



**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
Direction de l'amélioration de la
performance et de la conformité**

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

**Bureau régional de services de
Hamilton
119, rue King Ouest, 11^{ième} étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255**

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 28, 2012	2012_208141_0001	H-001974- 12, H- 002030-12	Complaint

Licensee/Titulaire de permis

**THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9**

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

**PEEL MANOR
525 MAIN STREET NORTH, BRAMPTON, ON, L6X-1N9**

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

SHARLEE MCNALLY (141)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 23, 24, 25, 2012

H-001974-12, H-002030-12, H-002097-12

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSWs)

During the course of the inspection, the inspector(s) reviewed resident records, observed care and medication administration

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Dignity, Choice and Privacy

Falls Prevention

Medication

Minimizing of Restraining

Personal Support Services

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (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 :



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1. The licensee did not ensure the care set out in the plan of care was provided to resident #1 as specified in the plan. The resident's plan of care stated staff were to monitor the resident for safety. In September, 2012 the resident was found on the floor near the nursing station without staff present. The resident stated they had leaned forward to get up and fell on the floor. The DOC confirmed staff should of accompanied the resident. [s. 6. (7)]

2. The home Corrective action plan related to an immediate order issued September 27, 2012 indicated that 60 residents' full length bed rails had been changed to quarter size bed rails and reassessments of the identified residents needs would be conducted October 2, 2012.

The licensee did not ensure resident #1 was reassessed and their plan of care reviewed and revised when the resident's care needs changed. The resident was changed from having two full length bed rails up when in bed to two quarter length bed rails up when in bed during September, 2012. Resident records did not indicate an assessment of the resident's needs had been completed at the time of change. The resident's current written plan of care identified the resident was at risk for falls. The DOC confirmed on October 25, 2012 that none of the reassessments of the 60 residents, who had full length bed rails converted to quarter length bed rails, had been completed. [s. 6. (10) (b)]

Additional Required Actions:

***CO # - 901 was 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 the care set out in the plan of care is provided
to resident as specified in the plan, 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**



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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. 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 was complied with.

The home's policy and procedure "Admission/Transfer/Discharge/Leave of Absence - Discharge Summary and Documentation" (LTC9-05.10.05) stated a final Discharge Summary (NF-012) was to be completed by the Attending Physician on every resident discharged from the centre. Registered Nursing Staff would document on the multidisciplinary notes. The Attending Physician would document on the progress notes. Resident #2 was discharged to an acute care facility in October, 2012 as per physician order. Resident records did not include a Discharge summary completed by the Attending Physician or documentation by the registered nursing staff or physician in the progress notes. The DOC confirmed that documentation was not completed.

2. The homes policy and procedure "Treatments - Head Injury Routine" (LTC9-05.08.12) stated Head Injury Routine (HIR) will be conducted for a resident who incurred a blow to the head with or without injury. The HIR was to be recorded on Head Injury Routine Form and include level of consciousness, blood pressure, vital signs, pupil reaction, grip strength, range of motion and change in behaviour. The "Falls Management Program" stated initiate HIR for all unwitnessed falls.

Resident #2 had a fall in October, 2012 and the progress notes indicated HIR was initiated. The resident's records did not include a completed Head Injury Routine Form and the progress notes did not include all pertinent data for each HIR assessment.

3. The homes policy and procedure "Treatments - Head Injury Routine" (LTC9-05.08.12) stated the physician must be notified of fall and head injury, and provided with all pertinent data. The physician must be called and provided with daily updates for the duration of the HIR. The "Falls Management Program" stated notify the Attending Physician and provide him with information regarding the fall. Resident #2 fell in October, 2012 and HIR was initiated. The resident demonstrated a change in behaviour and was transferred to hospital due to change in status. The resident's records did not identify the physician was contacted at the time of the incident, during the monitoring of HIR, or at the time of transfer to hospital. The physician communication book did not include an entry related to the resident's fall. Nursing staff confirmed the physician had not been contacted.

4. The homes policy and procedure "Treatments - Head Injury Routine" (LTC9-05.08.12) stated to hold all psychotropic and/or sedating drugs and pain medication while monitoring HIR.

a) The Medication Administration Record (MAR) identified Resident #2 on both



sedation and psychotropic medication. The MARs indicated that all psychotropic medications were administered after the resident HIR was initiated.

b) The MAR identified resident #1 was on sedating medication. The resident was commenced on HIR in September, 2012. The MARs indicated the resident received the sedating medication while HIR was ongoing.

c) The MAR identified resident #5 was on sedating medication. The resident commenced on HIR in September, 2012. The MARs indicated the resident received the sedating medication while HIR was ongoing.

5. The "Falls Management Program" stated after a fall of a resident the nursing staff were to complete the Internal Resident Risk & Medication Treatment Report. Resident #2 had an unwitnessed fall in October, 2012. The resident's records did not include an Internal Resident Risk & Medication Treatment Report. The DOC confirmed the report was not accessible and could not verify if it was completed. [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 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 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 117. Every licensee of a long-term care home shall ensure that,

Every licensee of a long-term care home shall ensure that,

(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and

(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :



1. The licensee did not ensure that no medical directive or order for the administration of a drug to a resident was used unless it was individualized to the resident's condition and needs. Resident #1 current written plan of care indicated medications were to be crushed due to a risk of choking and the Medication Administration Records (MARs) of September, 2012 indicated the resident's medications were to be crushed. The home converted to an electronic MAR (eMAR) system in October, 2012. The current eMAR did not indicate the resident's medication were to be crushed. Registered staff confirmed this resident's eMARs did not identify the need for medication to be crushed and other residents eMARs had been identified without the direction for crushing medication and that they were being updated as noted. [s. 117. (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 no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,

(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).

(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).

(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :



1. The licensee did not ensure that resident #3 received mouth care in the morning and evening including cleaning of dentures. The resident's lower teeth were observed by the inspector during the review on multiple occasions to have excessive amounts of plaque and food debris. The resident's breath was odourous. The resident's current plan of care identified specific need for staff assistance in providing oral care. Staff confirmed that the resident required assistance in oral care. The "PSW/NA Documentation Record" for October, 2012 stated that personal hygiene including brushing of teeth was total care with one person assist and the record was signed that care was provided as per care plan. [s. 34. (1) (a)]

2. The licensee did not ensure that resident #4 received mouth care in the morning and evening including cleaning of dentures. The resident's lower teeth were observed by the inspector to have excessive amounts of plaque and food debris. The resident's breath was odourous. The resident's current plan of care identified the need for staff assistance in providing oral care. Staff confirmed the resident required assistance in oral care. The "PSW/NA Documentation Record" for October, 2012 stated that personal hygiene including brushing of teeth was total care with one person assist and the record was signed that care was provided as per care plan. [s. 34. (1) (a)]

3. The licensee did not ensure that resident #5 received mouth care in the morning and evening including cleaning of dentures. The resident's lower teeth were observed by the inspector to have excessive amounts of plaque and food debris. The resident's breath was odourous. The resident's current plan of care identified the need for staff assistance in oral care. The "PSW/NA Documentation Record" for October, 2012 stated that personal hygiene including brushing of teeth was extensive assist by one person and the record was signed that care was provided as per care plan. [s. 34. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents



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Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not ensure the Director was informed no later than one business day after Resident #2 was transferred to hospital due to an injury from a fall. The resident had a fall in October, 2012 and was transferred to hospital one day later due to change in status. The home submitted the Critical Incident to the Director 5 days after admission to hospital. The DOC confirmed the report was not submitted within the specific time frame. [s. 107. (3)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/

LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

**COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:**



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REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #901	2012_208141_0001	141

Issued on this 14th day of December, 2012

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



**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

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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) : SHARLEE MCNALLY (141)

Inspection No. /

No de l'inspection : 2012_208141_0001

Log No. /

Registre no: H-001974-12, H-002030-12

Type of Inspection /

Genre d'inspection: Complaint

Report Date(s) /

Date(s) du Rapport : Nov 28, 2012

Licensee /

Titulaire de permis : THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9

LTC Home /

Foyer de SLD : PEEL MANOR
525 MAIN STREET NORTH, BRAMPTON, ON, L6X-
1N9

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : RANJIT GALAY

To THE REGIONAL MUNICIPALITY OF PEEL, you are hereby required to comply with the following order(s) by the date(s) set out below:



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Order # /

Ordre no : 901

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. (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;
- (b) the resident's care needs change or care set out in the plan is no longer necessary; or
- (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall complete a reassessment of all residents who have had their full length bed rails converted to quarter length bed rails without a reassessment of their needs for the purpose of bed rail conversion.

Grounds / Motifs :

1. The home Corrective action plan related to an immediate order issued September 27, 2012 indicated that 60 residents' full length bed rails had been changed to quarter size bed rails and reassessments of the identified residents needs would be conducted October 2, 2012.

The licensee did not ensure resident #1 was reassessed and their plan of care reviewed and revised when the resident's care needs changed. The resident was changed from having two full length bed rails up when in bed to two quarter length bed rails up when in bed during September, 2012. Resident records did not indicate an assessment of the resident's needs had been completed at the time of change. The resident's current written plan of care identified the resident was at risk for falls. The DOC confirmed on October 25, 2012 that none of the reassessments of the 60 residents, who had full length bed rails converted to quarter length bed rails, had been completed. [s. 6. (10) (b)] (141)



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

Immediate



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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



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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.



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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, 11^e 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.



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de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

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 25th day of October, 2012

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur :

SHARLEE MCNALLY

Service Area Office /

Bureau régional de services : Hamilton Service Area Office