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
May 12, 2017	2017_482640_0004	027694-15, 007206-16, 033067-16	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

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 13, 14, 15, 16, 21, 22, 23, 24, 27, 28, March 1, 2, 3, 7, and 8, 2017

The following intakes were included in this inspection;
027694-15 related to alleged abuse,
033067-16 related to alleged neglect and,
007206-16 related to skin and wound care
s.20(1) and r.50(2)(b)(i) are located in report #2017_546585_0003

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, RAI Coordinator, Skin and Wound Leads, Registered Nurses, Registered Practical Nurses and Personal Support Workers. The LTCH Inspector observed resident care, reviewed policy and procedure, interviewed staff and residents and reviewed contents of clinical records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Pain
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.
- **5 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (1) The skin and wound care program must, at a minimum, provide for the following:
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids. O. Reg. 79/10, s. 50 (1).

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 skin and wound program did not, at a minimum, provide for strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

Review of the clinical record for resident #008 was completed by Long Term Care Home (LTCH) Inspector. The clinical record revealed the resident to have a history of skin integrity issues. The annual interdisciplinary care conference identified the resident to be at risk for altered skin integrity. The clinical record did not identify the use of any equipment, supplies or devices for the reduction or prevention of skin breakdown. The Director of Care (DOC) confirmed to the LTCH Inspector, that at a minimum they would expect the use of equipment to be in place for this resident. The physician assessed the resident and directed staff to implement equipment to prevent skin breakdown. The clinical record contained no documentation of the implementation of any equipment. The DOC confirmed there was no documentation of the implementation of any equipment or

devices to prevent skin breakdown. [s. 50. (1) 3.]

2. The licensee failed to ensure that a resident who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection as required.

A) Resident #006 had a "Leisureworld Skin Assessment" completed upon admission which identified altered skin integrity. Further assessments were completed and interventions put in place to address the altered skin integrity for the reduction or prevention of skin breakdown. The interventions were included in the written plan of care but not implemented for six days. During an interview with the DOC, the DOC confirmed the treatment did not occur for six days after the skin assessments and it was the expectation of the home that interventions for altered skin integrity be initiated immediately.

B) As a result of a complaint regarding skin integrity for resident #008, the clinical record was reviewed by the LTCH Inspector and revealed the following; multiple skin integrity assessments were completed over an eight day period by different registered staff. The assessments indicated altered skin integrity however, the treatment was not immediately implemented to promote healing and prevent infection. During an interview, the DOC confirmed the treatment was not implemented immediately and it was the expectation of the home that treatment of identified altered skin integrity be implemented immediately. [s. 50. (2)(b) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r.50 (1)(3) where the skin and wound care program must, at a minimum, provide for the following: Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids, and with r. 50(2)(b)(i) where 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, and (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #2: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

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 every written or verbal complaint made to the licensee concerning the care of a resident, that a response was made to the person who made the complaint indicating what the licensee did to resolve the complaint.

The Executive Director (ED) received a verbal complaint from a family member. As the nature of the complaint was clinical, the ED delegated the investigation and resolution to the Director of Care (DOC). The "Complaint Record" did not indicate follow up with the complainant regarding the investigation and resolution to the complaint. The ED confirmed, according to the "Complaint Record", no follow up with the complainant was done. Interview with the DOC confirmed there had been no follow up with the complainant regarding the outcome of the investigation and what the licensee did to resolve the concerns addressed in the complaint. [s. 101. (1) 3.]

2. The licensee failed to ensure that a documented record was kept in the home that

included 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, 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.

Review of a "Complaint Record" did not include the name of the person lodging the complaint, the date of the investigation, the name of the person conducting the investigation, any responses made to the complainant regarding the complaint and if any, any response made in turn by the complainant. The internal investigation notes written on the form did not address all aspects of the complaint. No action was taken to resolve the complaint including the date of the action, time frames for action to be taken and any follow-up actions required, nor was there any final resolution to the complaint. No response was made to the complainant regarding the outcome of the investigation. The Executive Director confirmed the expectation of the home was that responses were to be made to complainant to include all actions taken to resolve the entire complaint, if possible, and the complaint record was to be completed fully to include date of investigation, who conducted the investigation, the outcome and resolution to the complaint and follow-up with the complainant and this did not occur. The ED confirmed the name of the complainant was not included in the "Complaint Record" and should have been. Interview with the Director of Care, who confirmed the form was not completed as per policy and legislation and the required actions were not carried out. [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 with r. 101. (1)(3) where every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief and r. 101(2) where the licensee shall ensure 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.

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. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear direction to staff and others who provided direct care to the resident.

Review of the written plan of care for resident #006, directed staff to use two different sizes of brief in two different locations of the written plan of care. Interview with Personal Support Workers who provided direct care, revealed that not all staff were using the same size brief. Interview with the Director of Care (DOC), who confirmed the written plan of care did not provide clear direction to staff as it directed staff to use two different sizes of briefs. [s. 6. (1) (c)]

2. 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.

As a result of a complaint regarding the care of skin and wound of resident #008, the clinical record was reviewed by the LTCH Inspector which revealed that multiple skin and wound assessments were completed over a six day period by registered staff and were not consistent with or compliment each other. Each of the assessments identified different types of wounds and varying degrees of healing that were not consistent. During an interview with a registered staff, the registered staff confirmed the assessments were not consistent with or compliment each other and it was the expectation of the home that assessment were to be consistent. [s. 6. (4) (a)]

3. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

Resident #008 returned from hospital and was assessed as having multiple skin integrity issues. Review of the clinical record revealed no treatment or intervention was implemented related to the skin integrity issues. Interview with staff revealed that treatment had been implemented but was not documented. The DOC confirmed the interventions for skin integrity issues were not documented and it was the expectation of the home that all interventions be documented in the clinical record. [s. 6. (9) 1.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

On five occasions, an external wound care expert assessed/reassessed resident #006's skin integrity. Review of the clinical record revealed the wound care expert documented the results of the assessment/reassessment and the recommendations on two of those occasions. On three occasions, there was no documentation by the external wound care expert in the clinical record or held within the home. During an interview with the Assistant Director of Care (ADOC), the ADOC confirmed the documentation was not available to the home nor had it been part of the clinical record and that it was expected that all assessments/reassessments were documented in the resident's clinical record. [s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

Staff completed a pain assessment for resident #008 on two separate occasions. Both assessments identified the resident was having significant pain. Review of the electronic Medication Administration Record (eMAR) revealed a physician's order for an analgesic medication for use when needed. The eMAR identified there were no pharmacological or non-pharmacological interventions provided as a result of the outcome of each assessment. Interview with the Director of Care (DOC) confirmed there were no interventions provided to the resident as a result of the assessments of pain and it was an expectation that medications were administered in accordance with directions for use as by the prescriber. [s. 131. (2)]

Issued on this 31st day of May, 2017

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

Original report signed by the inspector.