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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 25, 2017	2017_449619_0010	014712-16, 022942-16, 033921-16, 035307-16, 000423-17, 001445-17	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

Streetville Care Community
1742 BRISTOL ROAD WEST MISSISSAUGA ON L5M 1X9

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

SAMANTHA DIPIERO (619)

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): April 20, 24, 25, 2017

The following Critical Incident Inspections were completed:

#014712-16 - Fall with injury
#022942-16 - Fall with injury
#033921-16 - Fall with injury
#035307-16 - Dignity and privacy
#000423-17 - Personal support services
#001445-17 - Personal support services

During the course of the inspection, the inspector(s) spoke with the Director of Nursing and Personal Care (DOC), Assistant Director of Nursing Care (ADOC), Resident Relations Coordinator (RRC), Physiotherapist (PT), Registered Nurse (RN), Registered Practical Nurse (RPN), and Personal Support Worker (PSW).

During the course of the inspection the inspector toured the facility, observed the provision of care, reviewed the home's policies and procedures, and reviewed clinical records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee failed to ensure that the plan of care was reviewed and revised when care set out in the plan had not been effective and that different approaches were considered in the revision of the plan of care.

Resident #002 was considered a high risk for falls as per a falls risk assessment completed in June 2016, and employed a mobility device. A review of the resident's written plan of care, revised in March 2016, indicated that the resident had multiple fall prevention interventions in place and a significant number of falls in the past quarter. A review of the resident's written plan of care revised April 2016, and interview with PSW #107 indicated that the resident had a historical behaviour of removing or displacing falls prevention interventions. Interview with RPN #105 indicated that the resident was not reassessed for alternative falls prevention interventions. A review of the resident's clinical health record and interview with the Physiotherapist did not indicate that the resident was re-assessed for the use of alternative falls prevention interventions that they would be unable to remove. The Physiotherapist confirmed that the resident's falls preventions interventions were not reassessed or revised and that the resident continued to sustain falls. A review of the home's policy titled, " Falls Prevention", policy #VII-G-30.00, last revised January 2015, stated, "Each member of the interdisciplinary team (registered staff, PT, OT, and recreation) will complete their respective assessments and discuss the appropriate interventions with the multidisciplinary care team". Interview with the DOC confirmed that the resident was not reassessed and the written plan of care reviewed and revised and that different approaches to falls preventions were not considered when the care set out in the plan had not been effective.

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to ensure that every resident had the right to be afforded privacy in treatment and in caring for his or her personal needs.

On an identified date in December 2016, visitors discovered resident #004 unclothed in bed; they noted that the door to the resident's room was open, that the resident's privacy curtain was not closed and that the unclothed resident was visible to passersby in the hallway. A review of the resident's written plan of care updated in February 2013, indicated that the resident required total assistance for personal care. Interview with PSW #109 indicated that they were in the process of providing care to resident #004 and exited the room to obtain care supplies. Interview with PSW #109 confirmed that they left the privacy curtain open and the resident's door open. Interview with the Director of Care confirmed that the resident's rights in relation to privacy were violated by PSW #109.

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 S. 3(1) where every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted and every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

Issued on this 26th 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) :	SAMANTHA DIPIERO (619)
Inspection No. / No de l'inspection :	2017_449619_0010
Log No. / Registre no:	014712-16, 022942-16, 033921-16, 035307-16, 000423-17, 001445-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 25, 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 :	Streetville Care Community 1742 BRISTOL ROAD WEST, MISSISSAUGA, ON, L5M-1X9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Bock

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. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee shall review all residents currently identified at a high risk for falls to ensure all actions and interventions are effective and that different approaches are considered and implemented if current falls prevention interventions are not effective. The licensee shall further ensure that all revisions are documented in the revision of the plan of care.

Grounds / Motifs :

1. 1. Judgement Matrix
- Non-Compliance Severity: Actual harm or risk for actual harm
- Non-Compliance Scope: Isolated
- Compliance History: Despite Ministry of Health (MOH) action, non-compliance (NC) continues with original area of NC.

2. The licensee failed to ensure that the plan of care was reviewed and revised when care set out in the plan had not been effective and that different approaches were considered in the revision of the plan of care.

Resident #002 was considered a high risk for falls as per a falls risk assessment completed in June 2016, and employed a mobility device. A review of the resident's written plan of care, revised in March 2016, indicated that the resident had multiple fall prevention interventions in place and a significant number of falls in the past quarter.
A review of the resident's written plan of care revised April 2016, and interview with PSW #107 indicated that the resident had a historical behaviour of removing or displacing falls prevention interventions. Interview with RPN #105 indicated that the resident was not reassessed for alternative falls prevention interventions. A review of the resident's clinical health record and interview with the Physiotherapist did not indicate that the resident was re-assessed for the use of alternative falls prevention interventions that they would be unable to remove. The Physiotherapist confirmed that the resident's falls preventions interventions were not reassessed or revised and that the resident continued to sustain falls. A review of the home's policy titled, " Falls Prevention", policy #VII-G-30.00, last revised January 2015, stated, "Each member of the interdisciplinary team (registered staff, PT, OT, and recreation) will complete their respective assessments and discuss the appropriate interventions with the multidisciplinary care team". Interview with the DOC confirmed that the resident was not reassessed and the written plan of care reviewed and revised and that different approaches to falls preventions were not considered when the care set out in the plan had not been effective. (619)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2017

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

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 25th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Samantha Dipiero

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