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_0003	012207-16, 027224-16, 028009-16, 034228-16, 000004-17, 000592-17, 002071-17	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

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)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 8, 9, 10, 13, 16, 17, 27 and March 2, 3, 7, 8, 2017.

During the inspection, the following complaint inspections were completed:
Complaint log #012207-16 regarding abuse
Complaint log #027224-16 and Critical Incident System (CIS) log #028009-16/0963-000024-16 regarding abuse and personal support services
Complaint log #034228-16 regarding abuse and reporting and complaints
Complaint log #000004-17 regarding resident rights and housekeeping
Complaint log #000592-17 regarding continence care and bowel management
Complaint log #002071-17 regarding abuse and neglect, personal support services, dignity, choice and privacy, housekeeping and skin and wound.

The inspection was conducted concurrent to complaint inspection #2017_482640_0004 / 027694-15, 007206-16, 033067-16 and CIS inspection #2017_546585_0004 / 016188-16, 017293-16, 018574-16, 025576-16, 031874-16, 034395-16, 002136-17, 005399-17. In both concurrent inspections, non-compliance was identified under Ontario Regulation (O. Reg.) 79/10 s. 50. (2) (b) (i) and those findings of non-compliance have been included in grounds for compliance order (CO) #001 in this report.

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), Registered Dietitian (RD), Environmental Services Manager (ESM), Associate Director of Care (ADOC), Director of Care (DOC) and the Administrator.

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, infection, prevention and control records, job routines and investigation records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

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

- **6 WN(s)**
- **5 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	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. 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Review of the home's policy, "Skin & Wound Care Management Protocol, Policy # VII-G-10.80", dated July 2015, directed staff to conduct a skin assessment with a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

A) Review of resident #001's clinical record revealed on an identified date, a Leisureworld skin assessment and a skin/wound note were completed and both identified a new area of altered skin integrity. Review of the clinical record revealed no assessment was conducted using a clinically appropriate assessment instrument until an identified date the next month, where the assessment identified the area of altered skin integrity.

Interview with registered nurse (RN) #101 confirmed a skin assessment using a clinically appropriate assessment instrument was not completed related to the new wound identified on a specified date. RN #101 confirmed the expectation of the home was that

staff complete the weekly skin assessment tool, which was the clinically appropriate assessment instrument for skin assessment used in the home.

This non-compliance was issued as part of complaint log #002071-17.

B) On admission, a Leisureworld skin assessment was completed for resident #006, which identified multiple areas of altered skin integrity. On two identified dates, further skin assessments were conducted by the home's Skin Champion without the aid of a clinically appropriate assessment instrument. The home's "Weekly Skin Assessment", which was a clinically appropriate assessment instrument, was completed one week after the resident's admission and identified altered skin integrity. The home was unable to determine if any of the areas of altered skin integrity had worsened or changed since admission. Treatment was initiated on an identified date, prior to the completion of the clinically appropriate skin assessment instrument as noted in the treatment administration record.

During an interview with the Director of Care (DOC), they confirmed an assessment using a clinically appropriate tool was not completed for one week after the identification of altered skin integrity and should have been completed as soon as possible after identification of the altered skin integrity of resident #006.

This non-compliance was identified in the inspection of complaint log #007206-16/0963-000009-16, which was part of complaint inspection #2017_482640_0004 and issued in this report.

C) On an identified date, personal support worker (PSW) #137 reported to RN #101 that resident #012 had a new area of altered skin integrity. Review of the clinical record revealed no skin assessment was completed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment as a result of altered skin integrity.

Interview with the DOC who reported the expectation of the home was that an appropriate skin assessment be completed at the time of discovery of altered skin integrity. The DOC confirmed there was no appropriate assessment completed of the resident's skin at the time of discovery of the altered skin integrity.

This non-compliance was identified in the inspection of Critical Incident System (CIS) log #0011411-15/0963-000013-15, which was part of CIS inspection #2017_546585_0004

and issued in this report. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure a resident who exhibited altered skin integrity including skin breakdown pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) According to their clinical record, resident #001 exhibited one area of altered skin integrity, until an identified date, wherein a second area of altered skin integrity developed. Over a period of approximately six months, almost thirty weekly skin assessments were completed, which contained assessment information for one area of altered skin integrity; however, a second area of altered skin integrity was not identified or documented as being assessed.

In review of the documentation with RN #119 who was a skin and wound lead for the home, RN #119 reported that when a resident had two areas of altered skin integrity, there should be documentation of assessment of both areas to identify one from the other. RN #119 reviewed the assessment tool and noted that the expectation of the home was that each area of altered skin integrity was to have its own separate assessment completed on the same form.

The weekly skin assessments reviewed for resident #001 by RN #119 and revealed there were no separate assessments identifying the specific assessment of each area of altered skin integrity. The document included specific areas to document when there were more than one area being assessed. RN #119 confirmed a second assessment on resident #001's second area of altered skin integrity was not documented and it was the expectation of the home that each wound identified on a resident was to include a separate assessment.

This non-compliance was issued as part of complaint log #002071-17. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(c) that the local medical officer of health is invited to the meetings; O. Reg. 79/10, s. 229 (2).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that the local medical officer of health was invited to the infection prevention and control program meetings.

Review of Infection Control Committee meeting minutes for 2016, dated January 20, March 21, May 26, August 3 and November 8, 2016, revealed the local medical officer of health was not in attendance.

Interview with the DOC identified that Infection Control Committee meetings which were part of resident safety meetings held monthly. The DOC reported the local medical officer of health was invited to the Professional Advisory Committee (PAC) meetings; however, the home's infection prevention and control (IPAC) program was not included as a component of PAC meetings. The DOC confirmed the local medical officer of health was not invited to the Infection Prevention and Control meetings.

This non-compliance was issued as part of complaint log #002071-17. [s. 229. (2) (c)]

2. The licensee failed to ensure that on every shift symptoms indicating the presence of infection in residents were monitored in accordance with prevailing practices.

The Ministry of Health and Long Term Care (MOHLTC) has identified, “Best Practices for Infection Prevention and Control Programs in Ontario, In All Health Care Settings, May 2012”, developed by the Provincial Infectious Diseases Advisory Committee (PIDAC), as the prevailing practice for the establishment of a program to identify, prevent, control and treat health care associated infections in the long term care home.

During an identified period, resident #001 demonstrated symptoms of infection. During an interview with the IPAC lead for the home, they reported they had not been aware of the resident's symptoms, findings from assessments made by staff as well as the implemented treatment intervention.

In relation to the IPAC program, the IPAC lead confirmed that they may or may not review surveillance records daily and confirmed that the home did not track infection rates, offending organisms or results of any testing for microorganisms.

This non-compliance was issued as part of complaint log #002071-17. [s. 229. (5) (a)]

3. The licensee failed to ensure that on every shift, the symptoms of infection were recorded and immediate action taken as required.

The MOHLTC has identified “Best Practices for Infection Prevention and Control

Programs in Ontario, In All Health Care Settings, May 2012", developed by the Provincial Infectious Diseases Advisory Committee (PIDAC), as the prevailing practice for the establishment of a program to identify, prevent, control and treat health care associated infections in the long term care home.

During the inspection, the licensee's IPAC program did not include a program whereby resident's symptoms indicating the presence of infection were recorded and monitored, and that immediate action was taken to treat the infection.

On an identified date, resident #001's physician assessed the resident and ordered specified testing. Two days after the home received the test results, the physician reviewed results and ordered treatment for the resident. The ADOC and RN #101 confirmed the home's expectation was that the physician be notified immediately of the results of the testing and results were not to be left until the physician came in two days later.

This non-compliance was issued as part of complaint log #002071-17. [s. 229. (5) (b)]

4. The licensee failed to ensure that the information gathered under subsection (5) was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreak.

The home's policy, "Long-Term Care (LTC) Infection Prevention & Control", policy number IX-A-10.00", revised January 2015, directed the home's IPAC committee to track infection rates, analyze information, benchmark, and identify trends in order to support the program.

The home's policy, "LTC Infection Prevention & Control, policy number IX-E-10.20", revised January 2015, directed the Infection Control Practitioner to analyze and interpret the summarized information of infections and to calculate the prevalence of infections on a monthly basis.

In 2016, the home's IPAC committee met on five occasions: January 20, March 21, May 26, August 3 and November 8, 2016. Each of those meeting minutes was written identical to the meeting minutes from January 20, 2016, with nominal additions. For example, in May 2016, the minutes reflected a reminder to staff in attendance, to put diagnostic imaging/lab orders (i.e. swabs and urine) into the tracking tool which identified what was sent out. The August 2016 minutes added to ensure that Registered Dietitian

(RD) referral was sent for residents with urinary tract and respiratory tract infections.

In an interview with the home's IPAC lead regarding the meeting minutes from January and March 2016, the IPAC lead reported the minutes were identical because different staff were at the meetings and the information was repeated. There were no surveillance reviews for the home, analysis of audits was not completed, trends were not analyzed, no documentation was available regarding hand hygiene audit analysis, and prevalence or infection rates were not reviewed during the meetings or at any time. The IPAC lead confirmed the IPAC meetings did not review data, analyze audits, review trends or identify infection prevention and control issues.

The IPAC meeting was a dissemination of information to those in attendance as confirmed by the IPAC lead. The IPAC lead reported that calculations for prevalence of infection were not completed, trending of infectious organisms was not completed and the daily surveillance reports were not always reviewed daily to detect the presence of all types of infection for the purpose of reducing the incidence of infection and outbreak. The IPAC lead informed the inspector they were not aware tracking of organisms was required and therefore not done.

This non-compliance was issued as part of complaint log #002071-17. [s. 229. (6)]

Additional Required Actions:

CO # - 002, 003 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) Resident #001's plan of care indicated they used an incontinence product at a specified time and required assistance from staff for toileting. Interview with PSW #100 who reported the resident used an incontinence product at all times and required varying levels of assistance for toileting. Interview with the DOC confirmed the resident's plan of care did not set out clear directions to staff and others who provided direct care to the resident.

This non-compliance was issued as part of complaint log #000592-17.

B) Resident #005's admission continence/bowel assessment identified they experienced a specified type of incontinence and noted a type of incontinence product used. On a specified date, an Interdisciplinary Care Conference note identified the resident used a different type of incontinence product than what was identified on the admission continence/bowel assessment. Approximately four months later, an Interdisciplinary Care Conference note noted the resident used the type of incontinence product identified on their admission continence/bowel assessment. Review of their written plan of care and kardex at the time of the inspection identified they used one type of incontinence product on all shifts.

Interview with PSW #106 confirmed the resident used two types of incontinence products. PSW #106 confirmed the kardex did not set out clear direction to staff and others who provided direct care to the resident regarding their continence product requirements. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of the resident.

Review of the resident #001's plan of care identified they received two specified interventions. Review of progress notes revealed documentation on identified dates by registered nursing staff that indicated a different type of intervention was used. Interview with RN #101 reported they were aware the resident used the intervention that was not included in the plan of care. Interview with the Director of Dietary Services (DDS) also confirmed they were aware the resident had the intervention. The RD reported they were unaware the resident had the third intervention and confirmed they did not receive a referral to assess the resident's preference when staff became aware that the intervention was in place.

This non-compliance was issued as part of complaint log #002071-17. [s. 6. (2)]

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

Review of resident #001's clinical record revealed approximately 60 skin assessments were completed over a specified period.

Assessments completed throughout the reviewed period of time identified discrepancies in the assessment of the resident's altered skin integrity, including the amount of area(s) of altered skin integrity, the location(s) of the area(s), the degree of alteration and how the area(s) of alteration was required. In addition, the assessments varied in their level of completeness.

Interview with RN #101 who clarified the status of the resident's altered skin integrity and confirmed assessments that indicated otherwise were incorrect.

The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other when assessment of resident #001's areas of altered skin integrity were inconsistent in the type of altered skin integrity, location, cause and severity.

This non-compliance was issued as part of complaint log #002071-17. [s. 6. (4) (a)]

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

Resident #001's written plan of care included documentation revealing presence of an area of altered skin integrity and outlined specified interventions for staff to follow. Review of over 50 weekly skin assessments for between an identified period of time revealed that over 30 weekly skin assessments did not include all the components of what was required as part of the interventions specified in the plan of care. During an interview with RN #101, where the assessments were reviewed, RN #101 confirmed that the weekly skin assessments were to include all components as specified in the plan of care.

This non-compliance was issued as part of complaint log #002071-17. [s. 6. (7)]

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 clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment and that plan was implemented.

A) Review of progress notes revealed resident #001 did not receive continence care on two identified shifts as per their plan of care. Review of the plan of care which specified the type of assistance they required. Interview with PSW #113 confirmed during a specified time, they were assigned to provide care to the resident and at that time they

were not aware of their continence care needs. On two identified dates, resident #001's individualized plan of care to promote and manage continence was not implemented.

This non-compliance was issued as part of complaint log #000592-17.

B) On an identified date, a bowel and bladder assessment completed for resident #004 identified they used one type of incontinence product. Interview with PSW #106 reported the resident did not always wear an incontinence product. PSW #106 confirmed that at times, the resident used an incontinence product that differed from what was identified in their plan of care. Interview with the DOC who confirmed the resident's individualized plan of care to promote bowel and bladder continence was not implemented. [s. 51. (2) (b)]

2. The licensee failed to ensure that residents were provided with a range of continence care products based on their individual assessed needs.

A) In two identified dates, continence/bowel assessments completed for resident #001 identified they used one type of incontinence product. Review of their plan of care also listed the type of incontinence product used and that the product was provided by the family. The resident's family reported they supplied incontinence products and did not know whether the home offered the type of product the resident used.

Interview with PSW #100 confirmed the resident used the incontinence product as specified in their plan of care. Interview with PSW #100 and PSW #105, who were both regular staff, reported the home did not provide the type of incontinence product the resident used; therefore, residents or families were required to purchase them outside the home. Registered Practical Nurse (RPN) #103 and RPN #104 who were both regular full-time staff reported they were unaware if the home provided the specified type of incontinence product. During interview the DOC reported the home had the type of incontinence product available; which was verified by a tour of storage rooms; however, confirmed resident #001 was not provided a range of continence products based on their individual assessed needs.

This non-compliance was issued as part of complaint log #000592-17.

B) On admission on an identified date, a continence/bowel assessment was completed for resident #005 which identified they experienced incontinence, stated the type of incontinence product used they used and that they had their own incontinence product.

On a specified date, an Interdisciplinary Care Conference note identified the resident used a different type of incontinence product from what was identified in the continence/bowel assessment. The written plan of care and also stated they used a different type of incontinence product.

Interview with PSW #106 confirmed the resident supplied their own type of incontinence product and also used a different type of continence product supplied by the home. Interview with DOC reported the home did have the type of incontinence product the the resident supplied available; however, confirmed the resident was not provided a range of continence products based on their individual assessed needs on admission. [s. 51. (2) (h) (i)]

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 each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented and residents are provided with a range of continence care products that are based on their individual assessed needs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

On a specified date, resident #003 was observed receiving assistance with eating from PSW #102. The resident was seated in a reclined position; their torso was reclined and neck hyper-extended. PSW #102 confirmed the resident was not seated in an upright position. Interview with RN #101 confirmed the resident was to be in an upright seated position when receiving assistance with eating at meals. [s. 73. (1) 10.]

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 the home has a dining and snack service that includes, at a minimum, the following elements: proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

The home's policy, "Complaints Management Program – Policy #: XXIII-A-10.40", revised August 2016, stated if a concern/complaint is received at the care community, for verbal complaints, the Executive Director or designate will conduct and document an internal investigation utilizing the Complaint Record Form (XVIII-A-10.40(c)). Contact complainant and communicate actions taken to resolve the complaint. Ensure departmental managers report and follow-up on verbal complaints from any source within their department and complete a Complaint Record within one business day of receiving verbal complaint. For all complaints, file the complaint information, complaint record, and any other investigation notes in a Complaints Management Binder.

Review of the home's complaints management binder revealed seven occasions between an identified period of time when the home failed to ensure that a complete documented record was kept when verbal complaints were submitted by resident #001's family. Specifically, the records did not fully contain all required items, including actions taken to resolve all complaints, the dates of the action when staff and/or resident(s) were interviewed, follow-up action taken to resolve the identified issues, the dates of action when the home contacted the complainant, whether a response was provided to the complainant and any response made in turn by the complainant. This was confirmed in an interview with the DOC.

This non-compliance was issued as part of compliant log #034228-16. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

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)
Inspection No. / No de l'inspection :	2017_546585_0003
Log No. / Registre no:	012207-16, 027224-16, 028009-16, 034228-16, 000004-17, 000592-17, 002071-17
Type of Inspection / Genre d'inspection:	Complaint
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
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Astrida Kalnins

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 :

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 :

1. The licensee shall ensure that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

2. The licensee shall ensure that all registered nursing staff are provided re-training on the requirement to complete a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment when a resident is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

3. The licensee shall ensure that processes and schedules are developed and implemented for monitoring registered nursing staff's performance in completing skin assessments using a clinically appropriate assessment instrument when a resident is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

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 in the last three years of "ongoing non-compliance of a voluntary plan of correction (VPC) or CO."

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Review of the home's policy, "Skin & Wound Care Management Protocol, Policy # VII-G-10.80", dated July 2015, directed staff to conduct a skin assessment with a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

A) Review of resident #001's clinical record revealed on an identified date, a Leisureworld skin assessment and a skin/wound note were completed and both identified a new area of altered skin integrity. Review of the clinical record revealed no assessment was conducted using a clinically appropriate

assessment instrument until an identified date the next month, where the assessment identified the area of altered skin integrity.

Interview with registered nurse (RN) #101 confirmed a skin assessment using a clinically appropriate assessment instrument was not completed related to the new wound identified on a specified date. RN #101 confirmed the expectation of the home was that staff complete the weekly skin assessment tool, which was the clinically appropriate assessment instrument for skin assessment used in the home.

This non-compliance was issued as part of complaint log #002071-17.

B) On admission, a Leisureworld skin assessment was completed for resident #006, which identified multiple areas of altered skin integrity. On two identified dates, further skin assessments were conducted by the home's Skin Champion without the aid of a clinically appropriate assessment instrument. The home's "Weekly Skin Assessment", which was a clinically appropriate assessment instrument, was completed one week after the resident's admission and identified altered skin integrity. The home was unable to determine if any of the areas of altered skin integrity had worsened or changed since admission. Treatment was initiated on an identified date, prior to the completion of the clinically appropriate skin assessment instrument as noted in the treatment administration record.

During an interview with the Director of Care (DOC), they confirmed an assessment using a clinically appropriate tool was not completed for one week after the identification of altered skin integrity and should have been completed as soon as possible after identification of the altered skin integrity of resident #006.

This non-compliance was identified in the inspection of complaint log #007206-16/0963-000009-16, which was part of complaint inspection #2017_482640_0004 and issued in this report.

C) On an identified date, personal support worker (PSW) #137 reported to RN #101 that resident #012 had a new area of altered skin integrity. Review of the clinical record revealed no skin assessment was completed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment as a result of altered skin integrity.

Interview with the DOC who reported the expectation of the home was that an appropriate skin assessment be completed at the time of discovery of altered skin integrity. The DOC confirmed there was no appropriate assessment completed of the resident's skin at the time of discovery of the altered skin integrity.

This non-compliance was identified in the inspection of Critical Incident System (CIS) log #0011411-15/0963-000013-15, which was part of CIS inspection #2017_546585_0004 and issued in this report. [s. 50. (2) (b) (i)] (640)

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. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required.
O. Reg. 79/10, s. 229 (5).

Order / Ordre :

1. The licensee shall develop a system to ensure that on every shift, symptoms indicating the presence of infection in residents are monitored and documented by registered staff in accordance with evidence-based practices.
2. The licensee shall ensure that when symptoms indicating the presence of infection in residents are identified immediate action is taken as required.
3. The licensee shall train all registered staff to ensure that they are aware of the expectation to monitor residents with symptoms of infection on each shift and to take immediate action as required. Training is to include the required actions to be taken when symptoms of infection are identified.
4. The licensee shall develop a auditing system to ensure that there is monitoring and documentation of residents with symptoms of infection on every shift.

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 in the last three years of "ongoing non-compliance of a voluntary plan of correction (VPC) or CO."

2. The licensee failed to ensure that on every shift, the symptoms of infection were recorded and immediate action taken as required.

The MOHLTC has identified "Best Practices for Infection Prevention and Control Programs in Ontario, In All Health Care Settings, May 2012", developed by the Provincial Infectious Diseases Advisory Committee (PIDAC), as the prevailing practice for the establishment of a program to identify, prevent, control and treat health care associated infections in the long term care home.

During the inspection, the licensee's IPAC program did not include a program whereby resident's symptoms indicating the presence of infection were recorded and monitored, and that immediate action was taken to treat the infection.

On an identified date, resident #001's physician assessed the resident and ordered specified testing. Two days after the home received the test results, the physician reviewed results and ordered treatment for the resident. The ADOC and RN #101 confirmed the home's expectation was that the physician be notified immediately of the results of the testing and results were not to be left until the physician came in two days later.

This non-compliance was issued as part of complaint log #002071-17. [s. 229. (5) (b)] (640)

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

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. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Order / Ordre :

1. The licensee shall ensure that information gathered related to the presence of symptoms of infection as required under subsection (5) is analyzed daily.
2. The licensee shall develop as part of the infection prevention and control program methodology for analysis and shall identify who in the home will be responsible for completing the daily analysis.
3. The licensee shall ensure that the infection prevention and control includes the expectation that at least monthly information gathered related to symptoms of infection control are analyzed for trends, for the purpose of reducing the incidence of infections and outbreaks. The program will identify methodologies for this analysis and will identify who will be responsible for the completion of monthly analysis.
4. The licensee will maintain records of analysis completed to detect the presence of infection and trends.
5. The licensee shall develop an auditing process to confirm the information is gathered and analyzed to include the tracking required.

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 in the last three years of "ongoing non-compliance of a voluntary plan of correction (VPC) or CO."

2. The licensee failed to ensure that the information gathered under subsection (5) was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreak.

The home's policy, "Long-Term Care (LTC) Infection Prevention & Control", policy number IX-A-10.00", revised January 2015, directed the home's IPAC committee to track infection rates, analyze information, benchmark, and identify trends in order to support the program.

The home's policy, "LTC Infection Prevention & Control, policy number IX-E-10.20", revised January 2015, directed the Infection Control Practitioner to analyze and interpret the summarized information of infections and to calculate the prevalence of infections on a monthly basis.

In 2016, the home's IPAC committee met on five occasions: January 20, March 21, May 26, August 3 and November 8, 2016. Each of those meeting minutes was written identical to the meeting minutes from January 20, 2016, with nominal additions. For example, in May 2016, the minutes reflected a reminder to staff in attendance, to put diagnostic imaging/lab orders (i.e. swabs and urine) into the tracking tool which identified what was sent out. The August 2016 minutes added to ensure that Registered Dietitian (RD) referral was sent for residents with urinary tract and respiratory tract infections.

In an interview with the home's IPAC lead regarding the meeting minutes from January and March 2016, the IPAC lead reported the minutes were identical because different staff were at the meetings and the information was repeated. There were no surveillance reviews for the home, analysis of audits was not completed, trends were not analyzed, no documentation was available regarding hand hygiene audit analysis, and prevalence or infection rates were not reviewed during the meetings or at any time. The IPAC lead confirmed the IPAC meetings did not review data, analyze audits, review trends or identify infection prevention and control issues.

The IPAC meeting was a dissemination of information to those in attendance as confirmed by the IPAC lead. The IPAC lead reported that calculations for prevalence of infection were not completed, trending of infectious organisms was not completed and the daily surveillance reports were not always reviewed daily to detect the presence of all types of infection for the purpose of reducing the incidence of infection and outbreak. The IPAC lead informed the inspector they were not aware tracking of organisms was required and therefore not done.

This non-compliance was issued as part of complaint log #002071-17. [s. 229.

(6)] (640)

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