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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 21, 2017	2017_546585_0004	016188-16, 017293-16, 018574-16, 025576-16, 031874-16, 034395-16, 002136-17, 005399-17	Critical Incident System

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

Tullamore Care Community
133 KENNEDY ROAD SOUTH BRAMPTON ON L6W 3G3

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

LEAH CURLE (585), HEATHER PRESTON (640), THERESA MCMILLAN (526)

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): February 24, 27, 28, March 1, 2, 3, 7, 8 and 9, 2017.

During the inspection, the following Critical Incident System (CIS) inspections were completed.
log #016188-16/CIS #0963-000015-16 regarding prevention of abuse and neglect

log #017293-16/CIS #0963-000018-16 regarding prevention of abuse and neglect
log #018574-16/CIS #0963-000019-16 regarding prevention of abuse and neglect
log #025576-16/CIS #0963-000023-16 regarding prevention of abuse and neglect
log #031874-16/CIS #0963-000030-16 regarding falls prevention and management
log #034395-16/CIS #0963-000035-16 regarding falls prevention and management
log #002136-17/CIS #0963-000002-17 regarding prevention of abuse and neglect
log #005399-17/CIS #0963-000005-17 regarding prevention of abuse and neglect and responsive behaviours

Two on-site inquiries were conducted:
log #011411-15/CIS #0963-000013-15 regarding abuse
log #021900-15/CIS #0963-000019-15 regarding improper care resulting in injury

The inspection was conducted concurrent to complaint inspection #2017_482640_0004 and complaint inspection #2017_546585_0003.

During the course of the inspection, the inspector(s) spoke with Residents, Families, Personal Support Workers (PSWs) Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Director of Dietary Services (DDS), Resident Assessment Instrument (RAI) Coordinator, Physiotherapist (PT), Behavior Support Ontario (BSO) Champion, Director of Resident Programs, Environmental Services Manager (ESM), Associate Director of Care (ADOC), Director of Care (DOC) and the Executive Director (ED).

During the course of the inspection, the inspector(s) toured the home, observed provision of care and services to residents, reviewed records that included, but was not limited to: resident clinical records, policies and procedures, program evaluations, training records, complaint logs, critical incident system (CIS) investigation notes and employee files.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

8 WN(s)
4 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy to promote zero tolerance of abuse and neglect of residents, titled "Prevention of Abuse and Neglect of a Resident, policy number VII-G-10.00", which included attachments (b) and (c), revised January 2015, outlined the following requirements the licensee was to comply with:

i. If any employee or volunteer witnesses an incident, or has any knowledge of an incident, that constitutes resident abuse or neglect; all staff are responsible to immediately take these steps: 1) Stop the abusive situation and intervene immediately if safe for them to do so while ensuring the safety of the resident. 2) Remove resident from the abuser, or it that is not possible, remove the abuser from the resident if safe for them to do so while ensuring the safety of the resident. 3) Immediately inform the Executive Director (ED)/Administrator and/or Charge Nurse in the home."

ii. The Charge Nurse will: Check the resident's condition to assess his/her safety, emotional, and physical well being; provide support to the staff member reporting, in immediately reporting of the following to the (MOHLTC) Director (with ED/Administrator or designate, if available). Monday to Friday 8 a.m. to 5 p.m. the staff member will take the action immediately to notify the Ministry of Health and Long Term Care by initiating the online Mandatory Critical Incident System (MCIS) form using the mandatory report section. If outside of normal business hours, call the MOHLTC toll-free Action Line. Staff who do not have access to the MOHLTC online report must call) for abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident; inform the Power of Attorney for Care or the family of the alleged

abuse if the incident caused harm, pain, or distress to the resident and the current status of the resident; after obtaining resident or resident's representative consent, take photographs demonstrating evidence of abuse, if applicable.

iii. Attachment VII-G-10.00 (b) titled "Prevention of Abuse and Neglect of a Resident – Actual or Suspected: Nursing Checklist for Investigating Alleged Abuse of Resident by Family or Staff or Visitor or Volunteer", stated "this checklist is to be used with any issues of suspected or actual abuse of a resident. Please refer to the Policy and Procedure for details regard item details for each".

iv. Attachment VII-G-10.00 (c) titled "Prevention of Abuse – Investigation Template", stated "this is completed only after ensuring the that the resident is safe, has been assessed, and appropriate treatment has been initiated...Documentation should include, but is not limited to the following: who may have witnessed or had knowledge of the event...written, signed, dated statements from people interviewed".

A) On an identified date, CIS report #0963-000015-16 was submitted to the Director regarding abuse.

According to the home's investigation notes, on an identified date, resident #012 was found to have a new area of altered skin integrity. A request was made for the home to investigate.

Review of the clinical record revealed a head-to-toe assessment using the "Leisureworld Skin Assessment" tool and a "Weekly Skin Assessment" were completed the following day. There were no vital signs taken at the time of the incident or during either of the completed assessments the day following. Further review of the home's incident file revealed the nursing checklist and the investigation template were not used as per the home's policy nor was a photograph taken.

Interview with the DOC who reported it was an expectation that a head-toe assessment, skin assessment and vital signs to be done immediately upon discovery of the injury. Interview with the Assistant Director of Care (ADOC) who at the time was the acting DOC and the lead investigator, revealed there were no photographs taken, the checklist was not implemented, the investigation template was not completed and the resident's roommate was not interviewed. The ADOC confirmed that it was the expectation of the home that a head-to-toe assessment and a head injury routine be completed immediately, the assessments were not done and the home's "Prevention of Abuse and

Neglect of a Resident" policy was not followed.

This non-compliance was issued as part of of CIS inspection log #016188-16/CIS #0963-000015-16.

B) On an identified date, CIS report #0963-000019-16 was submitted to the Director regarding improper/incompetent treatment of a resident that resulted in harm or risk to a resident.

According to resident #017's health record and the home's investigative notes, on an identified date, personal support worker (PSW) #140 caused injury and pain when providing care to resident #017. Review of investigation notes revealed that the checklist had not been used according to the home's policy. When asked if they used the checklist, Registered Practical Nurse (RPN) #141, RPN #145, RPN #146 and Registered Nurse (RN) #144 stated that they did; however, they were unable to produce it.

Interview with the DOC confirmed that the Director had not been immediately notified according to the home's policy when RN #143 did not use the on call pager during off hours on the date of the incident, or when the report was not submitted via the CIS until the following day. The DOC also confirmed staff did not follow the home's policy to complete the "Prevention of Abuse and Neglect of a Resident – Actual or Suspected: Nursing Checklist for Investigating Alleged Abuse of Resident by Family or Staff or Visitor or Volunteer" when investigating the allegation of abuse against resident #017.

This non-compliance was issued as part of CI inspection log #018574-16/CIS #0963-000019-16.

C) On an identified date, CIS report #0963-000023-16 was submitted to the Director regarding staff to resident abuse/neglect.

According to the CIS report, on an identified date, allegations were made of staff to resident abuse between PSW #138 and resident #014.

Review of resident #014's clinical record revealed a progress note on the date of the alleged incident completed by RPN #103 who documented that they received the allegations of abuse. RPN #130 documented that abuse did not occur; however, the resident's clinical record did not reveal any further documentation of an assessment of the resident's condition until the next day when the ADOC completed a skin assessment

and documented the presence of altered skin integrity.

Interview with RPN #103, who reported that on the date of the incident, they were made aware of allegation, spoke with the resident and PSW, completed a progress note, believed they informed the charge nurse and confirmed they conducted no further action to assess the resident during their shift.

Interviews with the ADOC confirmed that the ED/Administrator and/or Charge Nurse was not immediately notified when any staff had knowledge of an incident that constituted resident abuse or neglect, a CIS report was not submitted immediately to the Director regarding allegations of abuse, and the nursing checklist for investigating alleged abuse of resident by family or staff or visitor or volunteer was not completed.

This non-compliance was issued as part of CI inspection log #025576-16/CIS #0963-000023-16.

D) On an identified date, CIS report #0963-000005-17 was submitted to the Director regarding resident to resident abuse/neglect.

i) According to progress notes and interview with RPN #147, on an identified date, RPN #147 received report of an altercation between resident #018 and resident #019. Following the altercation, RPN #147 confirmed actions taken by the home increased the risk for injury and altercations when an abuse had been reported to them.

ii) According to health records and interviews with the home's Executive Director, Director of Care, Behaviour Support Ontario (BSO) RPN #160, RPN #147 and PSW #150, on an identified date, PSW #150 and PSW #151 witnessed resident to resident abuse between resident #018 and resident #019.

During an interview, PSW #150 confirmed that there was an increased risk of altercations and actual or potential harm to resident #019 and confirmed that they had not followed the home's policy when they witnessed resident to resident abuse.

Interview with RPN #147 confirmed that they did not assess resident #019's condition according to the home's policy. RPN #147 confirmed that they had not notified the charge nurse about the incident.

RN #119 confirmed that when they became aware of the resident to resident abuse they

did not assess the residents or report the incident to the DOC/ADOC according to the home's abuse policy.

During interview, the Executive Director stated that they became aware of the incident after PSW #150 informed them.

This non-compliance was issued as part of CI inspection log #005399-17/CIS #0963-000005-17. [s. 20. (1)]

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. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimized the risk of altercations and potentially harmful interactions between and among residents.

i) According their clinical record, resident #018 had a history of responsive behaviours. Review of progress notes indicated that on an identified date, resident #018 was responsive toward resident #019. This was confirmed in an interview with PSW #154. RPN #160 stated that prior to this incident on the identified date, resident #018 had not been responsive toward resident #019. RPN #160 updated the plan of care regarding responsive behaviours; however, the update did not include any strategies to decrease risk of harm specifically to resident #019.

ii) According to progress notes and interview with RPN #147, on an identified date, another altercation occurred between resident #018 and resident #019. Interview with RPN #147 confirmed that following the incident, actions taken by the home increased risk of altercations and actual or potential harm to resident #019.

iii) According to health records and interviews with the home's Executive Director, DOC, BSO RPN #160, RPN #147 and PSW #150, on the identified date, PSWs #150 and PSW #151 observed resident #018 being responsive toward resident #019. Interview with PSW #150 who confirmed that actions taken by the home increased risk of altercations and actual or potential harm to resident #019. Interview with RPN #147 confirmed that they did not assess resident #019's condition following the incident. Interview with RN #119 confirmed that they did not report the incident to the DOC/ADOC, and did not assess the residents immediately.

After the third altercation, home initiated action in the development and implementation of interventions to minimize the risk of altercations and potentially harmful interactions between resident #018 and resident #019; however, prior to the third incident, procedures and interventions had not been developed and implemented in relation to altercations between the residents.

This non-compliance was issued as part of CI inspection log #005399-17/CIS #0963-000005-17. [s. 55. (a)]

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) During an identified month, resident #010 experienced four falls. The fourth fall resulted in injury and transfer to hospital. Post fall huddle notes completed for the three falls prior to the fourth fall noted an intervention to prevent reoccurrence; however, review of the resident's written plan of care did not include documentation of the intervention.

Interview with PSW #133, PSW #134 and PSW #135 reported there were multiple fall prevention interventions in place prior to the fourth fall, which was confirmed by the DOC. The written plan of care was reviewed and did not include the fall intervention as noted in post-fall assessments, nor did it include implemented interventions as reported by PSW #133, PSW # 134, PSW #135 and the DOC.

This non-compliance was issued as part of CIS inspection log #031874-16/CIS #0963-000030-16.

B) On an identified date, resident #011 was assessed by the physiotherapist who identified the resident as high fall risk and made falls prevention recommendations.

Two months later, the resident experienced three falls within a month. After each fall, staff documented new falls intervention strategies in the clinical record; however, interventions were not updated in the written plan of care.

On an identified date, the resident experienced a fall that resulted in injury. Four days later, falls interventions were added to the written plan of care. At the time of the inspection, two interventions noted in the clinical record were not included in the written plan of care.

Interview with registered staff #130 confirmed the fall interventions were part of the resident's plan of care, that one was not added to the written plan until after the fall resulting in injury and two interventions were not in the written plan at the time of the inspection.

This non-compliance was issued as part of CIS inspection log #034395-16/CIS #0963-000035-16. [s. 6. (1) (a)]

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

A) On an identified date, resident #010 experienced a fall, was transferred to hospital and diagnosed with an injury. The resident also had a history of recent falls. On an identified date, the Occupational Therapist (OT) completed an assessment and documented two recommendations; however, review of the written plan of care following the their assessment did not include one of their recommended interventions.

Interview with PSW #136 and registered staff #103 who were regular staff reported the resident did not use the intervention the OT recommended. Registered staff #103 reported the intervention recommended by the OT was available in the home. Interview with the DOC and ADOC reported they were unaware of the recommendations made by

the OT and the home did not provide their recommended intervention. The DOC confirmed the resident was not reassessed nor was the plan of care reviewed and revised when the resident's care needs changed after experiencing an increase in falls prior to sustaining an injury on an identified date.

This non-compliance was issued as part of CIS inspection log #031874-16/CIS #0963-000030-16. [s. 6. (10) (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 and ensure that there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On an identified date, the home submitted CIS report #0963-000019-16 to the Director regarding abuse and neglect.

Review of resident #017's health record and the home's investigative notes revealed that on a specified date, PSW #140 used force when providing care to resident #017 that resulted in injury and pain that required treatment.

Interview with RPN #141 confirmed that resident #017 acquired an injury after receiving care from PSW #140. PSW #140 confirmed they caused injury when they provided care to the resident. The DOC confirmed that the home failed to protect resident #017 from abuse on a specified date.

This non-compliance was issued as part of CI inspection log #018574-16/CIS #0963-000019-16. [s. 19. (1)]

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 and ensuring that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, which was reported to the licensee, was immediately investigated.

A) On an identified date, the home submitted CIS report #0963-000015-16 to the Director.

According to the investigation notes, PSW #137 reported to RN #101 that resident #012 had a new area of altered skin integrity with an unknown cause. Interview with RN #101 revealed no immediate investigation occurred to determine if the altered skin integrity was a result of abuse. Review of the investigative notes from the home, revealed the investigation was initiated two days later. Interview with the ADOC who, at the time was the DOC confirmed there was no immediate investigation.

This non-compliance was issued as part of of CIS inspection log #016188-16/CIS #0963-000015-16.

B) On an identified date, CIS report #0963-000023-16 was submitted to the Director regarding alleged staff to resident abuse.

According to the CIS, on the day prior to the CIS submission, PSW #138 allegedly abused resident #014 when providing care.

Interview with registered staff #103 who reported that on the day of the incident, they received the allegations, spoke with the resident and PSW #138, believed they informed the charge nurse and confirmed they conducted no further action during their shift.

Review of the home's investigation notes included an assessment of the resident the following day at which time an area of altered skin integrity was found. Interview with the ADOC who reported they were made aware of the incident the day after and confirmed that the home failed to ensure every alleged, suspected or witnessed incident of abuse of a resident by anyone, which was reported to the licensee, was immediately investigated.

This non-compliance was issued as part of CIS inspection log #025576-16/CIS #0963-000023-16. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, actions taken to respond to the needs of the resident, including assessments, reassessments and interventions that the resident's responses to the interventions are documented.

A) On an identified date, CIS report #0963-000023-16 was submitted to the Ministry of Health and Long-Term Care (MOHLTC) regarding an allegation of abuse to resident #014. The CIS report stated a specified type of monitoring was completed as an immediate action to prevent recurrence.

Review of the home's investigation record confirmed the monitoring was implemented; however, review of the monitoring record revealed occasions when observations of the resident were not documented every 30 minutes on six days. Interview with the ADOC reported the resident was being monitored every 30 minutes; however, confirmed the record was not completed as required.

This non-compliance was issued as part of CIS inspection log #025576-16/CIS #0963-000023-16.

B) On an identified date, CIS report #0963-000002-17 was submitted to the MOHLTC regarding an allegation of abuse to resident #016. The CIS report stated a specified type of monitoring was completed as an immediate action to prevent recurrence.

Review of the home's investigation record confirmed monitoring was implemented; however, review of the monitoring record revealed occasions when observations of the resident were not documented every 30 minutes for seven days. Interview with the ADOC reported the resident was being monitored every 30 minutes; however, confirmed the record was not completed as required.

This non-compliance was issued as part of CIS inspection log #002136-17/CIS #0963-000002-17. [s. 53. (4) (c)]

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 and ensure that for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires, any plan, policy, protocol, procedure, strategy or system was complied with.

A) In accordance with O. Reg. 79/10, r. 48. (1) requires every licensee of a long-term care home to ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's policy, "Falls Prevention, Policy #: VII-G-30.00", revised January 2015, stated the registered staff or designate will complete a Falls Risk Assessment at the following times: within 24 hours of admission or readmission.

On a specified date, resident #010 experienced a fall and was transferred to hospital. The resident returned to the home on a specified date. Review of the clinical record indicated a Fall Risk Assessment was not completed until two weeks after the resident returned to the home. Registered staff #103 confirmed the Fall Risk Assessment was not completed and documented within 24 hours readmission to the home.

This non-compliance was issued as part of CIS inspection log #031874-16/CIS #0963-000030-16. [s. 8. (1) (a),s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

On an identified date, the home submitted CIS report #0963-000019-16 to the MOHLTC regarding staff to resident abuse.

According to resident #017's health record and the home's investigative notes, on an identified date, PSW #140 caused injury and pain when providing care to resident #017. Interview of RPN #141 confirmed resident #017 acquired an injury and experienced pain that required treatment after PSW #140 provided care. PSW #140 confirmed that their actions caused injury to the resident.

Review of the home's investigative notes indicated that the appropriate police force was not immediately notified about this incident. Interview with the ADOC who completed the investigation confirmed that police had not been called and should have been.

This non-compliance was issued as part of CIS inspection log #018574-16/CIS #0963-000019-16 regarding prevention of abuse and neglect. [s. 98.]

Issued on this 8th day of May, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	LEAH CURLE (585), HEATHER PRESTON (640), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2017_546585_0004
Log No. / Registre no:	016188-16, 017293-16, 018574-16, 025576-16, 031874-16, 034395-16, 002136-17, 005399-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 21, 2017
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Tullamore Care Community 133 KENNEDY ROAD SOUTH, BRAMPTON, ON, L6W-3G3
	Astrida Kalnins

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee will do the following:
1. Ensure the written policy to promote zero tolerance of abuse and neglect of residents is complied with.
2. All staff receive re-education on the requirements and duties of all staff as set out in home's written policy to promote zero tolerance of abuse and neglect.
3. Ensure the home maintains records that correspond with requirements as outlined in the abuse policy that includes, but is not limited:
a) Attachment VII-G-10.00 (b) "Prevention of Abuse and Neglect of a Resident – Actual or Suspected: Nursing Checklist for Investigating Alleged Abuse of Resident by Family or Staff or Visitor or Volunteer"
b) Attachment VII-G-10.00 (c) "Prevention of Abuse – Investigation Template"

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of "minimal harm or potential for actual harm", a scope of "widespread" and a compliance history of "one or more related non-compliance in last three years".

2. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy to promote zero tolerance of abuse and neglect of residents, titled "Prevention of Abuse and Neglect of a Resident, policy number VII-G-10.00", which included attachments (b) and (c), revised January 2015, outlined the following requirements the licensee was to comply with:

i. If any employee or volunteer witnesses an incident, or has any knowledge of an incident, that constitutes resident abuse or neglect; all staff are responsible to immediately take these steps: 1) Stop the abusive situation and intervene immediately if safe for them to do so while ensuring the safety of the resident. 2) Remove resident from the abuser, or it that is not possible, remove the abuser from the resident if safe for them to do so while ensuring the safety of the resident. 3) Immediately inform the Executive Director (ED)/Administrator and/or Charge Nurse in the home."

ii. The Charge Nurse will: Check the resident's condition to assess his/her safety, emotional, and physical well being; provide support to the staff member reporting, in immediately reporting of the following to the (MOHLTC) Director (with ED/Administrator or designate, if available). Monday to Friday 8 a.m. to 5 p.m. the staff member will take the action immediately to notify the Ministry of Health and Long Term Care by initiating the online Mandatory Critical Incident System (MCIS) form using the mandatory report section. If outside of normal business hours, call the MOHLTC toll-free Action Line. Staff who do not have access to the MOHLTC online report must call) for abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident; inform the Power of Attorney for Care or the family of the alleged abuse if the incident caused harm, pain, or distress to the resident and the current status of the resident; after obtaining resident or resident's representative consent, take photographs demonstrating evidence of abuse, if applicable.

iii. Attachment VII-G-10.00 (b) titled "Prevention of Abuse and Neglect of a Resident – Actual or Suspected: Nursing Checklist for Investigating Alleged Abuse of Resident by Family or Staff or Visitor or Volunteer", stated "this checklist is to be used with any issues of suspected or actual abuse of a resident. Please refer to the Policy and Procedure for details regard item details for each".

iv. Attachment VII-G-10.00 (c) titled "Prevention of Abuse – Investigation Template", stated "this is completed only after ensuring the that the resident is safe, has been assessed, and appropriate treatment has been initiated...Documentation should include, but is not limited to the following: who may have witnessed or had knowledge of the event...written, signed, dated statements from people interviewed".

A) On an identified date, CIS report #0963-000015-16 was submitted to the Director regarding abuse.

According to the home's investigation notes, on an identified date, resident #012 was found to have a new area of altered skin integrity. A request was made for the home to investigate.

Review of the clinical record revealed a head-to-toe assessment using the "Leisureworld Skin Assessment" tool and a "Weekly Skin Assessment" were completed the following day. There were no vital signs taken at the time of the incident or during either of the completed assessments the day following. Further review of the home's incident file revealed the nursing checklist and the investigation template were not used as per the home's policy nor was a photograph taken.

Interview with the DOC who reported it was an expectation that a head-toe assessment, skin assessment and vital signs to be done immediately upon discovery of the injury. Interview with the Assistant Director of Care (ADOC) who at the time was the acting DOC and the lead investigator, revealed there were no photographs taken, the checklist was not implemented, the investigation template was not completed and the resident's roommate was not interviewed. The ADOC confirmed that it was the expectation of the home that a head-to-toe assessment and a head injury routine be completed immediately, the assessments were not done and the home's "Prevention of Abuse and Neglect of a Resident" policy was not followed.

This non-compliance was issued as part of of CIS inspection log #016188-16/CIS #0963-000015-16.

B) On an identified date, CIS report #0963-000019-16 was submitted to the Director regarding improper/incompetent treatment of a resident that resulted in harm or risk to a resident.

According to resident #017's health record and the home's investigative notes, on an identified date, personal support worker (PSW) #140 caused injury and pain when providing care to resident #017. Review of investigation notes revealed that the checklist had not been used according to the home's policy. When asked if they used the checklist, Registered Practical Nurse (RPN) #141,

RPN #145, RPN #146 and Registered Nurse (RN) #144 stated that they did; however, they were unable to produce it.

Interview with the DOC confirmed that the Director had not been immediately notified according to the home's policy when RN #143 did not use the on call pager during off hours on the date of the incident, or when the report was not submitted via the CIS until the following day. The DOC also confirmed staff did not follow the home's policy to complete the "Prevention of Abuse and Neglect of a Resident – Actual or Suspected: Nursing Checklist for Investigating Alleged Abuse of Resident by Family or Staff or Visitor or Volunteer" when investigating the allegation of abuse against resident #017.

This non-compliance was issued as part of CI inspection log #018574-16/CIS #0963-000019-16.

C) On an identified date, CIS report #0963-000023-16 was submitted to the Director regarding staff to resident abuse/neglect.

According to the CIS report, on an identified date, allegations were made of staff to resident abuse between PSW #138 and resident #014.

Review of resident #014's clinical record revealed a progress note on the date of the alleged incident completed by RPN #103 who documented that they received the allegations of abuse. RPN #130 documented that abuse did not occur; however, the resident's clinical record did not reveal any further documentation of an assessment of the resident's condition until the next day when the ADOC completed a skin assessment and documented the presence of altered skin integrity.

Interview with RPN #103, who reported that on the date of the incident, they were made aware of allegation, spoke with the resident and PSW, completed a progress note, believed they informed the charge nurse and confirmed they conducted no further action to assess the resident during their shift.

Interviews with the ADOC confirmed that the ED/Administrator and/or Charge Nurse was not immediately notified when any staff had knowledge of an incident that constituted resident abuse or neglect, a CIS report was not submitted immediately to the Director regarding allegations of abuse, and the nursing checklist for investigating alleged abuse of resident by family or staff or visitor or

volunteer was not completed.

This non-compliance was issued as part of CI inspection log #025576-16/CIS #0963-000023-16.

D) On an identified date, CIS report #0963-000005-17 was submitted to the Director regarding resident to resident abuse/neglect.

i) According to progress notes and interview with RPN #147, on an identified date, RPN #147 received report of an altercation between resident #018 and resident #019. Following the altercation, RPN #147 confirmed actions taken by the home increased the risk for injury and altercations when an abuse had been reported to them.

ii) According to health records and interviews with the home's Executive Director, Director of Care, Behaviour Support Ontario (BSO) RPN #160, RPN #147 and PSW #150, on an identified date, PSW #150 and PSW #151 witnessed resident to resident abuse between resident #018 and resident #019.

During an interview, PSW #150 confirmed that there was an increased risk of altercations and actual or potential harm to resident #019 and confirmed that they had not followed the home's policy when they witnessed resident to resident abuse.

Interview with RPN #147 confirmed that they did not assess resident #019's condition according to the home's policy. RPN #147 confirmed that they had not notified the charge nurse about the incident.

RN #119 confirmed that when they became aware of the resident to resident abuse they did not assess the residents or report the incident to the DOC/ADOC according to the home's abuse policy.

During interview, the Executive Director stated that they became aware of the incident after PSW #150 informed them.

This non-compliance was issued as part of CI inspection log #005399-17/CIS #0963-000005-17. [s. 20. (1)] (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

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. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee shall do the following:

1. Develop and implement procedures to assist resident #019 who is at risk of harm as a result of resident #018's behaviours to minimize the risk and/or prevent altercations and potentially harmful interactions between them.

2. Update the plan of care so that direct care staff have clear direction in relation to procedures to be implemented to minimize the risk and/or prevent altercations between residents #018 and #019.

3. Assess residents #018 and #019 following any altercation between these residents.

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of "actual harm/risk" a scope of "isolated" and a compliance history of "previous non-compliance unrelated in last three years".

2. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of

harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimized the risk of altercations and potentially harmful interactions between and among residents.

i) According their clinical record, resident #018 had a history of responsive behaviours. Review of progress notes indicated that on an identified date, resident #018 was responsive toward resident #019. This was confirmed in an interview with PSW #154. RPN #160 stated that prior to this incident on the identified date, resident #018 had not been responsive toward resident #019. RPN #160 updated the plan of care regarding responsive behaviours; however, the update did not include any strategies to decrease risk of harm specifically to resident #019.

ii) According to progress notes and interview with RPN #147, on an identified date, another altercation occurred between resident #018 and resident #019. Interview with RPN #147 confirmed that following the incident, actions taken by the home increased risk of altercations and actual or potential harm to resident #019.

iii) According to health records and interviews with the home's Executive Director, DOC, BSO RPN #160, RPN #147 and PSW #150, on the identified date, PSWs #150 and PSW #151 observed resident #018 being responsive toward resident #019. Interview with PSW #150 who confirmed that actions taken by the home increased risk of altercations and actual or potential harm to resident #019. Interview with RPN #147 confirmed that they did not assess resident #019's condition following the incident. Interview with RN #119 confirmed that they did not report the incident to the DOC/ADOC, and did not assess the residents immediately.

After the third altercation, home initiated action in the development and implementation of interventions to minimize the risk of altercations and potentially harmful interactions between resident #018 and resident #019; however, prior to the third incident, procedures and interventions had not been developed and implemented in relation to altercations between the residents.

This non-compliance was issued as part of CI inspection log #005399-17/CIS #0963-000005-17. [s. 55. (a)] (526)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 03, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 21st day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Leah Curle

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