Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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
Apr 19, 2016	2016_347197_0008	008151-16	Resident Quality Inspection

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Trillium Retirement and Care Community
800 EDGAR STREET KINGSTON ON K7M 8S4

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

JESSICA PATTISON (197), HEATH HEFFERNAN (622), JESSICA LAPENSEE (133), SUSAN DONNAN (531), WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 4-8 and 11-14, 2016

Eight Critical Incident inspections, 2 complaint inspections and one inquiry were completed concurrently with the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Associate Directors of Care, the Director of Support Services, the Food Service Supervisor, the Resident and Program Manager, Maintenance and Building Services Manager, Program Manager, RAI/MDS Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a Dietary Aide, housekeeping and maintenance staff, Resident Council President, Family Council President, residents and residents' family members.

Inspectors conducted a full tour of the home, observed resident care including medication pass and dining services, reviewed resident heath care records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **4 WN(s)**
- **2 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	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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The following finding is related to log #006087-16:

The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2)(a) in that the licensee has failed to ensure that the home is kept clean and sanitary, specifically related to bathroom sink drains, a toilet, and a commode, in identified resident bedrooms in the Ridge building.

On April 12th, 2016, Inspector #133 observed a heavy accumulation of beige gelatinous matter on the prongs of two resident bathroom sink drains. In another resident bedroom, the inspector observed a heavy accumulation of black gelatinous matter on the bathroom sink drain prongs.

On April 13th, 2016, Inspector #133 shared pictures of the gelatinous accumulation observed in the sink drains of the three rooms with the Director of Support Services (DSS). The DSS indicated a process would be implemented to ensure that such accumulations did not recur.

On April 12th, 2016, at approximately 1230 hours, Inspector #133 observed that a raised toilet seat was dirty with an area of dried brown matter, on the back upper right area. The Inspector observed the raised toilet seat again on April 13th, 2016 at 1720 hours and on April 14th, 2016 at 0916 hours. The DSS was shown a picture of the raised toilet seat on April 14th 2016.

On April 12th, 2016, at approximately 1230 hours, Inspector #133 observed a resident's commode. There was a piece of hair on the upper area of the commode insert. On the commode seat, on the back right section, there was an area with a small amount of light brown dried matter, and a small amount light brown matter on the inner edge. There was second area with a very small amount of light brown matter, to the right of the first area, towards the middle of the seat. The Inspector observed the commode seat again at 1730 hours on April 12th, 2016, and on April 13th, 2016 at 1720 hours and on April 14th, 2016 at 0916 hours. Urine that was in the insert at 1730 hours on April 12th, 2016 was still there on April 13th, 2016 at 1720 hours, with a dried ring around the pool of urine. The hair in the insert remained as did the areas of light brown matter on the seat. On April 14th, 2016, there was more urine in the insert, the hair remained in place, and the areas of light brown matter remained. At 0943 hours on April 14th, 2016, the Associate Director of Care (ADOC), #106, accompanied the Inspector into the bedroom to observe

the commode, and also to observe the toilet (as described above). The ADOC confirmed that it is expected that the commode would be cleaned daily. The ADOC explained that nursing staff on the day shift should empty the insert into the toilet, spray it down with the cleaning product available in the soiled utility room, which can be used without rinsing the insert, and then wipe it out. Alternately, staff could take the insert into the utility room and rinse it out before spraying it. The ADOC indicated that the insert should not be rinsed out in the bathroom sink. Prior to this interaction, on April 14th, 2016 at 0936 hours, the Inspector had spoken with a Personal Support Worker (PSW), #130, about the cleaning of commodes in general. The PSW had indicated to the Inspector that for a commode with urine in it, it could be emptied into the toilet and rinsed in the bathroom sink before being sprayed. [s. 15. (2) (a)]

2. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2)(c) in that the licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, specifically related to bedside tables and bathroom sinks in identified bedrooms in the Ridge building.

On April 11th, 2016, Inspector #133 observed that the bedside tables in two resident rooms were in poor repair. The laminate surface was worn away along the front and side edges and the absorbent particle board subsurface was exposed. Such a surface cannot be effectively cleaned and disinfected.

On April 11th, 2016, Inspector #133 observed that the bathroom sink basins in four resident rooms were in poor repair. In one room, the porcelain surface was worn away in two distinct areas, near the drain and at the overflow. There was accumulation of rust all around the drain, and rust spots in the porcelain between the drain and the overflow. In the second room, the porcelain surface was worn away in two distinct areas, near the drain. There was rust accumulation on one side of the drain. In a third bedroom, there was heavy accumulation of rust on one side of the drain and rust around the overflow. The area beneath the overflow was rust stained and the porcelain surface was chipped within the rust stained area. On the underside of the sink there were areas of heavy rust accumulation and on the floor beneath the sink there were two distinct areas of rust accumulation. In the fourth room, the porcelain between the overflow and the drain was chipped and there were rust spots. Such surfaces cannot be effectively cleaned and disinfected. [s. 15. (2) (c)]

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 bathroom sinks, toilets and commodes are kept clean and sanitary and that bedside tables and bathroom sinks are maintained in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services. O. Reg. 79/10, s. 230 (4).

s. 230. (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information. O. Reg. 79/10, s. 230 (6).

Findings/Faits saillants :

1. The following finding is related to log 004727-16:

The licensee has failed to comply with O. Reg. 79/10, s. 230 (4) 1. viii in that the licensee has failed to ensure that the emergency plans provide for dealing with the loss of water, which is an essential service.

On April 13th, 2016, Inspector #133 met with the Administrator and the Maintenance and Building Services Manager to discuss emergency plans, in relation to two reported Critical Incidents. One of the reported incidents was related to flooding that occurred in areas of the Ridge building on February 14th 2016, due to burst ceiling pipes. The incident had required the home to shut off the water to the building, at approximately 0530 hours. Following repair of the damaged pipes, the water was turned back on at approximately 0930 hours.

The Inspector was provided with the home's Emergency Management Policy Manual and upon initial review of the table of contents, the Inspector was unable to find a plan that provided for dealing with the loss of water, which is an essential service. On April 14th, 2016, the Administrator, the Maintenance and Building Services Manager and the Inspector confirmed that the home does not have an emergency plan that provides for dealing with the loss of water. [s. 230. (4) 1.]

2. The following finding is related to log 011120-16:

The licensee has failed to comply with O. Reg. 79/10, s. 230 (6) in that the licensee has failed to ensure that the emergency plans for the home are updated at least annually.

On April 13th, 2016, Inspector #133 met with the Administrator and the Maintenance and Building Services Manager (MBSM) to discuss emergency plans, in relation to two reported Critical Incidents. The first incident was a fire that occurred in the multipurpose room in the Court building on January 12th, 2016 and the second incident was flooding that occurred in areas of the Ridge building on February 14th, 2016. The flooding incident resulted in a loss of water to the building, as well as a horizontal evacuation. The Inspector was given the Administrator's "Emergency Management Policy" Manual which contained the home's emergency plans. Looking at the Table of Contents, the Inspector noted that the plans had revisions dates ranging from June 2010 to April 2013. The various plans that provided for dealing with evacuation of the home (Code Green), for example, had revision dates of March 2011 or April 2013. The Administrator explained to the Inspector that the emergency plans were provided to the home by the head office, and therefore the home was not in a position to update the plans annually. The Administrator explained that in 2015, the home had reviewed the emergency plans for which a practice exercise had been conducted, as scheduled by the head office, but the plans had not been updated. As per information provided by the Administrator, a practice exercise had not been conducted for the home's Code Green plans in 2015. It was however noted that in 2015, the home did conduct a Vulnerable Occupancy Fire Drill

scenario, in collaboration with the local fire department.

On April 14th 2016, the Administrator confirmed that the head office had reviewed all of the emergency plans in 2015, but had not updated them.

The home's site specific fire plan, as provided to the Inspector by the MBSM on April 14th, 2016, had been last updated in November 2011. The MBSM explained that the emergency contact information for management and support staff in the provided plan was current as of approximately Spring 2015. The MBSM indicated that he had been working on an updated version of the plan that would soon be released. The MBSM provided the Inspector with a copy of the fire plan that he was working on, following the conclusion of the Resident Quality Inspection, on April 15th, 2016, as the Inspector had remained in the home to conduct a Complaint Inspection.

The licensee has failed to ensure that the home's emergency plans are updated annually. [s. 230. (6)]

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 there are emergency plans for dealing with the loss of water and that all emergency plans are updated at least annually, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The following finding is related to log 007752-16:

The licensee has failed to ensure that the plan of care sets out clear direction to staff and others who provide direct care to the resident.

Resident #047 has a history of impaired skin integrity. The resident is also dependent on staff for repositioning, both when in bed and up in chair.

On April 13, 2016, Inspector #197 observed the resident up in a chair being repositioned approximately every hour between 1030 and 1227 hours.

On April 14, 2016, Inspector #197 reviewed the current care plan for resident #047, which indicated in one section that resident #047 was to be turned and repositioned every two hours while in bed and to reposition every thirty minutes while in chair. A different section of the same care plan stated that resident #047 was to be repositioned every hour while up in chair and every two hours when in bed.

On April 11, 2016 at 1200 hours, Inspector #622 interviewed Personal Support Worker (PSW) #128 who indicated resident #047 is repositioned every two hours.

On April 13, 2016 at 0930 hours, Inspector #622 interviewed PSW #114 who revealed the direction staff follow for care of the resident is found in the care plan and kardex. PSW #114 confirmed that resident #047 is repositioned every two hours and that this direction is the same for chair and bed.

On April 13, 2016 at 1325 hours, Inspector #622 interviewed the Associate Director of Care (ADOC) #109 who indicated the direction on the care plan between the two identified sections for turning and positioning should match. The discrepancy was pointed out to the ADOC at the time by inspector #622. The ADOC confirmed the expectation for repositioning the resident would be every two hours while in bed and every one hour while up in chair.

Therefore direction set out in the plan of care did not provide clear direction to staff and others who provide direct care to resident #047 related to repositioning. [s. 6. (1) (c)]

WN #4: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

During stage one of the inspection, Inspectors observed a strong odour of urine in two resident washroom areas.

On April 11, 2016 at 1550 hours, Inspector #622 observed that the same two rooms had a strong odour of urine and continued to be strong and lingering the next day, April 12, 2016 at 1010 hours.

A review of Policy # XII-G-10.30 Odour Neutralizers - Housekeeping dated January 2015, revealed odour neutralizers will be used in specific areas to eliminate offensive odours when cleaning. Urine odours inherent to carpet or floor tile (carpet or floor should be budgeted for replacement).

On April 12, 2016 at 1012 hours, Inspector #622 interviewed housekeeper #129 who revealed that the two identified rooms have lingering odours. Housekeeper #129 stated she thought the flooring, the wood and tile, were replaced a year ago. Housekeeper #129 indicated she uses the Clorox urine remover around the toilets in these rooms daily. She stated she had used the Clorox urine remover that morning. Housekeeper #129 confirmed the process for removing lingering odours in washrooms is with Clorox urine remover and they had a spray to use along the edges of the baseboard, but said they do not have that right now.

On April 12, 2016 at 1300 hours, Inspector #622 interviewed the Director of Support Services who stated she was not aware of any rooms with lingering odours in the

specified building, but stated the home has residents who do urinate on the floor and they use a chemical to destroy odours for urine. The Director of Support Services revealed the process for dealing with lingering odours is that the home has a chemical that is used that subsides the lingering odour of urine and she said she would check to ensure staff are using it. Inspector #622 informed the Director of Support Services of the two room where there was a strong odour of urine. The Director of Support Services stated there may be urine under the flooring. The Director of Support Services admitted there are a couple of washrooms that are quite bad and indicated if the Clorox urine remover doesn't work it would probably need further intervention of tearing out the flooring. The Director of Support Services indicated some of the floors are caulked around the toilet and some are not.

On April 13, 2016, Inspector #622 interviewed the Director of Support Services who stated the flooring in the two identified room had been changed but this was probably two years ago or more. She indicated she spoke with the chemical supplier who suggested caulking around the front and sides of the base of the toilet leaving the back side open in case of leaks. The Director of Support Services indicated air fresheners would be placed in the two identified washroom .

During observation of the two identified rooms on April 14, 2016 at 1245 hours, Inspector #622 observed a smell of air freshener over-powered by the strong lingering odour of urine. Therefore, procedures developed and implemented for addressing incidents of lingering offensive odours have not been effective. [s. 87. (2) (d)]

Issued on this 19th day of April, 2016

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

Original report signed by the inspector.