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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Jul 14, 2015	2015_215123_0011	H-002392-15	Resident Quality Inspection

Licensee/Titulaire de permis

VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

LEISUREWORLD CAREGIVING CENTRE - TULLAMORE
133 KENNEDY ROAD SOUTH BRAMPTON ON L6W 3G3

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

MELODY GRAY (123), KATHLEEN MILLAR (527), LAURA BROWN-HUESKEN (503), THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 26, 27, 28 & 29, June 2, 3, 4, 5, 8, 9, 10, 11 & 15, 2015.

Concurrent Inspections: H-001327-14; H-001903-15; H-002086-15; H-002309-15; H-002528-15; H-000434-14; H-000990-14; H-000991-14; H-000992-14; H-000993-14; H-000994-14; H-000995-14.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers (PSWs), registered staff, Physiotherapy Assistant (PTA), Environmental Services Manager (ESM), Director of Resident Programs, Resident Assessment Instrument Coordinator back-up (RAI Coordinator), Cook, Dietitian, Food Services Coordinator, Associate Directors of Care (ADOC), Director of Care (DOC) and Administrator.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **9 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 134.	CO #007	2013_205129_0007	123
O.Reg 79/10 s. 15. (1)	CO #004	2014_210169_0012	526
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #003	2013_205129_0007	123
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2014_210169_0012	123
O.Reg 79/10 s. 26. (3)	CO #005	2013_205129_0007	123
O.Reg 79/10 s. 26. (3)	CO #006	2013_205129_0007	123
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2013_205129_0007	123
LTCHA, 2007 S.O. 2007, c.8 s. 33. (4)	CO #002	2014_210169_0012	527
O.Reg 79/10 s. 36.	CO #005	2014_210169_0012	123
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #002	2013_205129_0007	123 526
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #008	2013_205129_0007	123 526
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #006	2014_210169_0012	526
O.Reg 79/10 s. 8. (1)	CO #003	2014_210169_0012	123

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. 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of a resident was fully respected and promoted: 4. Every resident had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs as evidenced by:

A review of the clinical record of resident #302 revealed that the resident was admitted to the home in 2014 with a device and an order to change the device monthly.
In July, 2014 the resident's physician ordered that the resident's device was now to be changed as need only.

The review of the resident's Treatment Administration Records (TAR) from July, 2014 to January, 2015 and Progress Notes did not reveal any evidence that the resident's device changed during that seven month period.

In January, 2015 resident #302 was noted to have a decreased level of consciousness; was difficult to rouse and had increased tone in all extremities. The resident was sent to the hospital and was admitted to hospital with an infection.

The home's records including an identifiifed policy # V3-294, revised March, 2012 was reviewed. It included: "Change devices according to clinical indications such as infection, obstruction, or when the closed system is compromised rather than at routine, fixed intervals." and "Physician order will state that the device should be changed according to clinical indications, as stated above. There will be no physician order for routine device change." The Associate Director of Care (ADOC) confirmed that this was the current policy which provided direction to the staff regarding device changes.

The ADOC was interviewed and reported that the home's practice was to change residents' device monthly and as needed. All resident's with devices were monitored for infection and blockage.

The home was unable to provide information to demonstrate that the resident was assessed and monitored for infections or that the device was changed from July, 2014 until January 2015, when requested.
The home did not ensure that resident #302 was cared for in a manner consistent with their device care needs. [s. 3. (1) 4.]

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. 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. (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).

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

Findings/Faits saillants :

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

A review of the clinical record of resident #302 revealed that the resident was admitted to the home in 2014 with a device and an order to change it monthly. In July 2014 the resident's physician ordered that the resident's device was now to be changed as needed only. In January, 2015 the resident was admitted to hospital with an infection. There was no evidence found in the resident's record indicating that the device was changed from July, 2014 to January, 2015.

The resident's plans of care were reviewed specifically related to the focus of the device. The goal was identified as "The resident will show no signs or symptoms of infections". The care plans did not contain any interventions or directions to the staff related to monitoring and or assessing the resident for signs and symptoms of urinary infection nor the frequency of assessments. The ADOC confirmed that the resident's plan of care related to the device did not include any information regarding monitoring the resident for infections and changing it.

The ADOC was interviewed reported that the home's practice was to change residents' catheters monthly and as needed. All residents with indwelling catheters were monitored for infection and blockage.

The home did not ensure that there was a written plan of care for resident #302 that set out the planned care related to the device. [s. 6. (1) (a)]

2. The licensee failed to ensure that staff and others involved in different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other as evidenced by:

Between fifteen days in May, 2015 and June, 2015, resident #100 was observed to have limited range of motion (ROM) with loss of voluntary movement to their lower extremities. During interviews, registered staff and the physiotherapist (PT) confirmed this. Resident #100's Minimum Data Set-Resident Assessment Instrument (MDS-RAI) assessments completed in October, 2014; January, 2015 and April, 2015, indicated that resident had no limitations or loss of voluntary movement to any of their extremities. During interview the ADOC and the Director of Care (DOC) stated that staff had not completed the April, 2015, MDS-RAI assessment to reflect the resident's current functional status. They confirmed that staff and MDS-RAI assessments for resident #100 were not integrated,

consistent with or complemented each other. [s. 6. (4) (a)]

3. 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 as evidenced by:

A. Resident #103 was prescribed a nutritional supplement to be administered three times per day. During interview in June, 2015, a Registered Practical Nurse (RPN) told the Long Term Care Homes (LTCH) Inspector that, in the morning of that day, they administered a diabetic supplement instead of the prescribed supplement since the resident was diabetic. The RPN stated that they had not consulted with a physician or dietitian about administering the diabetic supplement instead of the one that was ordered for resident #103 as per the plan of care. In addition, the RPN stated that they documented the administration using the Electronic Medication Administration Record (EMAR) as though they had administered the ordered nutritional supplement.

The home's policy "Medication-Administration", #V3-890, reviewed April, 2013 directed staff that "All medications and treatments including prescription, non-prescription, vitamins, minerals, herbals, and non-traditional medications require a prescribing order".

During interview, the DOC confirmed that resident #103 had received a nutritional supplement without a prescribing order and not according to their plan of care. The DOC also confirmed that the RPN had incorrectly documented the administration of the supplement in the resident's EMAR. (526)

B. A review of the clinical record revealed that in March, 2015 resident #400 was assessed to have altered skin integrity, variable intake and a low body mass index. The resident was ordered a nutritional supplement to be administered three times daily. A review of the resident's EMAR for April, 2015 and May, 2015 revealed that the nutritional supplement had not been administered, this was also confirmed through interview with registered staff. An interview with the home's Registered Dietitian (RD) revealed that the order had not been correctly inputted into the home's electronic system, and as a result, did not appear on the EMAR. The RD further confirmed that the nutritional supplement had not been administered to the resident as per the order. [s. 6. (7)]

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

by:

A. A review of the MDS-RAI assessment for resident #115 for the self-performance of the activity of daily living (ADL) of dressing showed a decline from limited to extensive assistance between January, 2015 and April, 2015. A review of Point of Care (POC) documentation revealed that the resident required extensive assistance or was totally dependent on staff for dressing on 23 out of 30 identified days in May, 2015 and June, 2015.
An interview with a Personal Support Worker(PSW) revealed that the resident was frequently totally dependent on staff for dressing. The resident's plan of care, which was last updated in February, 2015 related to dressing, directed staff to provide the resident with limited assistance including guided maneuvering of limbs for dressing. An interview with the home's ADOC confirmed that the plan of care had not been updated to reflect the current care needs of resident #115. (503)

B. According to resident #100's clinical record, in December, 2014 they were admitted to hospital and treated for a disorder. The resident returned to the home in January, 2015. Review of the document the home referred to as resident #100's "care plan" indicated that the plan of care had not been revised to include monitoring post-hospitalization. The two post-readmission progress notes completed in January, 2015 indicated that staff were monitoring the resident.
The DOC confirmed that resident #100's plan of care had not been changed when care needs changed in relation to assessing the resident for further complications that led to their hospitalization. (526)

C. The health record of resident #202 was reviewed and revealed that in July, 2014 the resident returned from hospital and began palliative care. The resident passed away later.

The MDS-RAI assessment completed in August, 2014, indicated that resident #202 had total dependence from two persons for bed mobility, transfer, locomotion, dressing, eating, toilet use, personal hygiene and bathing. According to the assessment, the resident did not walk in their room or corridor. The document the home referred to as resident #202's "care plan" last reviewed one week after the August, 2014 MDS-RAI assessment was completed, indicated that they were able to perform part of the bathing process, required supervision from one person with bed mobility, and required extensive

assistance from one person for dressing, personal hygiene, toilet use, and transfer. Review of progress notes between July, 2014 and August, 2014 indicated that the resident was lethargic, not swallowing, required repositioning in bed by staff, and was receiving comfort measures.
The DOC was interviewed and confirmed that staff had not revised resident #202's written plan of care when their care needs had changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002 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 to ensure that:
1. Staff and others involved in the different aspects of care of the residents collaborate with each other, in the assessment of the residents so that their assessments are integrated and are consistent with and complement each other.

2. The care set out in the plans of of care is provided to the residents as specified in the plans

3. The residents are reassessed and the plans of care reviewed and revised at least every six months and at any other time when, the residents' care needs change or care set out in the plans is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices, to minimize risk to the resident as evidenced by:

Over an identified seven day period in May, 2015 and June, 2015 resident #106 was observed laying in bed with one quarter bed rail in the raised position. During interview, resident #106 stated that they liked the bed rail to help them to move while in bed. Upon review of resident #106's clinical record an undated assessment was found that indicated that the resident did not use bed rails. No other assessment of resident #106 in terms of their use of bed rails was noted in the resident's clinical record. The document the home referred to as resident #106's "care plan" completed in June, 2015 indicated that they used bed rails to assist with mobility. During interview, a Registered Nurse (RN) and the DOC confirmed that resident #106 used bed rails for mobility as a Personal Assistive Services Device (PASD). They confirmed that resident #106 had not been assessed in their bed system to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that: Where bed rails were used, the residents are assessed and their bed systems are evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if all of the following were satisfied:

1. Alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or had not been, effective to assist the resident with the routine activity of living.

2. The use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.

3. The use of the PASD had been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations.

4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent as evidenced by:

A. Over an identified seven day period in May, 2015 and June, 2015 resident #106 was observed lying in bed with one quarter bed rail in the raised position. During interview resident #106 stated that they liked the bed rail to help them to move while in bed. Upon review of resident #106's clinical record an undated assessment was found that indicated that the resident did not use bed rails. The document the home referred to as resident #106's "care plan" completed in June, 2015 indicated that they used bed rails to assist with mobility. During interview, a RN and the DOC confirmed that resident #106 used bed rails for mobility as a PASD. They confirmed that resident #106 had not been assessed for alternatives to the use of bed rails as a PASD, or for the reasonableness of the use of bed rails. They confirmed that the bed rails had not been approved by a designated person and that consent for the use of bed rails as a PASD had not been provided. [s. 33. (4)]

2. Resident #111 was observed to have a quarter bed rail raised to assist with bed mobility. The resident was interviewed and stated the bed rail assisted with getting in and

out of bed. The written plan of care identified the resident had a PASD, specifically quarter bed rails for bed mobility. The registered staff and PSWs confirmed the resident had a PASD for bed mobility. The clinical record was reviewed and there was a consent dated in October, 2014 for a PASD. There was a bed rail assessment in the resident's clinical record from April, 2015 which identified the resident no longer required bed rails. There was no physician's order for the use of the PASD, which was required according to the home's policy called "Restraint and PASD Mechanical", #V3-1340, revised April, 2013.
The ADOC was interviewed by LTCH Inspector #123 and the ADOC confirmed that the use of the PASD was not approved by a designated person. [s. 33. (4) 3.]

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: The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: 1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5), to be implemented voluntarily.

WN #5: 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 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 as evidenced by:

According to the clinical record, resident #102 returned from hospital in May, 2015 and staff noted an area of redness over the resident's coccyx as recorded in the progress notes. An initial skin assessment was completed when the resident returned from the hospital and weekly skin assessment was completed eight days later. Review of the Electronic Treatment Administration Record (ETAR) indicated that the resident was receiving a treatment to their coccyx area three times per day for 18 days in May, 2015 and June, 2015.

The home's "Skin Care Program" policy #V3-1400 revised February, 2012 directed staff to "complete a weekly skin assessment for all residents with altered skin integrity." During interview, the RN responsible for skin and wound care and the ADOC confirmed that a weekly skin assessment had not been completed for resident #102's reddened coccyx after the second weekly skin assessment was completed in May, 2015 according to the home's policy. [s. 50. (2) (b) (iv)]

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: Residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose as evidenced by:

According to resident #202's clinical record, in July, 2014 the resident returned from hospital and became palliative days later. The information indicated that they were ordered analgesia to be administered every two hours as needed beginning August, 2014. Four days later, the dosage of the medication and the frequency of the medication administration was increased. Two days later, the resident was administered the medication every two hours and could also receive it every one hour as needed.

Review of the resident #202's EMAR indicated that they had received 17 doses of analgesia as needed between five identified dates in August, 2014. Seven of these doses were noted to be ineffective in relieving the resident's pain. For the next five days in August, 2014 in addition to 49 doses of regularly schedule analgesia, the resident received an additional 17 doses of analgesia and of these, eight were noted to be ineffective in managing the resident's pain.

The clinical record review also indicated, that in July, 2014 and August, 2014 resident #202 had been assessed for pain using an instrument that was specifically designed for that purpose. The August, 2014 assessment indicated that the resident was experiencing pain. No other pain assessments could be located in the electronic or paper records to indicate that the resident's pain had been assessed using a clinically appropriate assessment instrument.

During interview, the DOC confirmed that when resident #202's pain was not relieved by initial interventions, the resident's pain had not been assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (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 to ensure that when any resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following were developed to meet the needs of residents with responsive behaviors: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other as evidenced by:

In May, 2015, resident #200 was observed to exhibit responsive behaviors in relation to another resident. Resident #203 reported to the Long Term Care Homes (LTCH) Inspector that they had been threatened by resident #200 and felt afraid of them.

Review of progress notes indicated that resident #200 had exhibited behaviors in relation to co-residents once in November, 2014 and twice in May, 2015. During interview, PSW and registered staff confirmed that resident #200 had exhibited behaviors during care and also toward co-residents which included verbal and physical aggression especially when resident #200 was walking with a co-resident and attempts were made to separate them. Review of the resident's clinical record and staff interviews indicated Behavioral Supports Ontario (BSO) staff were involved in the resident's care. During interview the RN indicated that staff would leave the resident if they were agitated and PSW staff stated that they may provide care to resident #200 simultaneously with co-resident to decrease risk for altercations.

Review of the most recent document the home referred to as resident #200's "care plan" indicated that there were no written approaches to meet the needs of the resident related to preventing or addressing responsive behaviors toward co-residents. The RN, BSO staff person and DOC confirmed this. [s. 53. (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 the following are developed to meet the needs of residents with responsive behaviors:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioral triggers that may result in responsive behaviors, whether cognitive, physical, emotional, social, environmental or other, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality as evidenced by:

The preparation of the lunch meal was observed on an identified date in June, 2015 and not all items were prepared using methods to preserve taste, nutritive value, appearance and food quality.

The recipe for the pepper and leek quiche directed staff to cook onions, mushrooms, leeks and red peppers and to divide the vegetables among the prepared pie shells. Mushrooms were noted to be absent from the vegetable mixture. The cook confirmed that mushrooms were not available and they were omitted from the recipe. The recipe directed staff to sprinkle shredded Swiss cheese and dried parsley onto the vegetables. The cook was observed to substitute shredded cheddar cheese and to omit the dried parsley. The recipe directed staff to mix liquid whole eggs, milk and black pepper and to pour onto the vegetables. The cook was observed to omit the black pepper. The resulting product did not have all of the ingredients outlined in the recipe and resulted in altered nutritive value and altered taste of the final product. An interview with the home's Director of Food Services confirmed that it was the home's expectation that the cook followed the standardized recipes provided. [s. 72. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #9: 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: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's dining and snack service included course by course meal service for each resident, unless otherwise indicated by the resident or by the resident's assessed needs as evidenced by:

During an observation of the lunch meal on an identified date in June, 2015 residents #105, #402, #403 and #404 were observed to be served their main course while still consuming their course of soup. An interview with a PSW revealed that the identified residents had not requested an exception to course by course meal service. A review of the plans of care for the identified residents did not reveal that the residents had assessed needs for the service of multiple meal courses at one time. An interview with the home's Director of Food Services confirmed that each of the identified residents should have been provided course by course meal service. [s. 73. (1) 8.]

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 the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs, to be implemented voluntarily.

WN #10: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the home's infection prevention and control program as evidenced by:

On three identified days in May 2015 the following observations were made regarding staff implementation of the home's infection prevention and control program:

A) Unlabeled toothbrushes were found beside sinks in four identified rooms which were occupied by more than one resident and where contact and or droplet precautions were in place. During interview the ADOC, who was also the Infection Control person in the home, stated that the home's expectation regarding the storage of residents' toothbrushes was that they should be labeled and stored at the resident's bedside.

B) Unlabeled cream was found on the counter beside the sink in the bathroom of an identified room that was used by two residents and where contact and or droplet precautions were in place. The ADOC stated that the cream should have been labeled, stored in the medication cart, and posed an infection control risk when stored beside the sink used by multiple residents.

C) Unlabeled urine collection devices were observed:
i) An unlabeled urine collection "hat" was found positioned on the grab bar behind the toilet in the bathroom between two identified rooms, each occupied with two residents and both rooms had contact precautions in place.
ii) An unlabeled catheter bag was observed stored in a mesh bag hanging on the wall, and an unlabeled urine collection container was observed on the floor in the bathroom of an identified room that was used by four residents.

The home's "Cleaning, Disinfection and Sanitization" Infection Control policy #V6-030, revised August, 2013 directed staff to do the following: "Personal care items such as… urine collection items will be labeled with the resident name and room number". The ADOC stated that the home's expectation was that urine collection items should be labeled, sanitized and stored in the resident's washroom only if dry.

D) The bath tub on Pansy Garden was noted to have black debris and hair on the bottom of the tub; the debris could be removed by the LTCH Inspector using a paper towel. The home's "Cleaning, Disinfection and Sanitization" Infection Control policy #V6-030, revised August, 2013 directed staff to do the following: "Tubs are to be cleaned and sanitized after each resident use by the PSW". During interview regarding the cleanliness of the tub on Pansy Garden, a PSW confirmed that the bath tub had not been cleaned according to the home's policy.

The ADOC confirmed that staff had not implemented the home's infection prevention and control program in terms of the storage of tooth brushes, urine collection items, cream and cleaning of the tub on Pansy Garden. [s. 229. (4)]

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 all staff participate in the implementation of the home's infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination as evidenced by:

The clinical record of resident #108 revealed that in October, 2014 the resident was assessed as being usually continent of urine where they were found to have occasional incontinence episodes of once per week or less. The resident's bowel assessment indicated that they were usually continent. In January, 2015 there was a noted decline in the resident's urinary continence level and they were assessed as having frequent incontinence, being incontinent of urine daily but having some control for example, during the day shift. They were noted to have occasional bowel incontinence. The assessments also indicated that pads and or briefs were being used to manage the resident's incontinence.
The October, 2014 and January, 2015 care plans of resident #108 were reviewed and they did not contain any information about the resident's incontinence, goals of care or interventions in place to address their incontinence.

The back-up MDS-RAI Coordinator was interviewed and they confirmed that the resident was assessed in October, 2014 as being usually continent of bowel and bladder and after approximately 90 days they were assessed as having occasional bowel incontinence and frequent incontinence of bladder requiring the use of incontinence products. The MDS-RAI Coordinator also confirmed that the resident's October, 2014, and January, 2015 plans of care did not include any information related to the October, 2014 and January, 2015 interdisciplinary assessments of the resident's bladder or bowel elimination.

The home did not ensure that the October, 2014 and the January, 2015 plans of care for resident #108 included any information from the interdisciplinary assessments of the resident's bladder and bowel continence. [s. 26. (3) 8.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee ensured that procedures were developed and implemented for, (a) cleaning of the home, including, (i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces as evidenced by:

On two identified days in May, 2015 during morning and afternoon observations, the LTCH Inspector detected a feces odour and observed brown/yellow feces colored splatters on the back of the toilet, toilet rim and within the toilet of an identified resident room.

The home's "Cleaning Frequencies-Housekeeping" policy number #XII-D-10.50 revised January, 2015 indicated that resident bathroom cleaning frequency including toilet, should be daily. Interview with the Environmental Services Manager(ESM) confirmed that resident bathrooms should be cleaned daily and staff should alert the housekeeping staff to areas in the home needing cleaning. [s. 87. (2) (a)]

2. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee ensured that procedures were developed and implemented for, addressing incidents of lingering offensive odours as evidenced by:

On three identified days in May, 2015, during morning and afternoon observations by the LTCH Inspector, offensive urine odours were noted in the bathrooms of two identified residents' rooms. The ADOC and the ESM confirmed this.

Review of the home's maintenance records of "Resident Rooms Checked" for the identified room indicated that the home should monitor for a smell in the bathroom; no documentation was found regarding the home's response. The DOC indicated that the expectation in the home regarding odours, was that staff should inform housekeeping regarding lingering offensive odours, the source should be identified if possible and addressed, and deodorizers should be in place in rooms where odours had been identified.

In June, 2015, the DOC stated that the two identified rooms had been cleaned and confirmed that rooms did not have deodorizers in place on that day, according to the home's procedures and that the home's procedure for the management of odours in the two identified rooms had not been implemented between the three day period in May, 2015 as noted above. [s. 87. (2) (d)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including the following: 1. All areas where drugs were stored were not kept locked at all times, when not in use as evidenced by:

A) On an identified day in May, 2015 a bottle containing medication was observed on resident #102's shelf by their bed. The resident stated that staff administered the medication and that they did not to administer it themselves.

B) On three identified days in May, 2015 a tube containing a topical medication was stored by the sink in the bathroom used by residents #106 and #201. Review of clinical records for the resident indicated that they had not been prescribed this medication.

The home's "Medications-Storage and Safety" policy #V3-1060 revised April, 2013 indicated that "All medications are kept in a designated secure locked area such as the medication room or medication cart". During interview, the ADOC and DOC confirmed that these medications should have been stored in the medication cart and or in a locked area. [s. 130. 1.]

Issued on this 16th day of July, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELODY GRAY (123), KATHLEEN MILLAR (527), LAURA BROWN-HUESKEN (503), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2015_215123_0011
Log No. / Registre no:	H-002392-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 14, 2015
Licensee / Titulaire de permis :	VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR 302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - TULLAMORE 133 KENNEDY ROAD SOUTH, BRAMPTON, ON, L6W-3G3
	ASTRIDA KALNINS

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

To VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that: The rights of all residents with indwelling catheters, to be cared for in a manner consistent with their needs related to monitoring for urinary infections, will be fully respected and promoted. The plan is also to include, but not be limited to, ongoing monitoring activities to ensure compliance. The plan is to be submitted on or before July 30, 2015, by mail to Melody Gray at 119 King Street West, 11th Floor, Hamilton, Ontario L8P 4Y7 or by email to Melody.Gray@Ontario.ca.

Grounds / Motifs :

1. Previous non-compliance was identified with a VPC issued on July 7, 2014. A review of the clinical record of resident #302 revealed that the resident was admitted to the home in 2014 with a device and an order to change the device monthly. In July, 2014 the resident's physician ordered that the resident's device was now to be changed as needed only.

The review of the resident's Treatment Administration Records (TAR) from July, 2014 to January, 2015 and Progress Notes did not reveal any evidence that the resident's urinary catheter was changed during that seven month period.

In January, 2015 resident #302 was noted to have a decreased level of consciousness; was difficult to rouse and had increased tone in all extremities. The resident was sent to the hospital and was admitted to hospital with an infection.

The home's records including the policy and procedure # V3-294, revised March, 2012 was reviewed.
It included: "Change devices according to clinical indications such as infection, obstruction, or when the closed system is compromised rather than at routine, fixed intervals." It also included: "Physician order will state that device should be changed according to clinical indications, as stated above. There will be no physician order for routine device change."

The Associate Director of Care (ADOC) was interviewed and reported that the home's practice is to change residents' device monthly and as needed. All residents with devices are monitored for infection and blockage. The ADOC also confirmed that the policy above is the document which provided direction to the home regarding urinary catheter changes.

The home did not ensure that resident #302 was cared for in a manner consistent with their care needs.

(123)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 30, 2015

Order # / Ordre no : 002

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. (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).

Order / Ordre :

The licensee shall ensure that all nutritional supplements within the residents plans of care are provided to the residents, including residents #103 and #400, as specified in the plans.

Grounds / Motifs :

1. Previously identified as non-complaint with an order issued on July 7, 2014.
A. A review of clinical records revealed that in March, 2015, resident #400 was assessed to have altered skin integrity, variable intake and a low body mass index. The resident was ordered a nutritional supplement to be administered three times daily. A review of Electronic Medication Administration Record (EMAR) for April, 2015 and May, 2015 revealed that the nutritional supplement had not been administered, this was further confirmed through interview with registered staff. An interview with the home's Registered Dietitian (RD) revealed that the order had not been correctly inputted into the home's electronic system, and as a result, did not appear on the EMAR. The RD further confirmed that the supplement had not been administered to the resident as per the order. (503)

B. Resident #103 was prescribed a dietary supplement to be administered three times per day. During interview in June, 2015, a Registered Practical Nurse (RPN) told the Long Term Care Homes (LTCH) Inspector that, in the morning of that day, they administered a diabetic supplement instead of the prescribed supplement since the resident was diabetic. The RPN stated that they had not consulted with a physician or dietitian about administering the diabetic supplement instead of the one that was ordered for resident #103 as per the plan of care. In addition, the RPN stated that they documented the administration using the EMAR as though they had administered the ordered supplement.

The home's "Medication-Administration" policy number V3-890, reviewed April, 2013 directed staff that "All medications and treatments including prescription, non-prescription, vitamins, minerals, herbals, and non-traditional medications require a prescribing order".

During interview, the Director of Care (DOC) confirmed that resident #103 had received a medication or treatment without a prescribing order and not according to the resident's plan of care. The DOC also confirmed that the RPN had incorrectly documented the administration of the medication in the EMAR.

(526)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 30, 2015

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 14th day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MELODY GRAY

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