Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 5, 2020	2020_826606_0007	022373-19, 022523-19, 022900-19, 023134-19, 001214-20, 001672-20	Critical Incident System

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), HEATHER PRESTON (640)

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): February 3-6, and 11-13, 2020.

The following Critical Incident Intakes were inspected:
Log #: 022373-19 regarding an allegation of improper transfer by staff causing an injury to a resident; log #022523-19, #022900-19, #023134-19, #001214-20, regarding resident to resident responsive behaviour; and log #001672-20, regarding missing narcotics.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOCs), Physiotherapist (PT), Physiotherapist Therapist Assistant (PTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activation Aide, Director of Resident Programs, Resident and Family Experience Coordinator, Pharmacist Consultant, family members and residents.

The inspector(s) conducted observations of resident care, residents and staff interactions, completed interviews and reviewed residents' clinical records including progress notes, assessments, physician orders, plans of care, reviewed relevant home's investigation records, home's meeting minutes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Personal Support Services
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **6 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	Légende 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. (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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

A Critical Incident (CI) reported resident #001 alleged they had pain while being provided care by staff.

The Long Term Care Homes (LTCH) Inspector observed on an identified date Personal Support Worker (PSW) #147 enter resident #014's room, with an identified type of transfer equipment and at an identified time exited the room with the identified transfer equipment along with PSW #135 and resident #114.

Resident #014's care plan directed staff to use different types and levels of assistance to transfer the resident.

PSW #135 acknowledged they transferred resident #014 using an identified type of transfer equipment for their transfers and was not aware that the resident required another type of transfer equipment for their transfers. This was confirmed by the PT and RN #138.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #014. [s. 6. (1) (c)]

2. 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 of care.

A) The home submitted a CI report to the Director of the Ministry of Long Term Care (MLTC) regarding a resident to resident altercation.

The Behaviour Support Ontario (BSO) lead said resident #010 would display an identified responsive behaviour when they required an identified activities of daily living (ADL). They said the resident was at high risk for an identified responsive behaviour when their triggers were activated.

Resident #010's plan of care identified one of the triggers for resident #010, was when they required an identified ADL. The plan of care directed the staff to provide the identified ADL at specified times as a strategy to reduce the risk of responsive behaviours.

PSWs #111, #117 and #137 said the resident displayed an identified responsive behaviour when they wanted an identified ADL to be provided. They acknowledged that the resident was provided the identified ADL but acknowledged that they did not provide the care according to the resident's plan of care.

B) Resident #012 had an identified medical condition which triggered an identified responsive behaviour. The BSO lead confirmed this.

Resident #012's plan of care identified that a trigger for the resident's responsive behaviour was due to an identified medical condition. The plan of care directed staff to provide the resident an identified ADL at specified times. PSWs #127 and #128 acknowledged that they did not provide resident #012 the identified ADL as specified in the resident's plan of care.

Associate Director of Care (ADOC) #132 said that staff were expected to be aware of the contents of the resident's plan of care and provide the care as set out in the plan. They acknowledged that staff were not implementing the plans of care for residents #010 and #012 with regards to the identified ADL.

The licensee has failed to ensure that he care set out in the plan of care was provided to residents #010 and #012 as specified in their plans of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan of care, to be implemented voluntarily.

WN #2: 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 Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. s. 136 (2) (1), and in reference to O. Reg. 136 (1), the licensee was required to have a medication management policy developed in the home that ensured that drugs that are to be destroyed and disposed of must be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurred.

The home's policy on drug destruction and disposal of monitored medications including narcotics stated that the registered staff who processed the physician's order to discontinue the narcotic medication must be the registered staff to remove the

medication from the narcotic medication cart. This registered staff must retain the discontinued narcotic medication in the drug destruction bin with another registered staff present to witness and sign.

A CI submitted to the Director of the MLTC reported discontinued cards which contained an identified number of a narcotic medication belonging to resident #008 were missing from the drug destruction bin.

Resident #008's stated there was a physician order to discontinue the resident's identified narcotic medication. Documentation showed that the order was discontinued on an identified date and time.

Registered Practical Nurse (RPN) #124 acknowledged that they observed the identified narcotic medication that had been discontinued but remained in the medication cart narcotic bin when they started their shift. They stated that when a physician ordered to discontinue a narcotic or controlled substance, the nurse who processed the order would be the nurse responsible to remove the medication from the narcotic bin located in the medication cart. ADOC #125 confirmed this.

RN #144 stated they were the nurse who processed the physician's order to discontinue the identified narcotic medication and acknowledged they did not remove the narcotic medication from the narcotic bin in the medication cart after they discontinued the order.

The home's policy entitled "Drug Destruction and Disposal" policy was not complied with in relation to discontinuing a narcotic medication. [s. 8. (1) (b)]

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 a policy put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CI reported resident #001 alleged they had pain while being provided care by staff.

Resident #001's progress notes stated PSW #108 reported the resident verbalized pain to an identified area of their body. The resident was assessed by RN #121 and the physician and suspected an identified medical condition. Resident #001 was transferred to the hospital for further assessment and was diagnosed with an identified medical condition.

Resident #001 stated that they required an identified number of staff and an identified transfer technique depending on how they felt at the time of the care. The resident's plan of care and the PT confirmed this.

The Home's policy on safe handling of residents stated to lift/transfer the resident, according to the plan of care. PSW #145, #146 and RN #144 acknowledged that on an identified date, resident #001 was not transferred according to the resident's plan of care and the Home's policy.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

A CI reported resident #001 alleged they had pain while being provided care by staff.

Resident #001's progress notes stated resident #001 was provided an identified ADL using an identified technique. RN #144 identified the transfer aide that the staff were going to use for the resident was inappropriate. The progress notes stated there was no transfer aide available that was appropriate for the resident at the time. PSW #108 confirmed that an identified transfer aide was not available for resident #001 and said they reported to management on an identified date that resident #001 required a transfer aide.

The Resident Family Coordinator said that an identified transfer aide was purchased for resident #001 on an identified date.

The licensee has failed to ensure that the appropriate identified transfer aide were readily available at the home to meet the nursing and personal care needs of resident #001. [s. 44.]

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 that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident had an assessment that included identification of causal factors, patterns, type of incontinence and the assessment was conducted with a clinically appropriate assessment instrument specifically designed or the assessment of continence.

Resident #011 was assessed on admission to have an identified level of care with regards to their continence care.

The licensee's policy "Continence Program - Guidelines for Care", policy, directed staff that upon admission to obtain information about the resident's bowel and bladder routine, identify contributing factors to incontinence, and reference the Bladder and Bowel Assessment tool.

The LTCH Inspector reviewed the clinical record, specifically the assessments, and found the admission bowel and bladder assessment form was blank.

RN #121 and ADOC #132 reviewed the bowel and bladder assessment form and said that it had not been completed and it was required to have been completed upon

admission.

The licensee failed to ensure that resident #011 had a bowel and bladder assessment to determine causal factors, type of incontinence and patterns using a clinically appropriate assessment instrument specifically designed for the assessment of continence. [s. 51. (2) (a)]

2. The licensee failed to ensure that resident #010 had an individualized plan to promote their continence that was based on an assessment.

A) The home submitted a CI report to the Director of the MLTC regarding a resident to resident altercation.

The Behaviour Support Ontario (BSO) lead said resident #010 would display an identified responsive behaviour when they required an identified ADL. They said the resident was at high risk for an identified responsive behaviours when their triggers were activated.

Resident #010's plan of care identified one of the triggers for resident #010, was when they required an identified ADL. The plan of care directed the staff to provide the identified ADL at specified times as a strategy to reduce the risk of responsive behaviours.

The BSO Lead and RN #118 said the home implemented an specific intervention to address the resident’s responsive behaviours. They both said there was no assessment conducted to determine the resident’s individual needs in regards to the identified care.

B) Resident #011 had an identified responsive behaviour. The resident fell a number of times while attempting to perform an identified ADL by themselves. The resident’s plan of care directed staff to provide the resident a specific intervention for the identified ADL.

RN #121 said that during a meeting, resident #011's falls were discussed and the team decided to implement a specific intervention to manage the resident's risk of falling. The LTCH Inspector reviewed the clinical record, specifically the assessments, and there were no continence assessments completed to develop the individualized plan to promote continence.

RN #121 and ADOC #132 acknowledged there were no assessments conducted to determine the resident’s individual needs related to their continence.

C) Resident #012 had an identified medical condition which triggered an identified responsive behaviour. The BSO lead confirmed this.

Resident #012's plan of care identified that a trigger for the resident's responsive behaviour was due to an identified medical condition. The plan of care directed staff to provide the resident an identified ADL at specific times.

The LTCH Inspector reviewed the clinical record, specifically the assessments and there were no continence assessments conducted to develop the individualized plan to promote continence.

ADOC #132 acknowledged there were no assessments conducted to determine the resident’s individual needs related to their continence.

The licensee failed to ensure residents #010, #011 and #012 had an assessment conducted to develop their individualized plans and promote continence. [s. 51. (2) (b)]

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 each resident has an assessment that includes identification of causal factors, patterns, type of incontinence and the assessment is conducted with a clinically appropriate assessment instrument specifically designed or the assessment of continence; and to ensure that each resident has an individualized plan to promote bowel and bladder continence that is based on an assessment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the behavioural triggers for resident #005 were identified.

The licensee submitted CI reports to the Director of the MLTC regarding resident #005's responsive behaviours towards other residents.

The resident had a history of an identified responsive behaviour associated with an identified trigger and a number of referrals to the Home's BSO lead were initiated.

The LTCH Inspector reviewed the clinical record and noted that on a number of occasions, the referral tool requested, a dementia observation system (DOS) observation, for the staff to complete were not initiated.There were no DOS observation documents in resident #005's clinical record. ADOC #125 said the DOS observation forms should be in the clinical record. They were not able to locate the forms.

The BSO lead said once the DOS observations were completed, the nurses on the home area were to highlight in colour the different observed behaviours. The BSO stated that they did not review, analyze and document the outcome of each DOS observation period to determine specific triggers, trends in time of day or type of behaviours that occurred during the observation period. They had not identified the behavioural triggers on the plan of care from the DOS observation forms, related to the the resident's identified triggers to their responsive behaviours.

The licensee failed to ensure that the behavioural triggers for resident #005 were

identified. [s. 53. (4) (a)]

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours that strategies were developed and implemented to respond to those behaviours.

The licensee submitted CI Reports to the MLTC regarding resident #005's responsive behaviours towards other residents.

The resident had an identified responsive behaviour often associated with an identified trigger. A number of referrals were initiated during an identified time period. The referrals included identified responsive behaviour related to specific triggers.Resident #005's responsive behaviours were triggered when they they had a change in their physical and mental state brought on by a number of identified triggers.

The plan of care indicated a number of specific interventions to address resident #005's responsive behaviours with the goals of de-escalation and eased of redirection.
The BSO lead said the strategies to respond to resident #005's most frequent responsive behaviours were not developed and implemented.

The licensee failed to ensure that strategies were developed and implemented to respond to resident #012's identified responsive behaviours. [s. 53. (4) (b)]

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 behavioural triggers are identified and to ensure that, for each resident demonstrating responsive behaviours that strategies are developed and implemented to respond to those behaviours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the following areas: 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person’s responsibilities.

A CI submitted to the Director of the MLTC reported discontinued cards which contained an identified number of a narcotic medications belonging to resident #008 were missing from the drug destruction bin.

ADOC #125 stated the Home completed an investigation and concluded RN #133 deposited the identified discontinued narcotic medications in an identified bin instead of the drug destruction bin. The DOC confirmed this and said the whereabouts of the narcotic medications were still unknown.

RN #133 stated that when they returned to work on an identified date, the pharmacy for the Home was a different company. The DOC and Executive Director (ED) confirmed this.

RN #133 stated that they were not provided orientation regarding the identified pharmacy's policies and procedures, in particular, the drug destruction bin, what it looked like, and where it was located in the home.They acknowledged that they deposited the discontinued narcotic medications in an identified bin which they mistook as the drug destruction bin.

There was no training record available to demonstrated RN #133 received training regarding the identified pharmacy's policies and procedures, specifically regarding, the policy and procedure on Drug Destruction.

RN #145 and RPN #124 stated they did not recall receiving an orientation regarding the identified pharmacy's drug destruction bin. The Home's training records provided by the DOC did not show evidence that RN #133, #145, and RPN #124 attended the orientation provided by the identified pharmacy.

The licensee failed to ensure that RN #133, #145 and RPN #124 performed their responsibilities before receiving training in the Medical Pharmacies policies and procedures in relations to the drug destruction bin. [s. 76. (2) 10.]

Issued on this 11th day of March, 2020

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

Original report signed by the inspector.