Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 30, 2019	2019_767643_0024	014117-19, 014417-19, 014701-19, 015289-19	Critical Incident System

Licensee/Titulaire de permis

Ina Grafton Gage Home of Toronto
40 Bell Estate Road SCARBOROUGH ON M1L 0E2

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

Ina Grafton Gage Home
40 Bell Estate Road SCARBOROUGH ON M1L 0E2

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

ADAM DICKEY (643), COREY GREEN (722)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 8, 9, 12-16, and 19, 2019.

The following Critical Incident System (CIS) intakes were inspected during this inspection:
Log #014417-19; CIS #C609-000020-19, Log #014701-19; CIS #C609-000022-19 and Log #014117-19; CIS #C609-000018-19 - related to falls prevention and management, and
Log #015289-19; CIS #C609-000023-19 - related to improper transferring and positioning techniques.

During the course of the inspection, the inspector(s) spoke with the Acting Executive Director (ED), Director of Care (DOC), Nurse Manager (NM), Registered Nurses (RN), Registered Physiotherapist (PT), Registered Practical Nurses (RPN), student RPN, Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) conducted observations of staff to resident interactions and the provision of care, record review of resident health records, the home's internal investigation notes, relevant policies and procedures, staff training materials and training attendance documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 actions taken with respect to residents #001, #002 and #007 under the skin and wound care program, including interventions and the residents' responses to interventions, were documented.

a. A CIS report was received on an identified date, related to a fall involving resident #001, where the resident sustained specified injuries.

The progress notes in the electronic health record were reviewed, and indicated that the resident was transferred to hospital on the above identified date, and had a specified surgical intervention in hospital. The progress notes indicated that the resident returned to the home six days later, and a re-admission assessment indicated that the resident had a surgical incision. A note by a registered staff member, dated three days following return from hospital, indicated they had observed the incision status.There were no further progress notes identified by registered nursing staff related to the surgical incision, in terms of assessments or treatment interventions.

Inspector #722 reviewed the hospital Discharge Summary for resident #001 and there were no directions specified related to the surgical incision. Physician orders in the electronic health record as well as the resident's paper health chart, and the electronic treatment administration record (eTAR), were reviewed, and no treatments or other interventions related to the surgical incision were identified. Resident #001's care plan was also reviewed, and there were no interventions identified related to the resident's surgical incision.

Resident #001's assessments in PCC were reviewed, and there were no skin and wound assessments identified in the health record that provided information about the surgical incision or related treatment interventions.

Inspector #722 interviewed RPN #113, who confirmed that the resident had a surgical incision, a specified dressing treatment was in place when they returned from the hospital, that the incision closures were removed seven days after returning to the home, and that the area had healed well. RPN #113 indicated that the expectation was to follow the treatment directions in the hospital Discharge Summary, and to get an order from the physician if there were no directions specified. The RPN indicated that the treatment orders, either from the Discharge Summary or Physician's Orders, were to be transcribed to the resident's eTAR, and acknowledged that there were no treatments specified in the

eTAR related to resident #001's surgical incision. The RPN indicated that they never had treatment orders for the incision and acknowledged that the registered staff should have followed up with the physician to get treatment orders.

b. A CIS report was received on an identified date related to resident #002 who had sustained an identified injury which resulted in them being transferred to hospital where they had an identified surgical intervention. Resident #002 returned to the home two days following the CIS report with a surgical incision in place.

Inspector #722 reviewed the hospital Discharge Summary for resident #002, and there were no directions specified related to the surgical incision. Physician orders in the electronic record as well as the resident's paper health chart, and the eTAR were reviewed, and no treatments or other interventions related to the surgical incision were identified. Resident #002's care plan was reviewed, and there were no interventions identified related to the resident's surgical incision.

The progress notes were reviewed related to treatment interventions for resident #002's surgical incision. On return from hospital on the above identified date, a head-to-toe assessment was completed, and there was no mention of the surgical incision, nor treatment interventions. Several notes in the days that followed indicated that there was a dressing in place for the incision, but there were no details provided regarding the type of dressing. Ten days after readmission to the home, the physician ordered a specified topical medication for resident #002's surgical incision when the incision closures were removed; it was unclear if there was a dressing in place for the surgical incision after the closures were removed. Two days after the incision closures were removed a note by registered staff indicated that the area was cleaned and treated with a specified dressing. It was unclear to the inspector if the treatment and dressing documented was the appropriate treatment for the wound as it differed from the assessment below and there were no physician orders for treatment interventions.

Inspector #722 reviewed the assessments in the electronic record related to skin and wound care to identify treatment interventions for resident #002's surgical incision. No assessments that specified type of treatment intervention for the surgical incision were identified for 11 days following their return from hospital. A skin and wound assessment was identified on the 12th day, which indicated the resident had a second specified treatment and dressing applied. The treatment identified in this assessment conflicted with the treatment described by registered staff in the progress notes (see above).

Inspector #722 interviewed RPN #122, who confirmed that the resident had a surgical incision with specified closures in place when they returned from the hospital on the above identified date. The RPN indicated that a skin and wound assessment should have been completed when the resident returned from the hospital that provided details about the incision and type of treatment intervention; RPN #122 confirmed that an assessment was not completed using the required tool, and no treatment interventions were specified for the incision. The RPN was unclear about the appropriate treatment for resident #002's surgical incision, and confirmed that there were no treatment orders in the hospital Discharge Summary, no orders from the physician, no entries in resident #002's eTAR, and no interventions specified in the resident's care plan.

c. Resident #007's electronic health record was reviewed to expand the sample to determine the scope of the non-compliance related to O. Reg. 79/10, s. 30 (2) identified for residents #001 and #002.

Review of the progress notes indicated that resident #007 fell on an identified date, sustained an injury, and was transferred to the hospital. The resident was diagnosed with a specified injury which was treated with a surgical intervention two days later. The resident was readmitted to the home eight days after the fall, and the readmission assessment indicated "dressing to the surgical site is intact." No further details were provided related to resident #007's surgical incision or the type of dressing. There was a progress note 10 days following return to the home, by registered nursing staff, that indicated the incision closures were removed and the site was healed. A progress note five days following closure removal by the physician indicated that the surgical area showed no signs of infection. There were no further progress notes by registered staff related to the surgical incision or associated treatment interventions.

Inspector #722 reviewed the hospital Discharge Summary, Physician's orders, eTAR, and care plan for resident #007, and there were no treatments specified related to the resident's surgical incision on return from hospital. Inspector #722 also attempted to locate skin and wound assessments in the electronic record that identified treatments for the surgical incision, and no skin assessments were identified.

DOC #101 and Nurse Manager (NM) #111, the skin and wound care lead in the home, were interviewed separately by Inspector #722. Both indicated that registered staff were to follow the directions from the Discharge Summary for post-operative care of a resident's surgical incision and contact the physician for directions related to wound care if they were not specified in the Discharge Summary. Both indicated that registered staff

were to document the treatment directions in the Physician's Orders in the resident's health chart (if obtained verbally via telephone) and transcribe the order into the eTAR. Both the DOC and NM #111 acknowledged that there were no treatment interventions documented for residents #001, #002 and #007 related to post surgical incision care when the residents returned from the hospital. [s. 30. (2)]

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting residents #001 and #010.

a. A CIS report was received on an identified date, related to a fall involving resident #001, where the resident sustained specified injuries.

Review of the progress notes, readmission assessment, physiotherapy assessments, and care plan indicated that resident #001 had a specified weight-bearing tolerance upon return from the hospital, and required two-person assistance for all transfers using a specified method of transfer.

Inspector #722 made observations of resident #001 while in the home. On one occasion, the resident was observed to be assisted by PSW #108 to transfer from a dining chair to their specified mobility device, using a one-person transfer method. On another date, resident #001 was observed at the end of a meal service calling out that they wanted to leave the dining table. The resident stood up independently from a chair at the table and took approximately five steps along one side of the table while supporting themselves using the table; the resident was limping notably. A PSW was observed several metres away assisting another resident with mobility. The PSW looked at resident #001, informed the resident that they would return to assist them, and walked away down the

hall assisting the other resident. Inspector #722 stood up to call for help and to assist the resident, when RPN #113 and PSW #108 ran to the resident's side, and assisted the resident to sit in a chair.

Inspector #722 interviewed PSW #108, who indicated that they were aware that resident #001 required a two-person transfer and notified the inspector that they sometimes transfer the resident alone from their mobility device to their bed after meals. PSW #108 showed Inspector #722 where the directions related to transferring were located in the care plan, and also indicated that the physiotherapist had informed direct care staff that the resident had a specified weight-bearing tolerance, and required two-person assistance using a specified method when transferring.

Inspector #722 also interviewed PSW #112, who indicated that on the day of the interview, they went to resident #001's room, as they needed assistance. The PSW indicated that the resident was sitting up at the side of the bed, they raised the bed, and assisted the resident to transfer to their mobility device at the side of the bed. The PSW acknowledged that they were aware that resident #001 required a two-person assist for transfers, and confirmed that no other staff were present during the transfer.

During an interview with the PT, they indicated that they had assessed the resident when they returned form the hospital, and determined that the resident had specified weight-bearing tolerance, and needed to be transferred from one surface to another with two-person assistance using the above specified method.The PT indicated that they had updated the care plan with these directions for direct care staff, and notified staff verbally in the applicable resident home area.

Inspector #722 interviewed the DOC and NM #111, the falls prevention lead in the home, separately related to resident #001's transfer status. Both indicated that resident #001's plan of care indicated that they required two-person assistance using the above specified method when transferring between surfaces, and as the resident was transferred by one staff person they were not assisted with transferring using safe techniques.

b. A CIS report was submitted to the Ministry of Long-Term Care (MLTC) for an incident which occurred on an identified date which indicated that resident #010 had fallen during transfer from their mobility device to bed when a strap dislodged from the identified transfer device causing resident to fall, striking the edge of the bed. The CIS report further showed that resident #010 had been assisted with transferring by two staff using the resident's dedicated transfer sling.

Review of resident #010's care plan showed that they required total assistance from two staff members to be transferred. Resident #010 required the use of the above specified transfer device for all transfers.

Review of the home's investigation notes showed a typed statement from student RPN #117 which indicated that they were working on the above mentioned date, when at a specified time a PSW came out of resident #010's room and asked the student RPN to spot them while they assisted the resident with transferring. The student RPN's statement indicated that when they arrived in resident #010's room the sling had already been applied and connected to the transfer device. The statement indicated that at no point did student RPN touch any of the mechanics, controls, or sling and was not involved in their placement. The statement further indicated that when the PSW moved resident #010's mobility device away, a support strap dislodged from the transfer device and resident #010 slid from the sling onto the floor.

In an interview, student RPN #117 indicated that they were asked by PSW #118 to spot them while transferring resident #010 on the above identified date and specified shift. The student RPN indicated that they had arrived in resident #010's room and the resident was already in the sling with the sling attached to the transfer device. The student RPN indicated that they had not touched the transfer device or the sling and did not physically participate in assisting PSW #118 to transfer resident #010. The student RPN indicated that PSW #118 did not pause to check the sling once resident #010's weight was supported and raised the resident with the transfer device while student RPN stood behind resident #010 watching. Student RPN #117 indicated that PSW #118 moved the mobility device out of the way and was moving the transfer device when the strap came loose and resident #010 slid to the floor then stuck the side of the bed.

In an interview, PSW #118 indicated that they were assigned to provide care for resident #010 on the above identified date and specified shift. PSW #118 indicated that they were trying to find another PSW or RPN #121 to come and help them with transferring resident #010 but could not find anyone and asked student RPN #117 to assist them. PSW #118 indicated that they had hooked resident #010's sling to the transfer device prior to student RPN #117 arriving in the resident room. PSW #118 additionally indicated that the sling was not applied in a criss-cross pattern between resident #010's legs prior to operating the transfer device.

In an interview, NM #111 indicated that the expectation of the home was for both staff to

assist a resident to transfer with the above identified transfer device with physical assistance from both staff. One staff member would need to operate the device and the other staff member would need to hold the resident and sling to guide the resident into position once raised. NM #111 indicated that as student RPN #117 did not physically participate in the transfer process that the process was not completed by two staff members, and as a result, resident #010 had not been assisted with transferring using safe techniques. [s. 36.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents #001 and #007, who each had a surgical incision, received skin assessments by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

a. The progress notes in resident #001's electronic health record were reviewed, and indicated that the resident was transferred to hospital on an identified date, and was diagnosed with specified injuries which required surgical intervention. The progress notes indicated that the resident returned to the home six days later, and a re-admission head-to-toe assessment indicated that the resident had surgical incision with closures in place. The readmission assessment note was a head to toe assessment, with a single field for "Skin". A note by a registered staff member, dated three days following return from hospital, indicated they had observed the incision status. There were no further progress notes identified by registered nursing staff related to resident #001's surgical incision in terms of assessment or treatment.

Inspector #722 reviewed the electronic assessments for resident #001, and was unable to locate an assessment of resident #001's surgical incision using a clinical tool specifically designed for skin and wound assessments.

The home's policy titled "Wound Assessment Documentation" was reviewed, and indicated that registered staff needed to ensure that the following information was incorporated into their weekly wound assessment documentation, as per the wound assessment electronic software: dressing status (i.e., intact), drainage on dressing, location of wound, size, tracking, undermining, drainage, odour, necrotic tissue, signs of infection, stage pressure injuries, past treatment, current treatment and pain.

RPN #113 was interviewed by Inspector #722, and indicated that with any new alteration in skin integrity, registered staff were expected to use an application on a tablet at the resident's bedside to take a photo of the wound, measure the wound, and enter all relevant information regarding the wound in the application on the tablet (i.e., location, size, signs of infection, dressing, drainage, etc.). The RPN indicated that the photo and information from the tablet gets uploaded to the resident's electronic health record under the Assessment tab in the electronic record, which populates the Skin & Wound Evaluation form. RPN #113 confirmed that resident #001 returned to the home with a surgical incision, and the tool was never completed for this incision site.

The DOC and NM #111, the skin and wound care lead in the home, both confirmed in separate interviews the expectations and process for skin and wound assessments as described by RPN #113 above. Both verified that a photograph should have been taken of resident #001's surgical incision when they returned from the hospital, and relevant assessment data should have been entered into the tablet to populate the Skin & Wound Evaluation tool. Both the DOC and NM #111 confirmed that this was the required process

and clinical tool for skin and wound assessments, and that this tool was not completed for resident #001's surgical incision.

b. Resident #007's electronic health record was reviewed to expand the sample to determine the scope of the non-compliance related to O. Reg. 79/10, s. 50. (2) (b) (i) identified for resident #001.

Review of the progress notes indicated that resident #007 fell on an identified date, sustained an injury, and was transferred to the hospital. The resident was diagnosed with a specified injury which was treated with a surgical intervention two days later. The resident was readmitted to the home eight days after the fall, and the readmission assessment indicated "dressing to the surgical site is intact." No further details were provided related to resident #007's surgical incision or the type of dressing. There was a progress note 10 days following return to the home, by registered nursing staff, that indicated the incision closures were removed and the site was healed. A progress note five days following closure removal by the physician indicated that the surgical area showed no signs of infection. There were no further progress notes by registered staff related to the surgical incision or associated treatment interventions.

Inspector #722 reviewed the Assessments in the electronic record, and was unable to locate any skin and wound assessments related to resident #007's surgical incision, using the Skin & Wound Evaluation tool in the electronic record.

In an interview, NM #111 verified that the Skin & Wound Evaluation tool was not completed for resident #007's surgical incision. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that residents #001, #002 and #007 who each had surgical incisions, were reassessed at least weekly by a member of the registered nursing staff.

a. The progress notes in resident #001's electronic health record were reviewed, and indicated that the resident was transferred to hospital on an identified date, and was diagnosed with specified injuries which required surgical intervention. The progress notes indicated that the resident returned to the home six days later, and a re-admission head-to-toe assessment indicated that the resident had surgical incision with closures in place. The readmission assessment note was a head to toe assessment, with a single field for "Skin". A note by a registered staff member, dated three days following return from hospital, indicated they had observed the incision status. There were no further progress

notes identified by registered nursing staff related to resident #001's surgical incision in terms of assessment or treatment.

Inspector #722 reviewed the skin and wound assessments in the electronic record for resident #001, and was unable to locate any assessments related to resident #001's surgical incision.

Inspector #722 interviewed RPN #113, who confirmed that resident #001 returned from the hospital with a surgical incision. RPN #113 indicated that with any new alteration in skin integrity, registered staff were expected to use an application on a tablet at the resident's bedside to take a photo of the wound and enter all relevant information regarding the wound in the application on the tablet (e.g., location, size, signs of infection, dressing, drainage, etc.). The RPN indicated that the photo and information from the tablet gets uploaded to the resident's electronic health record under the Assessment tab in the electronic record, which populates the Skin & Wound Evaluation form. RPN #113 confirmed that the tool was never completed for resident #001's surgical incision. RPN #113 also indicated that skin and wound assessments by registered staff may be captured in progress notes, and acknowledged that there were no weekly assessment findings for resident #001's surgical incision documented in the progress notes by registered nursing staff after they returned from hospital until the time of inspection.

b. The progress notes were reviewed related to resident #002's surgical incision and there were no assessments identified from readmission on an identified date until 11 days later when a progress note indicated that a skin and wound assessment was completed, using the Skin & Wound Evaluation V6.0 tool.

Inspector #722 reviewed the skin and wound assessments for resident #002, and was unable to locate an assessment related to resident #002's surgical incision until 11 days following their return from hospital. The Skin & Wound Evaluation tool was completed indicating that the resident had a surgical incision with closures in place. A photograph of the incision site was also identified. This assessment was completed 11 days after the resident returned from hospital.

Inspector #722 interviewed RPN #122, who confirmed that resident #002 had a surgical incision with closures in place when they returned from the hospital. The RPN indicated that the Skin & Wound Evaluation tool should have been completed for the resident on readmission and weekly thereafter.

c. Resident #007's electronic health record was reviewed to expand the sample to determine the scope of the non-compliance related to O. Reg. 79/10, s. 50. (2) (b) (iv) identified for residents #001 and #002.

Review of the progress notes indicated that resident #007 fell on an identified date, sustained an injury, and was transferred to the hospital. The resident was diagnosed with a specified injury which was treated with a surgical intervention two days later. The resident was readmitted to the home eight days after the fall, and the readmission assessment indicated "dressing to the surgical site is intact." No further details were provided related to resident #007's surgical incision or the type of dressing. There was a progress note 10 days following return to the home, by registered nursing staff, that indicated the incision closures were removed and the site was healed. A progress note five days following closure removal by the physician indicated that the surgical area showed no signs of infection. There were no further progress notes by registered staff related to the surgical incision or associated treatment interventions.

Inspector #722 reviewed the Assessments for resident #007, and was unable to locate any skin and wound assessments related to resident #007's surgical incision, using the Skin & Wound Evaluation tool. No weekly assessments, nor progress notes indicating assessments completed were identified for resident #007's surgical incision over the 10 day period following return from hospital.

The DOC and NM #111, the skin and wound care lead in the home, both confirmed in separate interviews the expectations and process for weekly skin and wound assessments as described by RPN #113 above. Both verified that photographs should have been taken of resident #001, #002 and #007's surgical incisions when they returned from the hospital, and relevant assessment data should have been entered into the tablet to populate the Skin & Wound Evaluation tools in the electronic record. Both the DOC and NM #111 confirmed that this was the required process and clinical tool for weekly skin and wound assessments. NM #111 verified that weekly assessments were not completed for residents #001, #002 and #007 related to their surgical incisions. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place was complied with.

As required by the Regulation (O. Reg. 79/10, s. 48 (1). 1) the licensee was required to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home. As required by the Regulation (O. Reg. 79/10, s. 30 (1). 1) a written description of the program was required that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Review of the home's policy titled Post Fall Assessment Policy showed that if there was evidence of a head injury, staff were expected to initiate head injury routine (HIR) immediately and follow the HIR protocol. Review of the home's policy titled Head Injury Routine, policy index I.D. E-35 showed that the resident should be closely observed and assessed, and vital signs monitored according to established guidelines subsequent to a head injury or suspected head injury. The following vital assessments to be included in the HIR procedure were to include blood pressure, pulse, respiration, pupil reaction, and

level of consciousness (LOC). The above vital assessments were to be documented for 48 hours in the electronic progress notes as follows:
- Hourly (q1h) for the first four hours;
- Every two hours (q2h) for the next four hours;
- Every four hours (q4h) for the next 16 hours; and
- Every eight hours (q8h) for the next 24 hours.

A CIS report was submitted to the Ministry of Long-Term Care (MLTC) for an incident which occurred on an identified date which indicated that resident #010 had fallen during transfer from their mobility device to bed when a strap dislodged from the identified transfer device causing resident to fall.

Review of resident #010's electronic progress notes showed that on the above identified date, at an identified time, resident #010 had fallen onto the floor when being assisted to transfer. Post fall incident note was completed by RPN #121, documenting blood pressure, pulse, respirations, pupil reaction and LOC. Resident #010 was transferred to hospital for assessment approximately one hour following the fall incident. Further review of progress notes showed that resident #010 returned to the home approximately 16 hours following the fall incident. Documentation of resident #010's assessment and monitoring data was reviewed and showed incomplete documentation of the above vital signs and documentation frequency as per the home's HIR protocol.

In interviews, RPNs #113, #120 and #121 indicated that HIR would be initiated for residents who had sustained an un-witnessed fall, as well as those who were suspected to have hit their head during a fall incident. The RPNs indicated that the HIR would be initiated immediately in the above cases and would then be completed q1h four times, q2h two times, q4h four times and q8h three times for a total of 48 hours. The RPNs indicated that there was a specific HIR note in the electronic record which documented the required vitals, pupil reaction and LOC. The RPNs further indicated that a note would be placed at the nursing station indicating a resident was to be monitored for HIR and would be discussed at shift report as well.

In an interview, NM #111 indicated that registered staff were expected to initiate HIR immediately following an un-witnessed fall and for residents that have a suspected head injury. The NM indicated that the HIR should be completed as per the home's protocol for the 48 hours following the fall. NM #111 acknowledged that for resident #010 staff did not complete the HIR monitoring and assessment as per the home's HIR policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the strategies provided by the interdisciplinary falls prevention and management program required under O. Reg. 79/10, s. 48 (1) 1, to reduce or mitigate falls, including the monitoring of residents are complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to resident #003, for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident.

A CIS report was received by the Director on an identified date for an incident that occurred three days prior where resident #003 fell, sustained an injury, and was transferred to hospital.

Review of the progress notes indicated that resident #002 fell in an identified resident home area on the above identified date. RPN #124 and RN #125 assessed the resident post fall and identified injuries, notified the physician, called 911, and sent the resident to hospital. The progress notes indicated that on the date of the fall, a physician from the hospital contacted the home and indicated that resident #003 had sustained a specified injury and would require surgical intervention.

During separate interviews with RN #125 and RPN #124, they both indicated that resident #003 had a significant change in their status when they sustained their fall resulting from a specified injury that required surgical intervention. RN #125 indicated that in their assessment, they suspected the resident had sustained the specified injury. Both registered staff indicated that the incident occurred on their shift, and that they did not contact the after-hours line that day; they indicated that the home's on-call manager, who was notified of the incident, was responsible for reporting the critical incident to the Ministry. RN #125 indicated that maybe they should have called the after-hours line.

Inspector #722 interviewed Nurse Manager (NM) #111, the falls prevention lead in the home, who confirmed that resident's #003's fall resulted in a significant change in condition for the resident, and that the Ministry should have been notified via the after-hours pager when the resident sustained their fall. NM #111 confirmed that this critical incident was submitted to the Director two business days after the critical incident. [s. 107. (3) 4.]

Issued on this 6th day of September, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643), COREY GREEN (722)
Inspection No. / No de l'inspection :	2019_767643_0024
Log No. / No de registre :	014117-19, 014417-19, 014701-19, 015289-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 30, 2019
Licensee / Titulaire de permis :	Ina Grafton Gage Home of Toronto 40 Bell Estate Road, SCARBOROUGH, ON, M1L-0E2
LTC Home / Foyer de SLD :	Ina Grafton Gage Home 40 Bell Estate Road, SCARBOROUGH, ON, M1L-0E2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Althea Bess

To Ina Grafton Gage Home of Toronto, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 30. (2).

The licensee shall prepare, submit and implement a plan to ensure that any actions taken with respect to a resident under the skin and wound care program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The plan must include, but is not limited to the following:
1) For all residents returning to the home post surgical intervention, that treatment plans are reviewed from hospital discharge recommendations, or in the absence of treatment recommendations, an order is obtained from the resident's physician for treatment of surgical incision sites.
2) Documentation process for the provision of treatments ordered for all surgical wounds and incisions, and the status of the incision site(s).

Please submit the written plan, quoting inspection #2019_767643_0024 and inspector Adam Dickey by email to TorontoSAO.moh@ontario.ca no later than September 18, 2019.

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

Grounds / Motifs :

1. The licensee failed to ensure that actions taken with respect to residents #001, #002 and #007 under the skin and wound care program, including interventions and the residents' responses to interventions, were documented.

a. A CIS report was received on an identified date, related to a fall involving resident #001, where the resident sustained specified injuries.

The progress notes in the electronic health record were reviewed, and indicated that the resident was transferred to hospital on the above identified date, and had a specified surgical intervention in hospital. The progress notes indicated that the resident returned to the home six days later, and a re-admission assessment indicated that the resident had a surgical incision. A note by a registered staff member, dated three days following return from hospital, indicated they had observed the incision status.There were no further progress notes identified by registered nursing staff related to the surgical incision, in terms of assessments or treatment interventions.

Inspector #722 reviewed the hospital Discharge Summary for resident #001 and there were no directions specified related to the surgical incision. Physician orders in the electronic health record as well as the resident's paper health chart, and the electronic treatment administration record (eTAR), were reviewed, and no treatments or other interventions related to the surgical incision were identified. Resident #001's care plan was also reviewed, and there were no interventions identified related to the resident's surgical incision.

Resident #001's assessments in PCC were reviewed, and there were no skin and wound assessments identified in the health record that provided information about the surgical incision or related treatment interventions.

Inspector #722 interviewed RPN #113, who confirmed that the resident had a surgical incision, a specified dressing treatment was in place when they returned from the hospital, that the incision closures were removed seven days after returning to the home, and that the area had healed well. RPN #113 indicated that the expectation was to follow the treatment directions in the hospital Discharge Summary, and to get an order from the physician if there were no directions specified. The RPN indicated that the treatment orders, either from the Discharge Summary or Physician's Orders, were to be transcribed to the resident's eTAR, and acknowledged that there were no treatments specified in the eTAR related to resident #001's surgical incision. The RPN indicated that they never had treatment orders for the incision and acknowledged that the registered staff should have followed up with the physician to get treatment

orders.

b. A CIS report was received on an identified date related to resident #002 who had sustained an identified injury which resulted in them being transferred to hospital where they had an identified surgical intervention. Resident #002 returned to the home two days following the CIS report with a surgical incision in place.

Inspector #722 reviewed the hospital Discharge Summary for resident #002, and there were no directions specified related to the surgical incision. Physician orders in the electronic record as well as the resident's paper health chart, and the eTAR were reviewed, and no treatments or other interventions related to the surgical incision were identified. Resident #002's care plan was reviewed, and there were no interventions identified related to the resident's surgical incision.

The progress notes were reviewed related to treatment interventions for resident #002's surgical incision. On return from hospital on the above identified date, a head-to-toe assessment was completed, and there was no mention of the surgical incision, nor treatment interventions. Several notes in the days that followed indicated that there was a dressing in place for the incision, but there were no details provided regarding the type of dressing. Ten days after readmission to the home, the physician ordered a specified topical medication for resident #002's surgical incision when the incision closures were removed; it was unclear if there was a dressing in place for the surgical incision after the closures were removed. Two days after the incision closures were removed a note by registered staff indicated that the area was cleaned and treated with a specified dressing. It was unclear to the inspector if the treatment and dressing documented was the appropriate treatment for the wound as it differed from the assessment below and there were no physician orders for treatment interventions.

Inspector #722 reviewed the assessments in the electronic record related to skin and wound care to identify treatment interventions for resident #002's surgical incision. No assessments that specified type of treatment intervention for the surgical incision were identified for 11 days following their return from hospital. A skin and wound assessment was identified on the 12th day, which indicated the resident had a second specified treatment and dressing applied. The treatment

identified in this assessment conflicted with the treatment described by registered staff in the progress notes (see above).

Inspector #722 interviewed RPN #122, who confirmed that the resident had a surgical incision with specified closures in place when they returned from the hospital on the above identified date. The RPN indicated that a skin and wound assessment should have been completed when the resident returned from the hospital that provided details about the incision and type of treatment intervention; RPN #122 confirmed that an assessment was not completed using the required tool, and no treatment interventions were specified for the incision. The RPN was unclear about the appropriate treatment for resident #002's surgical incision, and confirmed that there were no treatment orders in the hospital Discharge Summary, no orders from the physician, no entries in resident #002's eTAR, and no interventions specified in the resident's care plan.

c. Resident #007's electronic health record was reviewed to expand the sample to determine the scope of the non-compliance related to O. Reg. 79/10, s. 30 (2) identified for residents #001 and #002.

Review of the progress notes indicated that resident #007 fell on an identified date, sustained an injury, and was transferred to the hospital. The resident was diagnosed with a specified injury which was treated with a surgical intervention two days later. The resident was readmitted to the home eight days after the fall, and the readmission assessment indicated "dressing to the surgical site is intact." No further details were provided related to resident #007's surgical incision or the type of dressing. There was a progress note 10 days following return to the home, by registered nursing staff, that indicated the incision closures were removed and the site was healed. A progress note five days following closure removal by the physician indicated that the surgical area showed no signs of infection. There were no further progress notes by registered staff related to the surgical incision or associated treatment interventions.

Inspector #722 reviewed the hospital Discharge Summary, Physician's orders, eTAR, and care plan for resident #007, and there were no treatments specified related to the resident's surgical incision on return from hospital. Inspector #722 also attempted to locate skin and wound assessments in the electronic record that identified treatments for the surgical incision, and no skin assessments were

identified.

DOC #101 and Nurse Manager (NM) #111, the skin and wound care lead in the home, were interviewed separately by Inspector #722. Both indicated that registered staff were to follow the directions from the Discharge Summary for post-operative care of a resident's surgical incision and contact the physician for directions related to wound care if they were not specified in the Discharge Summary. Both indicated that registered staff were to document the treatment directions in the Physician's Orders in the resident's health chart (if obtained verbally via telephone) and transcribe the order into the eTAR. Both the DOC and NM #111 acknowledged that there were no treatment interventions documented for residents #001, #002 and #007 related to post surgical incision care when the residents returned from the hospital.

The severity of this issue was determined to be a level 2 as there was minimal risk to residents #001, #002 and #007. The scope of this issue was a level 3 as it related to three of three residents reviewed. The home had a level 3 compliance history as they had previous noncompliance with O. Reg. 79/10, s. 30. (2) in the past 36 months that included:
- Written Notification (WN) issued December 15, 2017, (2017_324535_0021). (722)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 16, 2020

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically, the licensee must:
1) Ensure that for resident #001, #010 and all other residents who require assistance with transferring, that staff assist the residents with safe transferring techniques as per their plan of care.
2) Develop an auditing system in the home to ensure staff are assisting residents with transferring using safe techniques according to resident plans of care and the home's written policies.
3) Maintain a written record of audits conducted of transferring techniques in the home. The written record must include the date and location of the audit, the resident's name, staff members audited, equipment utilized, the name of the person completing the audit, the outcome of the audit and any actions taken as a result of the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting residents #001 and #010.

a. A CIS report was received on an identified date, related to a fall involving resident #001, where the resident sustained specified injuries.

Review of the progress notes, readmission assessment, physiotherapy assessments, and care plan indicated that resident #001 had a specified weight-bearing tolerance upon return from the hospital, and required two-person assistance for all transfers using a specified method of transfer.

Inspector #722 made observations of resident #001 while in the home. On one occasion, the resident was observed to be assisted by PSW #108 to transfer from a dining chair to their specified mobility device, using a one-person transfer method. On another date, resident #001 was observed at the end of a meal service calling out that they wanted to leave the dining table. The resident stood up independently from a chair at the table and took approximately five steps along one side of the table while supporting themselves using the table; the resident was limping notably. A PSW was observed several metres away assisting another resident with mobility. The PSW looked at resident #001, informed the resident that they would return to assist them, and walked away down the hall assisting the other resident. Inspector #722 stood up to call for help and to assist the resident, when RPN #113 and PSW #108 ran to the resident's side, and assisted the resident to sit in a chair.

Inspector #722 interviewed PSW #108, who indicated that they were aware that resident #001 required a two-person transfer and notified the inspector that they sometimes transfer the resident alone from their mobility device to their bed after meals. PSW #108 showed Inspector #722 where the directions related to transferring were located in the care plan, and also indicated that the physiotherapist had informed direct care staff that the resident had a specified weight-bearing tolerance, and required two-person assistance using a specified method when transferring.

Inspector #722 also interviewed PSW #112, who indicated that on the day of the interview, they went to resident #001's room, as they needed assistance. The PSW indicated that the resident was sitting up at the side of the bed, they raised the bed, and assisted the resident to transfer to their mobility device at the side of the bed. The PSW acknowledged that they were aware that resident #001 required a two-person assist for transfers, and confirmed that no other staff were present during the transfer.

During an interview with the PT, they indicated that they had assessed the resident when they returned form the hospital, and determined that the resident had specified weight-bearing tolerance, and needed to be transferred from one surface to another with two-person assistance using the above specified method.The PT indicated that they had updated the care plan with these directions for direct care staff, and notified staff verbally in the applicable

resident home area.

Inspector #722 interviewed the DOC and NM #111, the falls prevention lead in the home, separately related to resident #001's transfer status. Both indicated that resident #001's plan of care indicated that they required two-person assistance using the above specified method when transferring between surfaces, and as the resident was transferred by one staff person they were not assisted with transferring using safe techniques.

b. A CIS report was submitted to the Ministry of Long-Term Care (MLTC) for an incident which occurred on an identified date which indicated that resident #010 had fallen during transfer from their mobility device to bed when a strap dislodged from the identified transfer device causing resident to fall, striking the edge of the bed. The CIS report further showed that resident #010 had been assisted with transferring by two staff using the resident's dedicated transfer sling.

Review of resident #010's care plan showed that they required total assistance from two staff members to be transferred. Resident #010 required the use of the above specified transfer device for all transfers.

Review of the home's investigation notes showed a typed statement from student RPN #117 which indicated that they were working on the above mentioned date, when at a specified time a PSW came out of resident #010's room and asked the student RPN to spot them while they assisted the resident with transferring. The student RPN's statement indicated that when they arrived in resident #010's room the sling had already been applied and connected to the transfer device. The statement indicated that at no point did student RPN touch any of the mechanics, controls, or sling and was not involved in their placement. The statement further indicated that when the PSW moved resident #010's mobility device away, a support strap dislodged from the transfer device and resident #010 slid from the sling onto the floor.

In an interview, student RPN #117 indicated that they were asked by PSW #118 to spot them while transferring resident #010 on the above identified date and specified shift. The student RPN indicated that they had arrived in resident #010's room and the resident was already in the sling with the sling attached to

the transfer device. The student RPN indicated that they had not touched the transfer device or the sling and did not physically participate in assisting PSW #118 to transfer resident #010. The student RPN indicated that PSW #118 did not pause to check the sling once resident #010's weight was supported and raised the resident with the transfer device while student RPN stood behind resident #010 watching. Student RPN #117 indicated that PSW #118 moved the mobility device out of the way and was moving the transfer device when the strap came loose and resident #010 slid to the floor then stuck the side of the bed.

In an interview, PSW #118 indicated that they were assigned to provide care for resident #010 on the above identified date and specified shift. PSW #118 indicated that they were trying to find another PSW or RPN #121 to come and help them with transferring resident #010 but could not find anyone and asked student RPN #117 to assist them. PSW #118 indicated that they had hooked resident #010's sling to the transfer device prior to student RPN #117 arriving in the resident room. PSW #118 additionally indicated that the sling was not applied in a criss-cross pattern between resident #010's legs prior to operating the transfer device.

In an interview, NM #111 indicated that the expectation of the home was for both staff to assist a resident to transfer with the above identified transfer device with physical assistance from both staff. One staff member would need to operate the device and the other staff member would need to hold the resident and sling to guide the resident into position once raised. NM #111 indicated that as student RPN #117 did not physically participate in the transfer process that the process was not completed by two staff members, and as a result, resident #010 had not been assisted with transferring using safe techniques.

The severity of this issue was determined to be a level 3 as there was actual risk to resident #010. The scope of this issue was a level 2 as it related to two of four residents reviewed. The home had a level 3 compliance history as they had previous noncompliance with O. Reg. 79/10, s. 36. in the last 36 months that included:
- Voluntary Plan of Correction (VPC) issued June 19, 2017, (2017_644507_0006),
- VPC issued December 15, 2017, (2017_324535_0021),

- Compliance Order (CO) issued August 23, 2018, (2018_714673_0008) with a compliance order due date of November 19, 2018, and
- Written Notification (WN) issued March 13, 2019, (2019_630589_0008). (643)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 16, 2020

Order # / Ordre no : 003

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 O. Reg. 79/10, s. 50. (2).

Specifically, the licensee must:
1) Ensure that for all residents who return to the home following surgical procedures, and exhibiting altered skin integrity; that the resident 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.
2) Ensure that all residents exhibiting altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
3) Conduct meetings with registered nursing staff in the home to communicate that surgical incision sites should be treated as areas of altered skin integrity, and should be assessed as required using the home's established skin and wound protocols.
4) Maintain record of meetings held with registered staff to include but not be limited to: dates of meetings, staff attendance, topics discussed and name of presenter.

Grounds / Motifs :

1. The licensee failed to ensure that residents #001 and #007, who each had a surgical incision, received skin assessments by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

a. The progress notes in resident #001's electronic health record were reviewed, and indicated that the resident was transferred to hospital on an identified date, and was diagnosed with specified injuries which required surgical intervention. The progress notes indicated that the resident returned to the home six days later, and a re-admission head-to-toe assessment indicated that the resident had surgical incision with closures in place. The readmission assessment note was a head to toe assessment, with a single field for “Skin”. A note by a registered staff member, dated three days following return from hospital, indicated they had observed the incision status. There were no further progress notes identified by registered nursing staff related to resident #001’s surgical incision in terms of assessment or treatment.

Inspector #722 reviewed the electronic assessments for resident #001, and was

unable to locate an assessment of resident #001's surgical incision using a clinical tool specifically designed for skin and wound assessments.

The home's policy titled "Wound Assessment Documentation" was reviewed, and indicated that registered staff needed to ensure that the following information was incorporated into their weekly wound assessment documentation, as per the wound assessment electronic software: dressing status (i.e., intact), drainage on dressing, location of wound, size, tracking, undermining, drainage, odour, necrotic tissue, signs of infection, stage pressure injuries, past treatment, current treatment and pain.

RPN #113 was interviewed by Inspector #722, and indicated that with any new alteration in skin integrity, registered staff were expected to use an application on a tablet at the resident's bedside to take a photo of the wound, measure the wound, and enter all relevant information regarding the wound in the application on the tablet (i.e., location, size, signs of infection, dressing, drainage, etc.). The RPN indicated that the photo and information from the tablet gets uploaded to the resident's electronic health record under the Assessment tab in the electronic record, which populates the Skin & Wound Evaluation form. RPN #113 confirmed that resident #001 returned to the home with a surgical incision, and the tool was never completed for this incision site.

The DOC and NM #111, the skin and wound care lead in the home, both confirmed in separate interviews the expectations and process for skin and wound assessments as described by RPN #113 above. Both verified that a photograph should have been taken of resident #001's surgical incision when they returned from the hospital, and relevant assessment data should have been entered into the tablet to populate the Skin & Wound Evaluation tool. Both the DOC and NM #111 confirmed that this was the required process and clinical tool for skin and wound assessments, and that this tool was not completed for resident #001's surgical incision.

b. Resident #007's electronic health record was reviewed to expand the sample to determine the scope of the non-compliance related to O. Reg. 79/10, s. 50. (2) (b) (i) identified for resident #001.

Review of the progress notes indicated that resident #007 fell on an identified

date, sustained an injury, and was transferred to the hospital. The resident was diagnosed with a specified injury which was treated with a surgical intervention two days later. The resident was readmitted to the home eight days after the fall, and the readmission assessment indicated "dressing to the surgical site is intact." No further details were provided related to resident #007's surgical incision or the type of dressing. There was a progress note 10 days following return to the home, by registered nursing staff, that indicated the incision closures were removed and the site was healed. A progress note five days following closure removal by the physician indicated that the surgical area showed no signs of infection. There were no further progress notes by registered staff related to the surgical incision or associated treatment interventions.

Inspector #722 reviewed the Assessments in the electronic record, and was unable to locate any skin and wound assessments related to resident #007's surgical incision, using the Skin & Wound Evaluation tool in the electronic record.

In an interview, NM #111 verified that the Skin & Wound Evaluation tool was not completed for resident #007's surgical incision. (722)

2. The licensee failed to ensure that residents #001, #002 and #007 who each had surgical incisions, were reassessed at least weekly by a member of the registered nursing staff.

a. The progress notes in resident #001's electronic health record were reviewed, and indicated that the resident was transferred to hospital on an identified date, and was diagnosed with specified injuries which required surgical intervention. The progress notes indicated that the resident returned to the home six days later, and a re-admission head-to-toe assessment indicated that the resident had surgical incision with closures in place. The readmission assessment note was a head to toe assessment, with a single field for "Skin". A note by a registered staff member, dated three days following return from hospital, indicated they had observed the incision status. There were no further progress notes identified by registered nursing staff related to resident #001's surgical incision in terms of assessment or treatment.

Inspector #722 reviewed the skin and wound assessments in the electronic

record for resident #001, and was unable to locate any assessments related to resident #001's surgical incision.

Inspector #722 interviewed RPN #113, who confirmed that resident #001 returned from the hospital with a surgical incision. RPN #113 indicated that with any new alteration in skin integrity, registered staff were expected to use an application on a tablet at the resident's bedside to take a photo of the wound and enter all relevant information regarding the wound in the application on the tablet (e.g., location, size, signs of infection, dressing, drainage, etc.). The RPN indicated that the photo and information from the tablet gets uploaded to the resident's electronic health record under the Assessment tab in the electronic record, which populates the Skin & Wound Evaluation form. RPN #113 confirmed that the tool was never completed for resident #001's surgical incision. RPN #113 also indicated that skin and wound assessments by registered staff may be captured in progress notes, and acknowledged that there were no weekly assessment findings for resident #001's surgical incision documented in the progress notes by registered nursing staff after they returned from hospital until the time of inspection.

b. The progress notes were reviewed related to resident #002's surgical incision and there were no assessments identified from readmission on an identified date until 11 days later when a progress note indicated that a skin and wound assessment was completed, using the Skin & Wound Evaluation V6.0 tool.

Inspector #722 reviewed the skin and wound assessments for resident #002, and was unable to locate an assessment related to resident #002's surgical incision until 11 days following their return from hospital. The Skin & Wound Evaluation tool was completed indicating that the resident had a surgical incision with closures in place. A photograph of the incision site was also identified. This assessment was completed 11 days after the resident returned from hospital.

Inspector #722 interviewed RPN #122, who confirmed that resident #002 had a surgical incision with closures in place when they returned from the hospital. The RPN indicated that the Skin & Wound Evaluation tool should have been completed for the resident on readmission and weekly thereafter.

c. Resident #007's electronic health record was reviewed to expand the sample

to determine the scope of the non-compliance related to O. Reg. 79/10, s. 50. (2) (b) (iv) identified for residents #001 and #002.

Review of the progress notes indicated that resident #007 fell on an identified date, sustained an injury, and was transferred to the hospital. The resident was diagnosed with a specified injury which was treated with a surgical intervention two days later. The resident was readmitted to the home eight days after the fall, and the readmission assessment indicated "dressing to the surgical site is intact." No further details were provided related to resident #007's surgical incision or the type of dressing. There was a progress note 10 days following return to the home, by registered nursing staff, that indicated the incision closures were removed and the site was healed. A progress note five days following closure removal by the physician indicated that the surgical area showed no signs of infection. There were no further progress notes by registered staff related to the surgical incision or associated treatment interventions.

Inspector #722 reviewed the Assessments for resident #007, and was unable to locate any skin and wound assessments related to resident #007's surgical incision, using the Skin & Wound Evaluation tool. No weekly assessments, nor progress notes indicating assessments completed were identified for resident #007's surgical incision over the 10 day period following return from hospital.

The DOC and NM #111, the skin and wound care lead in the home, both confirmed in separate interviews the expectations and process for weekly skin and wound assessments as described by RPN #113 above. Both verified that photographs should have been taken of resident #001, #002 and #007's surgical incisions when they returned from the hospital, and relevant assessment data should have been entered into the tablet to populate the Skin & Wound Evaluation tools in the electronic record. Both the DOC and NM #111 confirmed that this was the required process and clinical tool for weekly skin and wound assessments. NM #111 verified that weekly assessments were not completed for residents #001, #002 and #007 related to their surgical incisions.

The severity of this issue was determined to be a level 2 as there was minimal risk to residents #001, #002 and #007. The scope of this issue was a level 3 as it related to three of three residents reviewed. The home had a level 2 compliance history as they had previous noncompliance to different subsections

in the last 36 months. (722)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 16, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

À l'attention du/de la registrateur(e)
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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 30th day of August, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Adam Dickey

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