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 soins 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
Mar 9, 2017	2017_505103_0004	032764-16, 034707-16, 035343-16	Critical Incident System

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

DARLENE MURPHY (103)

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): January 18, 19, February 3, 2017

The following intakes were included in this inspection:
Log #032764-16 (resident fall that resulted in a transfer to hospital),
Log #034707-16 (alleged staff to resident abuse/neglect),
Log #035343-16 (alleged resident to resident abuse).

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Assistant Director of Care (ADOC), and the Director of Care (DOC).

During the course of the inspection, the inspector made resident observations, reviewed resident health care records and the applicable home's policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. 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 :

1. The following finding relates to Log #034707-16:

The licensee has failed to ensure the care set out in resident #003's plan of care was provided as outlined in the plan.

Resident #003 was admitted to the home on an identified date and had identified diagnoses. On an identified date, on or about 2330 hour, resident #003 rang the call bell and indicated they required continence care. PSW #103 stated she would go and retrieve a second staff member to assist, but never returned to provide the care. Resident #003 indicated they fell back asleep and awoke at approximately 0130 hour. The resident attempted to call for assistance again, but the call bell had fallen off of the bed and was on floor out of reach.

The next morning, the day shift PSW went to check on resident #003 and was told they had required continence care the previous evening, requested staff assistance, but had not received any care. The PSW staff immediately provided care to resident #003 and then reported the incident to the charge nurse. The resident's skin was assessed and intact at that time.

Resident #003's plan of care was reviewed. Under "Bowel Incontinence" the plan indicated the following:
-resident will ring the call bell, staff to change brief.

Under "Risk for falls", the plan indicated the following:

-reinforce need to call for assistance. Call bell within reach when in bed.

The home investigated the incident and the Director of Care (DOC) was interviewed. She indicated PSW #103 stated she had forgotten resident #003 had requested assistance with continence care. The PSW was disciplined for failing to provide continence care to resident #003 and failing to ensure the resident's call bell was secured and available to the resident. [s. 6. (7)]

2. The following finding relates to Log #032764-16:

The licensee has failed to ensure resident #004 was reassessed when the resident's care needs changed.

The home submitted a critical incident to report an incident involving resident #004 that resulted in an injury for which the resident was taken to hospital. Resident #004 was admitted to the home on an identified date and had identified diagnoses.

The resident health care record was reviewed and indicated the resident had sustained a fall on an identified date, on or about 2200 hour. RPN #102 was the charge nurse on the unit at the time of this fall and assessed the resident for injuries. The RPN was interviewed and indicated she notified the on-call physician and contacted RN #105 who was in charge of the building. The RPN indicated she believed the resident had suffered a serious injury as a result of the fall. The RPN stated she called the on-call physician who directed the RPN to monitor the resident overnight, to order a mobile x-ray and to call back if unable to manage the resident's pain. The RPN stated she reviewed the resident's current orders for analgesics with the physician. RPN #102 stated she administered identified medications to resident #004 at 2248 hour. The RPN also stated the RN was present when she contacted the on-call physician and was made aware of the physician's directions. The RPN's shift ended at 2300 hour and was unable to determine the effectiveness of the analgesic at that time as the analgesic had just been given.

PSW #106 was interviewed and indicated she worked the night shift on the identified date. She stated she was the only staff member on the unit for the night shift and that this was normal staffing on nights. She stated she had been told in report that resident #004 had sustained a fall shortly after 2200 hour and may have a significant injury. The PSW stated she found the resident to be very agitated and restless and, in an effort to avoid another fall, the resident was placed in a Broda chair so she could move the

resident about the unit with her during rounds. The PSW stated that sometime around midnight, she was assisting another resident with toileting and heard a loud bang. She stated resident #004 was found sitting on the foot rests of the chair. She stated the resident was in obvious pain and described the resident as crying out in pain. PSW #106 stated she notified RN #105 and requested that she come to see the resident. She stated she told the RN she felt the resident needed something for pain but did not think the RN administered anything.

RN #105 was interviewed and stated she came and assessed the resident post fall at that time and did not administer any analgesics to resident #004 because they had received medication for pain at 2248 hour. The RN indicated she did not notify the on-call physician because she did not think the resident's pain was any worse than when she had completed an assessment at 2230 hour. During a review of resident #004's progress notes, the RN had documented the resident was "crying out in pain".

The PSW indicated she called RN #107 approximately one hour later. RN #107 was covering for RN #105 during her break. RN #107 is no longer employed by the home and therefore, could not be interviewed. The resident's electronic medication administration record was reviewed and indicated RN #107 administered identified medications at 0149 hour and had documented the previous doses of identified medications that were administered at 2248 hour had been ineffective. No calls were made to the on-call physician by RN #107.

PSW #106 recalled RN #105 returned to the unit around 0600 hour and had told her they would be sending resident #004 to the hospital in the morning. The PSW indicated resident #004 required constant supervision throughout the shift as the resident remained agitated and was at risk of falling again. The PSW expressed concern that resident #004 remained in pain all night and that no actions were taken to make them comfortable.

RN #105 indicated she did not attempt to provide any staffing support to monitor resident #004 for safety and she did not feel the need to call the on-call physician because, despite the resident being in pain, she did not feel the pain had worsened. At 0623, RN #105 did administer identified medications and documented the resident continued to moan in pain, cry out in pain, very restless and agitated, awaiting an x-ray and assessment by the physician or nurse practitioner in the morning.

Resident #004 was assessed by the Nurse Practitioner on an identified date at 0700

hour and arrangements were made to transport the resident to hospital. The oncoming RPN #108 documented in the resident progress notes that analgesics were given at 0730 for substantial amount of pain. The resident was diagnosed with an identified injury and returned to the home for palliation and a pain management regime.

RN #105 failed to reassess resident #004's plan of care when the resident demonstrated a change in care needs. There was no evidence of any efforts to ensure the resident's pain was managed and no effort to contact the on-call physician who had left directions to do so if the resident's pain could not be managed. [s. 6. (10) (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 the care is provided to resident #003 as outlined in the plan and that actions are taken to address residents who experience a change in the level of pain control, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The following finding relates to Log #032764-16:

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

In accordance with O. Reg 79/10, s. 48 (1) 1, a fall prevention and management program is a required program. All actions taken with respect to a resident under a required program must be documented.

On an identified date, resident #004 sustained a fall. RPN #102 was interviewed and indicated she assessed the resident for injuries and contacted the on-call physician as she was concerned the resident had sustained a serious injury. She stated she notified RN #105 who also completed a post fall resident assessment.

Resident #004's health care record was reviewed, but there was no evidence of a documented post fall assessment completed by RN #105. RN #105 was interviewed, confirmed she did complete a post fall assessment but had failed to document the assessment.

RN #105 failed to ensure all assessments completed under a required program were documented. [s. 30. (2)]

Issued on this 9th day of March, 2017

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

Original report signed by the inspector.