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

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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 6, 2016	2016_340566_0007	022530-15	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

Cheltenham Care Community
5935 BATHURST STREET NORTH YORK ON M2R 1Y8

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

ARIEL JONES (566), SLAVICA VUCKO (210)

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): March 8, 9, 10, 11, and April 1, 2016.

This inspection had an associated critical incident: #0922-000023-15.

During the course of the inspection, the inspector(s) spoke with the assistant Director of Care (ADOC), the registered dietitian (RD), registered nursing staff (RN/RPN), personal support workers (PSWs), residents, and the complainant.

During the course of the inspection, the inspectors observed staff to resident interactions, resident to resident interactions, meal and snack service, reviewed resident health care records, reviewed the home's investigation notes, staffing schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.

Findings/Faits saillants :

1. The licensee has failed to ensure that mobility devices, including wheelchairs, are available at all times to residents who require them on a short-term basis.

A review of resident #001's health care record revealed he/she was admitted to the home

on an identified date in June 2015, with identified primary medical diagnoses.

A review of resident #001's progress notes revealed that the resident was largely bedfast following his/her admission related to not having an appropriate identified mobility device. According to the resident's progress notes, his/her family provided a mobility device to the home the day after his/her admission. The identified mobility device that the family provided was deemed to be inappropriate for temporary use on assessment by registered staff and by the occupational therapist (OT), as the identified mobility device was inappropriately sized and did not adequately support the resident's mobility needs. Ten days after resident #001's admission, the OT completed an Assistive Devices Program (ADP) assessment, once POA consent had been received. The resident's new identified mobility device was delivered to the home three days after the OT's assessment, on an identified date in July 2015.

A review of resident #001's written plan of care revealed that the resident required the assistance of staff for his/her short-distance mobility needs, and that he/she required an identified mobility device for long distance locomotion on the unit. His/her sleep patterns were described as mostly confined to bed while awaiting a proper mobility device.

Interviews with PSW #106 and RPN #104 revealed that resident #001 stayed in bed because he/she did not have an appropriate identified mobility device. RPN #104 confirmed that the resident did not have any other medical conditions that would have prevented him/her from getting up from the bed, and that the resident was not provided with another mobility device by the home to be used on a short-term basis.

An interview with POA #002 confirmed that the resident was in bed for the duration of his/her stay at the home.

An interview with ADOC #100 revealed that the home only has a limited supply of an identified type of mobility device available for residents on a short-term basis, and that there were none available or suitable for resident #001 at the time of his/her admission. The ADOC revealed further that resident #001 was bedfast due to the lack of appropriate mobility device, and that he/she received identified meal service and physiotherapy services. ADOC #100 confirmed that the home did not offer or provide a suitable identified mobility device to resident #001 to be used on a short-term basis while the resident was waiting for the assessment and delivery of a permanent identified mobility device. [s. 39.]

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 mobility devices, including wheelchairs, are available at all times to residents who require them on a short-term basis, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the substitute decision maker (SDM) has been given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A review of resident #001's power of attorney (POA) for personal care document, revealed that on an identified date in 2013, the power of attorney was given to the resident's spouse. In the event that he/she was unable or unwilling to act or continue to act as his/her attorney then it was to be appointed to his/her children to jointly and severally be his/her attorneys for personal care. A review of the resident's admission documentation revealed that the resident's children had all shared POA responsibilities for both care and finances since the resident's admission to the home on an identified date in June 2015.

A review of resident #001's clinical record outlined an identified next of kin as the primary contact, and his/her other children as alternate contacts.

A review of resident #001's physician's orders revealed that on an identified date in June

2015, the resident was seen by the physician and prescribed two new identified medications. One medication was for a new identified condition and the second for a pre-existing condition. His/her previous order for an identified medication related to the second, pre-existing condition, was discontinued on the same date. A review of his/her progress notes revealed that the home attempted to contact the resident's primary contact, on the same date in June 2015, but there was no answer. There was no documented evidence of any further attempts made by the home to contact the resident's primary contact or the other SDMs regarding these medication changes. An interview with RN #108 confirmed that staff did not attempt to make further contact with the resident's SDMs.

A review of the resident's electronic medication administration record (eMAR) for June 2015, revealed that the resident's new identified medications were started on the date that they were prescribed in June 2015.

An interview with POA #002 revealed an unawareness by all SDMs about the new medication orders. POA #002 stated that he/she did not find out about the medication change related to the pre-existing condition until after the resident's transfer to hospital on an identified date in July 2015.

Interviews with ADOC #100 and RN #101 revealed that when there is a change in a resident's treatment or medications, the home's practice is to notify the SDMs or family members, and for the communication to be documented in the resident's progress notes.

An interview with ADOC #100 confirmed that when there was a change in resident #001's medication orders, the home did not contact the resident's identified SDMs, as listed by priority, in order to obtain informed consent or give the SDMs the opportunity to participate fully in the resident's medication plan of care. [s. 6. (5)]

2. A review of resident #001's progress notes revealed that the resident demonstrated identified responsive behaviours on admission to the home on an identified date in June 2015. On the date of admission, it was documented by nursing staff that the resident was displaying specific identified responsive behaviours in his/her bedroom. Later on the same date, at two identified times, it was documented that the resident was found physically displaying and verbalizing another identified type of responsive behaviours. The staff responded by taking an identified action to ensure the resident's safety, and initiated a specific behaviour monitoring tool.

An interview with POA #002 revealed that the resident's SDMs were not informed about the resident's specific identified responsive behaviours until a family care conference on an identified date in July 2015. He/She stated further that he/she was notified around the time of the resident's admission about a specific type of identified responsive behaviours, but not all of the resident's responsive behaviours, including a specific identified behaviour. He/She stated further that the identified behaviours were very out of character for resident #001.

Interviews with ADOC #100 and RN #101 confirmed that there was a lack of communication with resident #001's SDMs regarding the resident's identified behaviours and that they were not afforded the opportunity to participate fully in the development of the resident's responsive behaviour plan of care. [s. 6. (5)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director of the Ministry of Health and Long-term Care (MOHLTC).

A review of critical incident system (CIS) report #0922-000023-15 for a written care complaint received by the home on an identified date in August 2015, revealed that the home first submitted a report to the Director regarding these care-related concerns on a second identified date in August 2015. A review of the home's investigation into a verbal complaint from the family of resident #001 received on an identified date in July 2015, and a review of the resident's health care record revealed that an email complaint regarding similar care concerns was also sent to the home on a second identified date in July 2015, by POA #003 on behalf of the SDMs for resident #001.

An interview with ADOC #100 confirmed that the initial written care complaint received by email on the second identified date in July 2015, was not submitted to the Director immediately, as per the requirement. [s. 22. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The license has failed to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes: any mood and behaviour patterns, any identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day.

A review of resident #001's progress notes revealed that the resident demonstrated

identified responsive behaviours within the first 24 hours of admission to the home. On the day of admission, it was documented by nursing staff that the resident was displaying specific identified responsive behaviours in his/her bedroom. Later on the same date, at two identified times, it was documented that the resident was found physically displaying and verbalizing another identified type of responsive behaviours. The next day, at an identified time, the resident was documented as displaying identified responsive behaviours toward staff. During the resident's first week of admission, his/her identified behaviours were noted to have continued, and also included other identified behaviours related to care. Further review of the resident's progress notes revealed that resident #001's behaviours were monitored and documented using an identified tool beginning on his/her day of admission.

A review of the resident #001's physician's orders revealed that on an identified date in June 2015, the resident was prescribed new medications, including an identified medication for a new diagnosis.

A review of resident #001's written plan of care revealed that the resident had identified responsive behaviours related to his/her transition to long-term care and secondary to an identified diagnosis, as evidenced by identified responsive behaviours. The resident's written care plan identified multiple associated interventions to address the resident's behaviours including referral to the behaviour support team (BSO) after completion of the identified monitoring tool.

A review of resident #001's clinical record failed to reveal evidence of a referral to the BSO team lead or other external supports for a specific, interdisciplinary assessment of the resident's responsive behaviours.

An interview with the BSO nursing lead, RN #101, revealed that the home's process when a resident presents with either new responsive behaviours or those which exceed what would be considered a normal part of adjustment to the home, is to refer the resident to the home's internal BSO team for further assessment. RN #101 confirmed that a referral was not received for resident #001's identified behaviours and therefore he/she was not assessed by the BSO team. RN #101 stated further that the BSO team was not involved in the development of resident #001's plan of care, and was not notified about his/her behaviours until after his/her discharge from the home on an identified date in July 2015, when RN #101 was requested to conduct a chart review and summary around resident #001's behaviours. A review of this behavioural review summary for resident #001 and interview with RN #101 confirmed that he/she would have expected to

receive a referral to the BSO team for behavioural assessment of resident #001 based on the severity of the resident's mood and the identified responsive behaviours that he/she exhibited. [s. 26. (3) 5.]

Issued on this 19th day of April, 2016

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

Original report signed by the inspector.