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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 22, 2018	2018_520622_0001	000073-18	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

HEATH HEFFERNAN (622), DARLENE MURPHY (103), JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 15, 16, 17, 18, 19 2018

The following logs were inspected concurrently during this inspection:
Log # 028799-17 and Log #000807-18 related to falls resulting in injury
Log # 025645-17 related to alleged staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Practitioner (NP) Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident and Family Council Presidents, the residents and family.

During the course of the inspection, the inspector(s) completed a tour of the home, observed medication administration and storage areas, resident care and services, staff to resident and resident to resident interactions, reviewed health records, medication incident documentation, Critical Incident System reports (CIS), specific licensee investigations, Resident's Council and Family Council meeting minutes, and the home's policies, protocol and procedures specifically; prevention of abuse and neglect of a resident VII-G-10.00.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure drugs were administered in accordance with the directions for use by the prescriber.
The home's medications incidents were reviewed for a specified three month period.

On a specified date, resident #025 was prescribed a stat dose of a specified medication to be given subcutaneously. The RPN administered 1 ml of the specified medication. The concentration of the specified medication in the vial was 4mg/ml. As a result, the resident received 4 mg of the specified medication instead of the 2 mg prescribed.

On a specified date, a registered staff member noted that resident #026 had been given a specified medication the previous day. The narcotic card was checked and the remaining number of the narcotic confirmed the resident had received the medication. Resident #026's specified medication had been on hold since a specified date.

On a specified date, resident #027 approached the RPN who was administering medications and was observed to be in pain. The RPN administered specified medications, the RPN became aware that one of the medications had been discontinued the previous day. The narcotic card was still in the medication cart.

In all of the above noted medication incidents, there was no evidence of adverse effects for the three residents.

The licensee failed to ensure medications for residents #025, #026 and #027 were administered in accordance with the directions for use by the prescriber. [s. 131. (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 that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health and that every medication incident involving a resident was reported to the resident, resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the

resident and the pharmacy service provider.

The home's medication incidents were reviewed for a specified three month period.

As outlined in WN #1, resident #026 received a specified medication on a specified date, when the medication had been ordered to be on hold. During a review of the incident report, it was noted that the resident/resident's substitute decision maker (SDM) was not notified of this error.

As outlined in WN #1, resident #027 received specified medications on a specified date despite the medication having been discontinued. During a review of the medication incident, it was noted that the resident/SDM was not notified of this error.

The Director of Care (DOC) was interviewed and confirmed the above two incidents had not been reported to either the resident or the SDM. She indicated residents and SDM's are to be notified of all medication incidents that occur involving a resident. [s. 135. (1)]

2. The licensee has failed to ensure all medication incidents were documented, reviewed and analyzed, corrective action was taken as necessary and a written record of everything was kept.

During the review of the medication incidents involving residents #026 and #027, this inspector was unable to find any evidence to support that corrective action had been taken in regards to the incidents.

The DOC was interviewed and indicated she had no additional documentation that supported the completion of corrective action. The DOC indicated it is her practice to document the corrective action on the medication incidents and was unsure why this had not been completed for these two medication incidents. [s. 135. (2)]

3. The licensee has failed to ensure that a quarterly review is undertaken of all medications incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions including any changes and improvements identified in the review that are implemented and a written record of the above.

The DOC was interviewed in regards to the home's process for reviewing all medication incidents and adverse drug reactions on a quarterly basis. The DOC indicated to the

Inspector they are reviewed during the Professional Advisory Committee (PAC) meetings that are held every three months. The inspector was provided with the PAC meeting minutes, dated a specified date for review.

The inspector noted that the PAC meetings included a Medical Pharmacies report that described each medication incident reviewed and the assessed severity of the incident. Additionally the report included a summary of the stage of the incidents involved that led to the error (prescribing, order entry, dispensing, administration, monitoring) and an overall summary of the types of incidents (dose omission, incorrect duration, incorrect resident and other). The inspector was unable to find documentation that supported there had been discussion related to the reduction or prevention of the medication incidents that were reviewed during that quarter, or any changes and improvements that had been made or implemented.

The DOC was interviewed and stated the medication incidents are discussed at the PAC meetings, but that the discussion does not include reduction or prevention of medication incidents. The DOC did indicate medication education sessions are given regularly in the home, but that the topics are not always tailored to address any identified trends in medication incidents.

The licensee has failed to ensure a quarterly review of the medication incidents that occurred in the home since the last review included strategies to reduce and prevent medication incidents including any changes and improvements identified in the review and that a written record of the above was kept. [s. 135. (3)]

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 that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any; all medication incidents and adverse drug reactions are documented, reviewed and analyzed; corrective action is taken as necessary; a quarterly review of the medication incidents that occur in the home since the last review include strategies to reduce and prevent medication incidents including any changes and improvements identified in the review and that a written record is kept, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure all doors leading to non-residential areas were kept closed and locked when not being supervised by staff.

On January 15, 2018, this inspector conducted a walking tour of the home. On the second floor of the Court building at approximately 0900 hours, the inspector noted the door to the physiotherapy room, which is located across from the elevators, was closed but not locked. At the time of the observations, the lights were noted to be off. The door had signage posted to reflect that this door needed to be locked at all times when staff were not present. No staff were noted to be in the vicinity of this room at the time of the observation.

On January 15, 2018 on or about 0920 hours, the Wellness Centre, located behind the main office in the Court building was noted to have the door propped open. The door was observed to be equipped with a touch code access. This room is used primarily for hairdressing services and gives access to two offices at the back of the room. At the time of the observation, there were no staff noted in the vicinity or in the offices.

On January 15, 2018 on or about 0940 hours, this inspector observed the door leading to the soiled utility on the Lake resident unit was closed but not latched. The inspector was able to open the door by pushing on it. This door was noted to be equipped with a touch code access. The room was noted to contain a hopper, numerous resident urinals and bedpans and had a ladder mounted on the wall for access to the ceiling. The inspector noted that if the door was allowed to close spontaneously on its own, it would not properly latch without being pulled shut.

Observations of these same areas were conducted on January 16, 2018. The door leading to the physiotherapy room was noted to be closed but not locked at 0945 hours. The door leading to the Wellness Centre was observed at 0900 hours with the door propped open. No staff were observed in the vicinity of either of these doors at the time of the observations.

The soiled utility room was checked on January 16, 2018 at 0945 hours and at 1030 hours and the door was found to be closed and locked with both checks.

The Administrator was interviewed in regards to the status of the above mentioned doors. She indicated that all of these areas are considered to be non-residential areas and that the doors should be closed and locked when staff are not in the vicinity of the rooms. [s. 9. (1) 2.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff within 24 hours of the resident's admission, upon any return of the resident from hospital, and upon any return of the resident from an absence of greater than 24 hours.

Resident #009 was admitted to the home on a specified date.

The resident was admitted to the home with a specified area of altered skin integrity. A documented skin assessment was completed on the date of admission.

According to the staff interviewed, the resident was at risk for further skin breakdown.

On a specified date, the resident was admitted to hospital for a planned surgical procedure and returned to the home on a specified date seven days later. The staff noted other tissue damage in the progress notes however a documented skin assessment was not completed until a date four days later.

The ADOC was interviewed and confirmed a skin assessment had not been documented upon the resident's return from hospital and that the resident was at risk of skin breakdown related to the existing and long standing specified altered skin integrity.

The DOC was interviewed and indicated the staff would be expected to complete a skin assessment upon the resident's return to the home following a hospital admission. [s. 50. (2) (a) (ii)]

Issued on this 22nd day of January, 2018

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

Original report signed by the inspector.