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 # / No de registre	Type of Inspection / Genre d'inspection
Sep 14, 2018	2018_723606_0017	015278-18, 021063-18, 022907-18	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 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

JANET GROUX (606)

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): August 22, 23, 24, 29, 30, 31, and September 5, 2018.

The following intakes were completed during the inspection:

Critical Incident (CI)
log #012010-18 regarding an allegation of resident to resident abuse

Complaint (CO) Intakes:
log #022907-18 regarding an allegation of resident neglect, and falls prevention and management.
log #021063-18 regarding an allegation of physical abuse with injury, falls prevention and management, continence care and bowel management, improper care related to injuries of unknown cause and dining and snacks service.
log #015278-18 regarding an allegation of neglect and improper care of resident, and nutrition and hydration.

During the course of the inspection, the inspector(s) spoke with the interim Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian, (RD), Dietary Aide (DA), Physiotherapist (PT), Resident Relations Coordinator (RRC), Discharge Planner, Substitute Decision Makers (SDM), and Residents.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed relevant documents including but not limited to, clinical records, assessment records, policies and procedures, and internal investigation notes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Food Quality
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
2 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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, plan, policy, protocol, procedure, strategy was complied with.

In accordance with 49(1) The Falls Prevention and Management Program, must at a minimum, provide for strategies to reduce or mitigate falls, including monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment supplies, devices and assistive aids.

A) Review of a complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) reported an allegation of improper care related to injuries of unknown cause.

Review of the home's policy and procedure entitled, "Head Injury Neurological Observation Tips Sheet", VII-G 10.40 (b), January 2015, states the following:
When to complete the head injury routine (HIR):
Initiated each time a resident sustains:
-an injury to the head following a fall or impact with an object.
-an unwitnessed head injury or fall.

Resident #002's progress notes stated the resident was discovered with injuries in 2017. The home suspected that the resident sustained the injuries from a fall but according to the progress notes, there were no reported falls for the resident during the time the injuries were discovered.

PSW #116 stated they found resident #002 with injuries and informed the Charge Nurse. The PSW revealed that the resident was at risk of falls and they suspected that resident #002 may have sustained their injuries from a fall.

Interviews with PSWs #106, #118, and the Physiotherapist (PT) shared with the Long Term Care (LTC) Inspector that resident#002 was at risk of falling.

RN #107 told the LTCH inspector they were informed by PSW #116 that resident #002 had injuries. The RN revealed resident #002 was at risk of falling and the injuries may have been sustained from a fall. They stated that an HIR should have been initiated and was not.

Interview with the interim Director of Care (DOC) stated that a HIR should be initiated for a resident who is observed to have head injury or a suspected unwitnessed fall.

B) Review of a complaint alleged the home was neglectful in the care provided during a change in resident #004's condition and that the SDM was not notified of the resident's status.

The home's policy entitled,"Head Injury Routine", Policy # V11-G-10.40 directs the registered staff to report any deviations from the baseline vital signs, Glasgow Coma Scale, and/or level of cognition/consciousness immediately to the Physician and/or arrange for immediate transfer to the hospital; the POA/SDM will be notified.

Resident #004's progress notes revealed that the resident sustained a fall. The home initiated an HIR to monitor the resident's condition which included the resident's vital signs. The progress notes stated that the staff noted fluctuations in the resident's vital signs and was concerned about the change. The resident was notified of their change in condition and was asked to go to the hospital but resident #004 declined. The progress notes indicated that the resident's vital signs stabilized later during the shift.

Interview with resident #004's SDM revealed that the home did not notify them of the resident's fall and change in condition.

Interview with Registered Practical Nurse (RPN) #109 stated that they did not notify the physician or the SDM of the resident's change in condition.

Interviews with RNs #107, #112, #113, and RPN #111 stated that when there are changes in the resident's vital signs that is outside their baseline values, the physician should be notified of the deviations.

The licensee failed to ensure that the home's Head Injury Routine Policy and Procedure was complied with. [s. 8. (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 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, plan, policy, protocol, procedure, strategy is complied with, 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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to 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 was dealt with as follows: 1. The complaint shall be investigated.

Review of a complaint submitted to the MOHLTC reported an allegation of improper care related to injuries of unknown cause.

Interview with the complainant told the LTCH Inspector that the home was not able to provide what caused the resident to sustain injuries.

Resident #002 progress notes stated that the resident was discovered by staff with injuries of unknown cause.

Interview with the Resident Relations Coordinator (RRC) acknowledged that the SDM had verbalized concerns as to how the resident sustained the injuries.

The interim DOC acknowledged that the home did not complete an investigation concerning the resident's injuries.

The home failed to 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 was dealt with as follows: 1. The complaint shall be investigated. [s. 101. (1) 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 to 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: 1. The complaint shall be investigated and resolved where possible, to be implemented voluntarily.

Issued on this 27th day of September, 2018

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

Original report signed by the inspector.