wound evaluation but could no recall when it was completed. The RD said the evaluation was completed prior to “the derailment”.

The ADOC verified registered staff failed to follow the step by step process for impaired skin integrity. The registered staff failed to implement pain management as needed when pain was present during the dressing change and wound assessment and there was no follow up with the physician to recommend a change in the pain management orders to relieve the residents’ pain. Registered staff did not implement infection control measures (culture and sensitivity) were appropriate to promote wound healing. The registered staff did not monitor the residents’ temperature every shift when signs of wound infection were present and did not notify the physician for an antibiotic order or change in the current treatment plan that proved ineffective. The ADOC stated residents’ plans of care were incomplete with missing treatment records and the registered were signing for the administration of weekly wound assessments when the assessments were incomplete or missing. The ADOC also verified the wound assessments were incomplete and/or inaccurate. When a resident had low food and fluid intake, the 72 hours food and fluid intake monitoring was not implemented when appropriate.

The plan of care for one resident was not implement related to the therapeutic surface measures to protect the resident from further skin breakdown and for positioning while in bed. The ADOC also verified the monthly tracking and analysis did not occur in October 2019 and a new wound tracking form was started in November 2019.

The Surge Learning education was not provided to all staff related to the skin and wound program in 2019. The ADOC and Staff Development Coordinator (SDC) stated they reviewed the Surge Learning and there was no mandatory component for skin and wound. All other required programs including falls, continence, etc. were present and completed, but not for the skin and wound program.

The Ontario Regulation (O. Reg.) 79/10, s. 221 (1) states, “For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents: skin and wound care.” The Surge Learning education was not provided to all staff related to the skin and wound program in 2019.

The Responsive Health Management 2001 Skin & Wound Management Program last revised June 5, 2019 stated the primary goals of the skin and wound management program included proactively managing clinical outcomes for wound and risk management, identification and management of risk factors, wound assessment, classification and management, tracking and trending of wounds and risk patterns, annual evaluations of the wound and skin care program to reflect best practices, enhancements of clinical knowledge in wound management and enhancements of skills in the areas of prevention, wound assessment and documentation. “The risk factors for skin breakdown are mobility, activity, moisture, nutrition, friction, shear, and pressure.” Registered staff were to “Consider the need to change treatment plan if no healing seen within 2-3 weeks”. Pain management was identified as an important aspect of effective wound care and management and by decreasing the residents’ pain, clinicians cannot only increase comfort levels of the residents, but can also decrease sympathetic nervous system related vasoconstriction, which increases tissue oxygenation and perfusion. Pain management may also increase the rate of wound healing and decrease the chance of infection. The skin and wound program stated it was important to implement a plan of care tailored to the particular needs of the residents.

Based on the staff interviews, clinical record reviews and observations, the

licensee failed to ensure that three residents 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, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required, was assessed by a registered dietitian who was a member of the staff of the home, and was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. The licensee did not follow the Responsive Health Management 2001 Skin & Wound Management Program to proactively manage clinical outcomes for wound and risk management for the three residents. The program stated there should be enhancements of clinical knowledge in wound management and enhancements of skills in the areas of prevention, wound assessment and documentation. There was clear evidence that the registered staff required enhanced learning related to wound management, assessment and documentation, as well as their implementation of clinical judgement to follow up with the physician and other health practitioners to prevent infection and promote healing. The registered staff repeatedly did not consider the need to change the treatment plan if no healing was seen within two to three weeks. Pain management was identified as an important aspect of the skin and wound program and for effective wound care, registered staff were to ensure the comfort levels of the residents during dressing changes. Two of the three residents had an order for pain medication as needed and they were not administered the medication for as an intervention to reduce or relieve their pain. The medical directive for pain medication as needed was not administered for months for both residents when there was pain indicated during the dressing changes. Although, the plan of care was to complete wound dressing changes around scheduled administration of pain medication, that did not occur for one of the residents. When the scheduled pain medication did not alleviate another resident's discomfort, the wound dressing changes were never care planned around the resident's scheduled administration of pain medication. The skin and wound program stated it was important to implement a plan of care tailored to the residents' needs and that was not implemented for two of the three residents. Pain management may also increase the rate of wound healing and decrease the chance of infection. The three residents had infected wounds.

The licensee has failed to shall ensure that three residents 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, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required, were assessed by a registered dietitian who was a member of the staff of the home, were reassessed at least weekly by a member of the registered nursing staff if clinically indicated and the equipment, supplies, devices and positioning aids were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing. [s. 50. (2)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 4 th day of May, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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Inspection de soins de longue durée

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MELANIE NORTHEY (563) - (A2)
Inspection No. / No de l'inspection :	2019_778563_0041 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	021955-19 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	May 04, 2020(A2)
Licensee / Titulaire de permis :	Sharon Farms & Enterprises Limited 108 Jensen Road, LONDON, ON, N5V-5A4
LTC Home / Foyer de SLD :	Earls Court Village 1390 Highbury Avenue North, LONDON, ON, N5Y-0B6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rob Bissonnette

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Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Sharon Farms & Enterprises Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / No d'ordre: 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 must be compliant with r. 50 (2) of the O/Reg. 79/10.
Specifically, the licensee must:

a) Ensure a resident receives a skin assessment by a member of the registered nursing staff according to r. 50(2)(a).
b) Ensure that a resident 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.
c) Ensure that a resident receives immediate treatment and interventions to reduce or relieve pain. Ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed and the registered staff administer pain medications as ordered to the resident, including pain management as needed (PRN).
d) Ensure that a resident receives immediate treatment and interventions to promote healing, and prevent infection, as required. Ensure symptoms indicating the presence of a wound infection for a resident are documented as part of a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and the resident's temperature is monitored daily and documented as part of their clinical record.
e) Ensure that a resident is assessed by a Registered Dietitian (RD) 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. When those interventions are proven ineffective, or the resident refuses, or the wound continues to decline in status, ensure a Dietary Referral is completed.
f) Ensure that a resident's altered skin integrity is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
g) Ensure that a resident's plan of care related to the use of equipment, supplies, devices and positioning aids are provided as planned to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing. Ensure the plan of care provides clear direction to staff and others who provide direct care related to the use of pressure relieving interventions for a resident.
h) Ensure there is a treatment protocol order and weekly wound assessment order in the electronic Treatment Administration Record (eTAR) for each wound identified for a resident.
i) Ensure the registered staff are signing the eTAR when a treatment protocol and weekly wound assessment is provided to a resident.
j) Ensure that training is provided to all staff who provide direct care to

residents related to the skin and wound program. Ensure there is a written record of the education provided and a written record of attendance.
k) Ensure all registered staff and Nurse Managers are educated related to the Skin & Wound Program. Registered staff must be educated on the primary goals of the skin and wound management program including proactively managing clinical outcomes for wound and risk management, identification and management of risk factors, and wound assessment, classification and management. Ensure enhancements of clinical knowledge in wound management and enhancements of skills in the areas of prevention, wound assessment and documentation are provided to the registered staff. Ensure there is a written record of the education provided, and a written record of attendance with signatures.
l) Ensure the Skin and Wound Program includes an interdisciplinary team including team members for physiotherapy and nutrition care.
m) Ensure the home is tracking and trending wounds and risk patterns weekly including infections and hospitalizations related to wounds. Ensure there is a written record of the tracking and trending of wounds.
n) Ensure the home is auditing the accurate completion of initial and weekly skin assessments. A weekly audit shall be undertaken of the clinically appropriate assessment instrument that is specifically designed for skin and wound assessment to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. Ensure there is a written record of everything.

Grounds / Motifs :

1. The licensee has failed to shall ensure that three residents 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, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required, were assessed by a registered dietitian who was a member of the staff of the home, were reassessed at least weekly by a member of the registered nursing staff if clinically indicated and the equipment, supplies, devices and positioning aids were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

The Ministry of Health and Long Term Care Complaint Information Report documented an anonymous complaint regarding the skin and wound program at Earls Court Village. The complainant reported concerns related to wound treatments and worsening wounds for multiple residents. Specifically, three residents had worsening wounds with significant negative outcomes for the residents involved.

Ontario Regulation (O. Reg.) 79/10, s. 50 (3) states, altered skin integrity means potential or actual disruption of epidermal or dermal tissue.

The Assistant Director of Care (ADOC) stated moving forward the weekly completion of wound assessments would be audited and management would follow up with the registered staff involved. The ADOC stated there was an audit of the skin and wound assessments to ensure completion. The audit was completed by a Registered Nurse (RN) and a Registered Practical Nurse (RPN) at the end of the day on Wednesdays. Weekly wound assessments were routinely completed on Wednesdays by the RN and RPN . The ADOC stated there were a few knowledge gaps identified with registered staff, and the assessments were missing the basic information related to location and type of wound. The ADOC stated it was the small details that were required in the statistics related to wound monitoring and auditing. The information documented as part of the wound assessments were consistently inaccurate for the three residents and created an inaccurate picture of the wounds captured as part of the Point Click Care (PCC) audit.

The Skin & Wound Evaluation - V6.0 was the clinically appropriate assessment instrument that was specifically designed for skin and wound assessment used at Earls Court Village. The three residents were reassessed at least weekly by a member of the registered nursing staff and each of the five wounds were deteriorating over the course of several months. One of the three residents also developed an additional pressure ulcer during the course of the inspection.

The Skin & Wound Evaluation - V6.0 created a PUSH score. The Pressure Ulcer Scale for Healing (PUSH) tool measures three parameters that were considered most indicative of healing: wound size (greatest length x greatest width = wound surface area), exudate amount (estimate as light, moderate or heavy after removal of the dressing), and tissue type (closed/resurfaced, epithelial tissue, granulation tissue, slough, necrotic tissue). The ADOC stated the home did not use the PUSH score, but because the information imputed was consistently incorrect, the value for the PUSH

would also be wrong. Many assessments document "none" related to "dressing appearance" and sometimes the registered staff were choosing "missing", sometimes "none", and other times it was not completed. Also, "Pain" was documented "Cognitively Impaired – Yes" with no other assessment details documented. The ADOC stated the registered staff did not understand that when pain was identified, the resident was to be assessed and provided medications for pain and the assessment needed to reflect in the plan of care. The ADOC stated if the wound had evidence of infection, the registered staff were to follow up with the physician, possibly swab the wound and start the resident on antibiotics. The ADOC had found the registered staff required more education and needed to understand what the root cause was and what the preventative measures were. Additional care interventions were listed under the treatment section of the evaluation. The evaluations differed each week regarding the additional care interventions provided for the three residents. The ADOC stated the nurse would re-evaluate the interventions in place and reference the care plan and they were not referring to the current plan of care to assess whether interventions were still appropriate and document them as part of the wound assessment. The ADOC shared that the registered staff were choosing from a drop-down menu whether a wound was stable, healing, stalled or deteriorated and verified many assessments for multiple residents were inaccurate related to wound status. Many wound assessments document that the area was a stage IV, then some say Moisture Associated Skin Damage (MASD) for the same wound. The ADOC stated the nurse was also choosing the type of wound. The ADOC verified that when they evaluated the skin and wound program, they were able to study the assessments and soon realized the registered staff needed more education on using the skin and wound application.

The Skin and Wound audit was recently completed and documented multiple areas of altered skin integrity for multiple residents on each of the four resident care areas at Earls Court Village. Wounds varied from abrasions to unstageable pressure ulcers.

The "Impaired Skin Integrity" algorithm instructed the registered staff to enter the wound order in the electronic Treatment Administration Record (eTAR) and Medical Directive (MD) for "Weekly Skin and Wound Assessment Q Wed: (location and type of wound)", refer to the Registered Dietitian (refer to Physio if necessary) and update the plan of care to include the treatment order in the MD and eTAR. The ADOC stated it was an expectation to document in the eTAR when a wound assessment

was completed for both the scheduled weekly assessment and when the wound assessment was completed as needed (PRN). The ADOC stated the treatment order related to a wound would be in the eTAR and under the orders tab in PCC. There would also be the treatment protocol order and weekly wound assessment order in the eTAR and it was primarily the unit supervisor's responsibility to create the treatment order in the eTAR. It was also the Assistance Director of Care also creates eTAR wound orders in PCC. For one of the resident's, there was no treatment order for their wound upon return from hospital.

The Registered Dietitian (RD) stated a RD referral should be completed if a wound was progressively deteriorating and for the three residents, a RD referral was not sent when there was a progressive deterioration of their wounds. The RD explained they were not a current member of the skin and wound team and have not been asked to join the team since it was assembled by the ADOC and shared they would expect to be a member of the skin and wound team. The RD verified they were a part of the annual skin and wound evaluation but could no recall when it was completed. The RD said the evaluation was completed prior to "the derailment".

The ADOC verified registered staff failed to follow the step by step process for impaired skin integrity. The registered staff failed to implement pain management as needed when pain was present during the dressing change and wound assessment and there was no follow up with the physician to recommend a change in the pain management orders to relieve the residents' pain. Registered staff did not implement infection control measures (culture and sensitivity) were appropriate to promote wound healing. The registered staff did not monitor the residents' temperature every shift when signs of wound infection were present and did not notify the physician for an antibiotic order or change in the current treatment plan that proved ineffective. The ADOC stated residents' plans of care were incomplete with missing treatment records and the registered were signing for the administration of weekly wound assessments when the assessments were incomplete or missing. The ADOC also verified the wound assessments were incomplete and/or inaccurate. When a resident had low food and fluid intake, the 72 hours food and fluid intake monitoring was not implemented when appropriate. The plan of care for one resident was not implement related to the therapeutic surface measures to protect the resident from further skin breakdown and for positioning while in bed. The ADOC also verified the monthly tracking and analysis did not occur in October 2019 and a new wound tracking form was started in November 2019.

The Surge Learning education was not provided to all staff related to the skin and wound program in 2019. The ADOC and Staff Development Coordinator (SDC) stated they reviewed the Surge Learning and there was no mandatory component for skin and wound. All other required programs including falls, continence, etc. were present and completed, but not for the skin and wound program.

The Ontario Regulation (O. Reg.) 79/10, s. 221 (1) states, "For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents: skin and wound care." The Surge Learning education was not provided to all staff related to the skin and wound program in 2019.

The Responsive Health Management 2001 Skin & Wound Management Program last revised June 5, 2019 stated the primary goals of the skin and wound management program included proactively managing clinical outcomes for wound and risk management, identification and management of risk factors, wound assessment, classification and management, tracking and trending of wounds and risk patterns, annual evaluations of the wound and skin care program to reflect best practices, enhancements of clinical knowledge in wound management and enhancements of skills in the areas of prevention, wound assessment and documentation. "The risk factors for skin breakdown are mobility, activity, moisture, nutrition, friction, shear, and pressure." Registered staff were to "Consider the need to change treatment plan if no healing seen within 2-3 weeks". Pain management was identified as an important aspect of effective wound care and management and by decreasing the residents' pain, clinicians cannot only increase comfort levels of the residents, but can also decrease sympathetic nervous system related vasoconstriction, which increases tissue oxygenation and perfusion. Pain management may also increase the rate of wound healing and decrease the chance of infection. The skin and wound program stated it was important to implement a plan of care tailored to the particular needs of the residents.

Based on the staff interviews, clinical record reviews and observations, the licensee failed to ensure that three residents 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, received

immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required, was assessed by a registered dietitian who was a member of the staff of the home, and was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. The licensee did not follow the Responsive Health Management 2001 Skin & Wound Management Program to proactively manage clinical outcomes for wound and risk management for the three residents. The program stated there should be enhancements of clinical knowledge in wound management and enhancements of skills in the areas of prevention, wound assessment and documentation. There was clear evidence that the registered staff required enhanced learning related to wound management, assessment and documentation, as well as their implementation of clinical judgement to follow up with the physician and other health practitioners to prevent infection and promote healing. The registered staff repeatedly did not consider the need to change the treatment plan if no healing was seen within two to three weeks. Pain management was identified as an important aspect of the skin and wound program and for effective wound care, registered staff were to ensure the comfort levels of the residents during dressing changes. Two of the three residents had an order for pain medication as needed and they were not administered the medication for as an intervention to reduce or relieve their pain. The medical directive for pain medication as needed was not administered for months for both residents when there was pain indicated during the dressing changes. Although, the plan of care was to complete wound dressing changes around scheduled administration of pain medication, that did not occur for one of the residents. When the scheduled pain medication did not alleviate another resident's discomfort, the wound dressing changes were never care planned around the resident's scheduled administration of pain medication. The skin and wound program stated it was important to implement a plan of care tailored to the residents' needs and that was not implemented for two of the three residents. Pain management may also increase the rate of wound healing and decrease the chance of infection. The three residents had infected wounds.

The licensee has failed to shall ensure that three residents 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, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required, were assessed by a registered dietitian who was a member of the staff of the home, were reassessed at

least weekly by a member of the registered nursing staff if clinically indicated and the equipment, supplies, devices and positioning aids were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

The severity of this issue was determined to be a level 3 as there was actual harm and actual risk. The scope of the issue was a level 3 as it was related to 3 out of 3 residents reviewed. The home had a level 3 history as they had one or more non-compliance(s) with this section of the LTCHA that included:
- Voluntary Plan of Correction (VPC) for Complaint Inspection # 2017_607523_0001 issued March 16, 2017 for r. 50 (2)(a)(i) and r. 50 (2)(b)(iv).
- VPC for Resident Quality Inspection (RQI) # 2017_536537_0015 issued April 13, 2017 for r. 50 (2)(b)(iv).
- VPC for Complaint Inspection # 2017_607523_0032 issued January 4, 2018 for r.50 (2)(b)(i).
- VPC for RQI # 2018_722630_0007 issued May 24, 2018 for r.50 (2)(b)(i). (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2020(A2)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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:

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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 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

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
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 4 th day of May, 2020 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by MELANIE NORTHEY (563) - (A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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