Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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347 Preston St 4th Floor
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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
Nov 17, Dec 1, 2014	2014_236572_0027	O-001135-14	Resident Quality Inspection

Licensee/Titulaire de permis

SPECIALTY CARE EAST INC.
400 Applewood Crescent Suite110 VAUGHAN ON L4K 0C3

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

TRILLIUM CENTRE
800 EDGAR STREET KINGSTON ON K7M 8S4

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

BARBARA ROBINSON (572), JESSICA PATTISON (197), SUSAN DONNAN (531), WENDY BROWN (602)

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): November 17-21 and November 24-27, 2014.

Four Critical Incident inspections (Logs O-000622-14, O-000734-14, O-000743, and O-001031-14) and one Compliant inspection (Log O-000984-14) were completed concurrently with the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Directors of Resident Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping staff, a Registered Dietitian (RD), the Physician's Assistant, the Program Manager, the RAI Coordinator, Administrative Assistants, Activity staff, family members, and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
3 VPC(s)
1 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
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #901	2014_236572_0027	572

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to comply with LTCH Act, 2007, s.5, in that
the door to the laundry chute room located in the Ridge Building, Orchard House unit is not safe and secure.

On November 17, 2014, during the initial mid-morning tour of the home, Inspector #602 observed that the door to the laundry chute room in the Ridge Building, Orchard House unit was closed but unlocked and it opened easily. In the chute room, the laundry chute door itself was also unlocked and opened easily with a pinch handle. There were three unlocked electrical panels with wires visible, and a ladder affixed to the floor leading to a door on the ceiling.
The laundry chute is used for an area where approximately 100 residents reside, and it is across from the nursing station so there is a high level of activity in the area.
PSW #S100 stated that both the door to the chute room and the chute door itself are always kept unlocked.
At 1400 on November 17, 2014, the laundry chute room was again noted to be unlocked, and the Administrator viewed the area. She stated that she thought the room was locked, and asked if there was a key. PSW #S100 provided a key stating that he/she was the only person with a key. The room was locked. [s. 5.]

Additional Required Actions:

CO # - 901 was 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. (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 has failed to comply with the LTCHA 2007, c. 8, s. 6(7) whereby the falls prevention intervention set out in the plan of care was not provided to the resident as specified in the plan.

Re: Log # O-001031

As per Critical Incident #2790-000034-14, Resident #19 suffered a fall and sustained an injury that required treatment.

On November 27, 2014, the health record for Resident #19 was reviewed and the following information was provided:
-Resident #19 has had several previous falls.
-The plan of care for Resident #19 sets out the following fall prevention interventions:
-bed in low position
-hip protectors
-magnetic bed alarm, that is to be attached at all times when in bed
-check q1h to ensure safety
-transfer with one staff
-walks with one staff due to unsteadiness

On November 27, 2014, RPN #S131, PSW #S132 and observations of Resident #19 while in bed confirmed that the magnetic bed alarm was not applied as set out in the plan of care.

On November 27, 2014, the ADOC #S116 confirmed that the care set in the plan of care is to be provided to the resident as specified in the plan. [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 falls prevention intervention set out in the plan of care is provided to the resident as specified in the plan, 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 comply with O. Reg. 79/10 s. 15 (1)(a) whereby the licensee did not ensure that where bed rails are used, 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.

Evidence-based prevailing practices are identified in Health Canada's guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", effective March 17, 2008.

On November 19, 2014, a gap of 6.5 inches between the head board and the top of the mattress (Entrapment Zone #7) on the bed of Resident #22 was identified by Inspector #572. No steps had been taken to prevent the risk of resident entrapment.

The Administrator was notified, immediately replaced the mattress and initiated an assessment of all bed systems.

On November 20, a gap of 6 inches in Entrapment Zone #7 was identified by Inspector #197 on the bed of both Resident #23 and #24. A gap of 6 inches was identified by Inspector #602 on the bed of Resident #3. No steps had been taken to prevent the risk of resident entrapment.

The Administrator provided Bed Entrapment Inspection Sheets from 2011 which were the most recent bed assessments prior to the November 19, 2014 assessments.

The Administrator reported that the bed assessments completed on November 19, 2014 indicated that 18 beds posed a Zone #7 entrapment risk for residents and corrective action was taken. [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 are used, 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents’ Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents’ Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents’ Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 57(2) whereby the licensee has not provided the Resident Council with a written response to any concerns or recommendations about the operation of the home, within 10 days.

The minutes of the monthly Resident Council meetings were reviewed from September to November, 2014.

During the Resident Council meeting of September 5, 2014, residents raised concerns that residents were rushed in the dining room with food removed too early, soups were not being seasoned properly and that changes in the home were not communicated to residents. These issues were addressed at the October 3, 2014, meeting of the council.

During the Resident Council meeting of October 3, 2014, residents recommended that cleaning schedules for their rooms be provided and they also proposed additions to the scheduled activities. These issues were addressed at the November 10, 2014 meeting of the council.

On November 26, 2014, Program Manager #S117 stated that concerns or recommendations from the Resident Council monthly meetings are forwarded to the appropriate manager and an action plan is developed. This information is then delivered to the council and discussed at the next monthly meeting. The Resident Council does not receive a response to these issues in writing within 10 days. [s. 57. (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 the licensee provides the Resident Council with a written response within 10 days of being advised of any concerns or recommendations about the operation of the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 101(2) whereby the home did not ensure there was a documented record of a resident's complaint.

On November 20, 2014, Resident #2 indicated to Inspector #602 that she/he was missing items that had been removed by staff when his room was being treated.

When reviewing Resident #2's progress notes it was noted that the resident's room was treated approximately one year ago, and three months later.

Approximately one year ago, a progress note was made by the physician which stated "Not happy. Resident has been back in her/ his room for a week and still doesn't have her/his possessions. Resident says that she/he was told that everyone is 'too busy'. I took these concerns to the ADOC who was surprised to find that things had not been returned. She will look into this."
Approximately three months later, a progress note was written by RN #S123 stating "Resident very upset and agitated this afternoon about not having her/his belongings back in room. Resident expressed anger."

During an interview with ADOC #S116, she stated that she did not see this as a formal complaint and therefore did not keep a documented record. [s. 101. (2)]

Issued on this 3rd day of December, 2014

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

Original report signed by the inspector.

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) : BARBARA ROBINSON (572), JESSICA PATTISON (197), SUSAN DONNAN (531), WENDY BROWN (602)

Inspection No. / No de l'inspection : 2014_236572_0027

Log No. / Registre no: O-001135-14

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Nov 17, Dec 1, 2014

Licensee / Titulaire de permis : SPECIALTY CARE EAST INC.
400 Applewood Crescent, Suite110, VAUGHAN, ON, L4K-0C3

LTC Home / Foyer de SLD : TRILLIUM CENTRE
800 EDGAR STREET, KINGSTON, ON, K7M-8S4

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

To SPECIALTY CARE EAST INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee shall ensure that the laundry chute room located in the Ridge Building, Orchard House unit is immediately locked to restrict unsupervised residents' access to the laundry chute and electrical panels at all times. The licensee shall take immediate measures to ensure the residents' safety until the door to the laundry chute room is secured.

Grounds / Motifs :

1. The licensee has failed to comply with LTCH Act, 2007, s.5, in that the door to the laundry chute room located in the Ridge Building, Orchard House unit is not safe and secure.

On November 17, 2014, during the initial mid-morning tour of the home, Inspector #602 observed that the door to the laundry chute room in the Ridge Building, Orchard House unit was closed but unlocked and it opened easily. In the chute room, the laundry chute door itself was also unlocked and opened easily with a pinch handle. There were three unlocked electrical panels with wires visible, and a ladder affixed to the floor leading to a door on the ceiling. The laundry chute is used for an area where approximately 100 residents reside, and it is across from the nursing station so there is a high level of activity in the area.
PSW #S100 stated that both the door to the chute room and the chute door itself are always kept unlocked.
At 1400 on November 17, 2014, the laundry chute room was again noted to be unlocked, and the Administrator viewed the area. She stated that she thought the room was locked, and asked if there was a key. PSW #S100 provided a key stating that she was the only person with a key. The room was locked.
(572)

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

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 17th day of November, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Barbara Robinson

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