Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 24, May 14, 2015	2015_369153_0002	T-1526-14	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

MAIN STREET TERRACE
77 MAIN STREET TORONTO ON M4E 2V6

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

LYNN PARSONS (153)

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): February 4, 5, 17, 2015 March 2, 13, 19, 2015 and April 14, 27, 28, 2015.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Attending Physician, Coroner, Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family, Substitute Decision-Maker(SDM) and electronic software representative.

Conducted observations of resident to resident interactions, staff to resident interactions, reviewed clinical health records, staffing schedules/assignments, coroner's investigation statement and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 VPC(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care for Resident #1 was met related to the following areas:
- Collaboration with staff and others involved in the care and assessment of the resident [6 (4)(a)]
- Care is provided as set out in the plan of care [6(7)]
- Reassessment of the resident when the resident's care needs change [6(10)(b)]

The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

a) On an identified date in May 2014 (Day One), it was reported that Resident #1's LEFT heel was red, swollen and contained one blister.
An initial skin assessment was completed, physician notified and referrals were sent to wound care nurse, dietitian and physiotherapist. Treatment was implemented to relieve pressure on the LEFT heel.

b) On Day Two the RN completed a 'Head to Toe Assessment' indicating there were 2 blisters on Resident #1's RIGHT heel when in fact there was only 1 blister on the resident's LEFT heel as noted in: i) the previous assessment, ii) the resident's progress notes and iii) in the picture of the wound. Interview with the RN confirmed the documentation of 2 blisters on the RIGHT heel was an error.

c) On Day Two the wound care nurse initiated the 'Treatment Administration Record' (TAR) for the LEFT heel. In addition, the wound care nurse completed the 'INITIAL Wound Assessment-Treatment Observation Record' for a wound, but failed to identify the location of the wound. An interview with the wound care nurse confirmed that the location of the wound was not identified on the 'Initial Wound Assessment-Treatment Observation Record'.

d) On Day Two the wound care nurse also completed an 'ON-GOING Assessment-Treatment Observation Record' which indicated the wound was on the Resident #1's LEFT heel.

e) On Day Five the RN completed an 'INITIAL Wound Assessment-Treatment Observation Record' which indicated that Resident #1 had a blister on the RIGHT heel but did not complete a 'Head to Toe' skin assessment for the new wound on the RIGHT heel as required by the home's skin and wound policy. The RN initiated a treatment for the wound but did not enter the treatment on the TAR.

f) On Day Five the RN completed a 'Referral for Wound Care Assessment' for the blister on the RIGHT heel.

g) On Day Six the RN completed an 'INITIAL Wound Assessment-Treatment Observation

Record' and a 'Head to Toe Assessment' for a wound on Resident #1's coccyx area and implemented treatment for the identified area. Documentation on the 'Initial Wound Assessment-Treatment Observation Record identified the wound location as #2, which according to the diagram is the right ear while documentation under the present treatment section indicated coccyx. Interview with RN confirmed a documentation error regarding the location of the wound under the location section.

A review of the progress notes completed by a RPN on an identified date and time was stroked out indicating incomplete documentation and another entry on an identified date and time indicated the following entries:
- "received resident in bed alert and responsive"
- "remains in bed this shift"
- "meal tray served by bedside, staff assisted resident with meals, had 50% both fluid and solid"
- "resident repositioned every 2 hours"
Assessment: Wound noted on resident's coccyx
- "referral made to wound nurse, physio and RD"
Plan: "POA updated on resident current health condition, continue to monitor".
Interviews with Substitute Decision-Maker (SDM) and another family member indicated they were not notified of the wound on Resident #1's coccyx until the resident had been in hospital for several days.
It is unclear as to what or if anything was mentioned to the SDM regarding the area of skin breakdown on Resident #1's coccyx.

h) On Day Six the RN recorded additional information on the 'Referral for Wound Care Assessment' that was completed on Day Five, to add information related to the coccyx area without dating the new entry.
A review of the TAR for May 2014, identified the treatment for the LEFT heel wound for Day Three and Five but failed to include treatments for the wounds on the RIGHT heel and coccyx areas.

i) On Day Eight, Resident #1 was transferred to hospital at 6:40 a.m. with an elevated temperature.

j) On Day Eight, the wound care nurse documented on the 'Referral for Wound Care Assessment' initiated three days prior, "heel has been assessed", "coccyx- resident in hospital, picture shows breakdown due to incontinence". Interview with the wound care nurse indicated the comment regarding the heel was in reference to Resident #1's LEFT

heel because the wound care nurse did not realize the resident had a wound on the RIGHT heel.

k) On Day Eleven, the registered dietitian (RD) completed a paper assessment in reference to referral dated six days prior, regarding the wound on the RIGHT heel because Resident #1 was in hospital.

l) Review of the physician's communication lists for the identified two week period and an interview with the physician confirmed he/she was not informed of the wound located on Resident #1's coccyx. Interview with the wound care nurse confirmed the home's policies for skin and wound and documentation were not followed and there was a lack of collaboration between members of the interdisciplinary team in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

m) A review of documentation completed at the hospital and an interview with the Coroner who reviewed the clinical health record at the hospital confirmed the resident was assessed by the emergency physician on an identified date in May 2014, to have an advanced wound stage sacral ulcer with no evidence of infection. [s. 6.(4)(a)] [s. 6.]

2. The licensee failed to ensure that the care set out in the plan of care was provided to Resident #1 as specified in the plan.

a) On an identified date in May 2014, Resident #1 complained of pain in lower back and groin and an inability to weight bear following a fall the previous day.
A review of the health record failed to locate a pain assessment for Resident #1 who was experiencing pain in lower back and groin area.
The resident was transferred to hospital for assessment and diagnosed with an identified medical condition.
Upon return to the home the resident remained in bed for the majority of the time over the next eleven days.

b) On an identified date in May 2014, Resident #1 complained of groin pain, a physician order was received for for an analgesic four times a day as needed for pain.
Review of the progress notes revealed Resident #1 complained of pain on movement in left groin/hip on four separate occasions.
Review of the health record failed to locate a pain assessment for Resident #1 for the

above noted occasions.
Review of the medication administration records for May 2014, revealed the resident had not received pain medication on the four separate occasions.

c) On the evening shift of an identified date in May 2014, a physician order was received for for analgesic four times a day on a regular basis versus as required, along with a direction to monitor Resident #1 for pain.
Interviews with the RN and Director of Care (DOC) confirmed a 72 hour pain assessment should have been completed when Resident #1 complained of pain on return from hospital and reassessed when the pain was not relieved on the other identified dates. Both the RN and DOC confirmed pain medication should have been administered on the identified dates when the resident complained of pain. [s. 6. (7)] [s. 6.]

3. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

a) On an identified date in May 2014, Resident #1 was found unable to weight bear and verbalized pain in lower back and groin following a fall the previous day. The resident was transferred to hospital for assessment and diagnosed with an identified medical condition.

b) Interviews with nursing staff and DOC confirmed Resident #1 was provided care in bed for the majority of time over an eleven day period due to pain experienced on movement and the inability to weight bear by self.

c) A review of the health care record failed to reveal Resident #1 was reassessed and the plan of care reviewed and revised when the resident's ability to ambulate deteriorated significantly and required the provision of care to be completed in bed.
Care areas that were not reassessed included: continence, transfer, mobility, eating and positioning/repositioning.

d) Interviews with registered staff and the DOC confirmed Resident #1 was not reassessed and the plan of care revised when the resident's care needs changed significantly, ie. provision of care was completed in bed. [s. 6. (10) (b)]

The severity of the non-compliance and the severity of the harm and risk of further harm

is actual.
There was a lack of collaboration among staff related to the skin assessments to ensure they were integrated, consistent with and complemented each other. The skin assessments were inaccurate, incomplete and the prescribed treatments were not recorded on the TAR for the right heel and coccyx areas.
Resident #1 was not provided prescribed pain medication when complaints of pain were verbalized.
Resident #1 was not reassessed and the plan of care revised when the resident experienced a change in the ability to ambulate with a walker to the need to be provided care in bed.

The scope of the non-compliance is isolated to Resident #1.

A review of the Compliance History revealed the following non-compliances related to the

Long-Term Care Homes Act, 2007, s.6 plan of care:
A Voluntary Plan of Correction (VPC) was previously issued for s.6(4)(a) during a Complaint Inspection on August 6, 2014, under Inspection # 2014_163109_0026.
A VPC was previously issued for s.6(7) during a Critical Incident System Inspection on May 14, 2012, under Inspection # 2012_083178_0017 and a Written Notification(WN) was previously issued during the Resident Quality Inspection(RQI) on September 9, 2014,under Inspection # 2014_297558_014.
A WN was previously issued for s.6(10)(b) during the RQI on September 9, 2014, under Inspection # 2014_297558_014. [s. 6.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure the Pain Assessment and Symptom Management policy instituted or otherwise put in place is complied with.

A review of home policy titled, 'Pain Assessment and Symptom Management' LTC-E-80 revised August 2012, under assessment revealed the following:
- a quick pain assessment will be completed if a resident complains of pain using a provocative, quality, region, severity, timing (PQRST) assessment and documented.
- the resident's pain will be measured using a standardized, evidence- informed clinical tool.
- the nurse will determine what tool is most appropriate for accurate pain assessment based on the resident's cognitive, physical and behavioural characteristics.

On an identified date in May 2014, Resident #1 complained of pain in lower back and groin and was unable to weight bear without assistance following a fall the previous day. A review of the clinical health record failed to locate a quick pain assessment (PQRST) or a clinically appropriate assessment.
Interviews with the RN and DOC confirmed a clinically appropriate pain assessment should have been completed on the identified date and thereafter when the resident complained of pain. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to institute or put in place a Skin and Wound Program policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act.

O. Reg. 79/10 s. 50(2) (a) (ii) states,
Every licensee shall ensure that a resident at risk of altered skin integrity receives a skin

assessment by a member of the registered nursing staff upon any return of the resident from hospital.

A review of the home's policy titled, 'Skin and Wound Care Program' revised March 2014, under procedure #5 states the following:
- all residents will have a 'Head to Toe Assessment' completed within 24 hours of returning from hospital.

Interviews with registered staff and DOC confirmed knowledge of the home's policy/procedure but were unaware of the legislative requirements related to "a resident at risk of altered skin integrity" and that the skin assessment must be conducted by "a member of the registered nursing staff upon any return of the resident from hospital". The DOC confirmed the home's skin and wound care policy was not consistent with the LTCHA and Regulations and would require revision.
The Administrator indicated the issue would be forwarded to the Corporate office for follow-up. [s. 8. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that;
- that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act
- that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the repositioning of Resident #1 under the skin and wound program was documented.

A review of the progress notes for an identified period in May 2014, identified two entries to indicate the Resident #1 was repositioned on two identified dates, only after the coccyx wound was identified. There was no other documentation found to indicate the resident was repositioned every 2 hours while being cared for in bed for the majority of the time during the eleven day period.
Interview with the DOC confirmed there was no process in place to document turning/repositioning when Resident #1 was being cared in bed in May 2014. The DOC also confirmed there is limited documentation in progress notes by the registered staff to indicate Resident #1 was repositioned and there was no documentation completed by the PSWs regarding repositioning/turning.
The DOC confirmed there was no additional monitoring of the resident's skin when Resident #1's ambulation status changed.
According to the DOC a review of the Home's 'Skin and Wound Program' completed in August 2014, identified areas requiring improvement related to repositioning and documentation for residents who are being cared for in bed. Alterations to the point of care documentation were implemented to include a requirement for the PSWs to record positioning/repositioning interventions [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to repositioning a resident under the skin and wound program are documented, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon return of the resident from hospital.

On an identified date, Resident #1 was transferred to hospital for assessment following a fall at the bedside. The resident complained of pain in right shoulder, elbow and upon assessment by the registered staff, the identified areas were noted to be red, warm to touch and painful. Assessments completed at the hospital failed to identify any fractures or injuries, the resident was transferred back to the home the following day.
A review of the progress notes for Resident #1 failed to locate a completed skin assessment for resident #1 upon return from the hospital on an identified date.
Interviews with registered staff confirmed a skin assessment was unable to be located on Resident #1's health record upon return from hospital on the identified date.
Registered staff indicated the home's policy required a skin assessment be completed within twenty-four hours upon any return of the resident from hospital.

A review of the home policy titled, 'Skin and Wound Care Program' LTC-E-90 revised March 2014, indicated all residents will have a 'Head to Toe Assessment' completed within twenty-four hours of returning from hospital. This policy conflicts with Long-Term Care Homes Act (LTCHA) and Ontario Regulations legislation section 50(2)(a) (ii), which states a resident at risk for altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.
Interview with the DOC confirmed a skin assessment should have been completed on the identified date, when the resident returned from hospital. The DOC also confirmed the home's 'Skin and Wound Care' policy was not consistent with the LTCHA and Regulations and would require revision. [s. 50. (2) (a) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon return of the resident from hospital, to be implemented voluntarily.

WN #5: 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 failed to 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.

On an identified date in May 2014, Resident #1 complained of pain in lower back and groin and an inability to weight bear following a fall the previous day.
A review of the health record failed to locate a pain assessment for Resident #1 who was experiencing pain in lower back and groin area
The resident was transferred to hospital for assessment and diagnosed with an identified medical condition.
Upon return to the home the resident was cared for in bed for the majority of the time over an eleven day period.
On an identified date,Resident #1 complained of groin pain, a physician order was received for an analgesic four times a day as needed for pain.
Review of the progress notes revealed Resident #1 complained of pain on movement in left groin/hip on four identified dates.
Review of the health record failed to locate a pain assessment for Resident #1 for the above noted dates.
Review of the medication administration record for May 2014, revealed the resident had not received pain medication on the four identified dates.
On an identified date, on the evening shift a physician order was received for an analgesic four times a day and to monitor for pain.
Interviews with the RN and DOC confirmed a 72 hour pain assessment should have been completed when Resident #1 complained of pain on an identified date and thereafter and pain medication should have been administered on the dates when the resident complained of pain. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when 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, to be implemented voluntarily.

Issued on this 26th day of May, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNN PARSONS (153)
Inspection No. / No de l'inspection :	2015_369153_0002
Log No. / Registre no:	T-1526-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 24, May 14, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	MAIN STREET TERRACE 77 MAIN STREET, TORONTO, ON, M4E-2V6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ELIZABETH BRADSHAW

To REVERA LONG TERM CARE 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order / Ordre :

The Licensee shall:
1. Develop an education plan and provide training to nursing staff and others involved in the different aspects of care in relation to the completion of skin assessments to ensure all areas are completed in full and are accurate.
2. Develop and implement a process to monitor the completion of skin assessments to ensure completeness and accuracy.
3. Develop and implement a process to ensure skin assessments completed by all staff involved in the different aspects of each resident's care are consistent with and complement each other.
4. Develop and implement a process to ensure treatment orders for pressure ulcers are communicated to the staff and are transferred to the resident's Treatment Administration Record (TAR).
5. Develop and implement a process to ensure residents who are experiencing pain are assessed and administered pain medication as prescribed to relieve discomfort and to ensure the resident's pain level is monitored and reassessed for effectiveness of pain relief after medication is provided.
6. Develop and implement a process to ensure there is a reassessment of a residents' care needs when the resident is no longer ambulatory and becomes bed bound.
7. Provide education to the nursing staff regarding the need to reposition residents who are no longer ambulatory and confined to bed.

The licensee shall prepare, submit and implement a plan for complying with Orders 1-7 and identify who will be responsible for completing all of the tasks identified in the Orders and when the Orders will be complied with.

This plan is to be submitted via email to inspector - M.Lynn.Parsons@ontario.ca by May 27, 2015. The date for complying with Orders 1 - 7 shall not be later than June 30, 2015.

Grounds / Motifs :

1. The licensee failed to ensure the plan of care for Resident #1 was met related to the following areas:
- Collaboration with staff and others involved in the care and assessment of the resident [6 (4)(a)]
- Care is provided as set out in the plan of care [6(7)]
- Reassessment of the resident when the resident's care needs change [6(10)(b)]

The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

a) On an identified date in May 2014 (Day One), it was reported that Resident #1's LEFT heel was red, swollen and contained one blister.
An initial skin assessment was completed, physician notified and referrals were sent to wound care nurse, dietitian and physiotherapist. Treatment was implemented to relieve pressure on the LEFT heel.

b) On Day Two, the RN completed a 'Head to Toe Assessment' indicating there were 2 blisters on Resident #1's RIGHT heel when in fact there was only 1 blister on the resident's LEFT heel as noted in: i) the previous assessment, ii) the resident's progress notes and iii) in the picture of the wound. Interview with the RN confirmed the documentation of 2 blisters on the RIGHT heel was an error.

c) On Day Two the wound care nurse initiated the 'Treatment Administration Record (TAR) for the LEFT heel. In addition, the wound care nurse completed the INITIAL Wound Assessment-Treatment Observation Record' for a wound, but failed to identify the location of the wound. An interview with the wound care nurse confirmed that the location of the wound was not identified on the 'Initial wound Assessment-Treatment Observation Record'..

d) On Day Two the wound care nurse also completed an 'ON-GOING Assessment- Treatment Observation Record' which indicated the wound was on Resident #1's LEFT heel.

e) On Day Five the RN completed an 'INITIAL Wound Assessment- Treatment Observation Record' which indicated that Resident #1 had a blister on the RIGHT heel but did not complete a head to toe skin assessment for the new wound on the RIGHT heel as required by the home's skin and wound policy. The RN initiated a treatment for the wound but did not enter the treatment on the TAR.

f) On Day Five the RN completed a 'Referral for a Wound Care Assessment' for the wound on the RIGHT heel.

g) On Day Six the RN completed an 'INITIAL Wound Assessment- Treatment Observation Record and a 'head to toe assessment' for a wound on Resident #1's coccyx area and implemented treatment for the identified area. Documentation on the 'INITIAL Wound Assessment-Treatment Observation Record' identified the wound location as #2, which according to the diagram is the right ear while documentation under the present treatment section indicated coccyx. Interview with RN confirmed a documentation error regarding the location of the wound under the location section.

h) On Day Six the RN recorded additional information on the 'Referral for Wound Assessment' that was completed on Day 5, to add information related to the coccyx area without dating the new entry.
A review of the TAR for May 2014, identified the treatment for the LEFT heel wound for Day Three and Five, but failed to include treatments for the wounds on the RIGHT heel and coccyx areas.

i) On Day Eight, Resident #1 was transferred to hospital at 6:40 a.m. with an elevated temperature.

j) On Day Eight the wound care nurse documented on the'Referral for Wound Care Assessment' initiated three days prior, "heel has been assessed", "coccyx-resident in hospital, picture shows breakdown due to incontinence". Interview with the wound care nurse indicated the comment regarding the heel was in reference to Resident #1's LEFT heel because the wound care nurse did not realize the resident had a wound on the RIGHT heel.

k) On Day Eleven the registered dietitian (RD) completed a paper assessment in reference to referral dated six days prior, regarding the wound on RIGHT heel because Resident #1 was in hospital.

l) Review of the physician's communication lists from the identified two week period, and interview with the physician confirmed he/she was not informed of the wound located on Resident #1's coccyx. Interview with the wound care nurse confirmed the home's policies for skin and wound and documentation were not followed and there was a lack of collaboration between members of the interdisciplinary team in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

a) On an identified date in May 2014, Resident #1 complained of pain in lower back and groin and an inability to weight bear following a fall the previous day.
A review of the health record failed to locate a pain assessment for resident #1 who was experiencing pain in lower back and groin area.
The resident was transferred to hospital for assessment and diagnosed with an identified medical condition.
Upon return to the home the resident remained bed bound for the majority of the time over the next eleven days.

b) On an identified date in May 2014, Resident #1 complained of groin pain, a physician order was received for an analgesic four times a day as needed for pain.
Review of the progress notes revealed Resident #1 complained of pain on movement in left groin/hip on four separate occasions.

c) Review of the health record failed to locate a pain assessment for Resident #1 for the above occasions.
Review of the medication administration records for May 2014, revealed the resident had not received pain medication when the resident complained of pain on the four separate occasions.

d) On the evening shift of an identified date in May 2014, a physician order was received for an analgesic four times a day to be given regularly versus as needed along with a direction to monitor Resident #1 for pain.
Interviews with the RN and Director of Care (DOC) confirmed a 72 hour pain assessment should have been completed when Resident #1 complained of pain on return from hospital and reassessed when the pain was not relieved on the other identified dates. Both the RN and DOC confirmed pain medication should have been administered on the dates when the resident complained of pain.

3. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

a) On an identified date in May 2014, Resident #1 was found unable to weight bear and verbalized pain in lower back and groin following a fall the previous day. The resident was transferred to hospital for assessment and diagnosed with an identified medical condition.

b) Interviews with nursing staff and DOC confirmed Resident #1 was provided care in bed for the majority of time over an eleven day period due to pain experienced on movement and the inability to weight bear by self.

c) A review of the health care record failed to reveal Resident #1 was reassessed and the plan of care reviewed and revised when the resident's ability to ambulate deteriorated significantly and required the provision of care to be completed in bed.
Care areas that were not reassessed included: continence, transfer, mobility, eating and positioning/repositioning.

d) Interviews with registered staff and the DOC confirmed Resident #1 was not reassessed and the plan of care revised when the resident's care needs significantlly changed, ie. provision of care was completed in bed.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.
There was a lack of collaboration among staff related to the skin assessments to ensure they were integrated, consistent with and complemented each other. The skin assessments were inaccurate, incomplete and the prescribed treatments were not recorded on the TAR for the right heel and coccyx areas.
Resident #1 was not provided prescribed pain medication when complaints of pain were verbalized.
Resident #1 was not reassessed and the plan of care revised when the resident experienced a change in the ability to ambulate with a walker to the need to be provided care in bed.

The scope of the non-compliance is isolated to Resident #1.

A review of the Compliance History revealed the following non-compliances related to the Long-Term Care Homes Act, 2007, s.6 plan of care:
A Voluntary Plan of Correction (VPC) was previously issued for s.6(4)(a) during a Complaint Inspection on August 6, 2014, under Inspection # 2014_163109_0026.

A VPC was previously issued for s.6(7) during a Critical Incident System Inspection on May 14, 2012, under Inspection # 2012_083178_0017 and a Written Notification(WN) was previously issued during the Resident Quality Inspection(RQI) on September 9, 2014,under Inspection # 2014_297558_014. A WN was previously issued for s.6(10)(b) during the RQI on September 9, 2014, under Inspection # 2014_297558_014. (153)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 14th day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNN PARSONS

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