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
Oct 22, 2018	2018_505103_0027	024548-18, 026061-18, 026229-18	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): September 27, October 1-5, 9-11, 2018.

The following intakes were included in this inspection:
Log #026061-18-complaint related to resident care,
Log #026229-18 (CIS #2790-000041-18)-complaint related to resident care.

During the course of the inspection, the inspector(s) spoke with family members, Personal support workers (PSW), Registered Practical Nurses (RPN), Assistant Directors of Care (ADOC), the Nurse Practitioner (NP) and the Administrator.

During the course of the inspection, the inspector conducted walking tours of the Ridge building, reviewed resident health care records, a critical incident submitted by the home relevant to Log #026229-18, and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
4 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 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #001's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

On an identified date during the provision of morning care, resident #001 sustained an injury that was initially assessed as superficial. The staff provided wound care and applied a dressing at that time. Three days later, during a dressing change, the resident reported the area was painful and the laceration was assessed as deep.

The resident health care record was reviewed. According to the electronic medication administration record (eMAR), the wound required dressing changes for an identified period of time. During that period of time, only one documented wound and skin assessment was found.

ADOC #119 was interviewed and asked to review the resident health care record in regards to skin and wound assessments. The ADOC stated it was the home's practice to complete wound and skin assessments weekly and had no explanation as to why they were not completed for resident #001.

The licensee failed to ensure resident #001 was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 residents with altered skin integrity are reassessed at least weekly by a member of the registered nursing staff when clinically indicated, to be implemented voluntarily.

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. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #001’s substitute decision maker was given the opportunity to participate fully in the development and implementation of the resident’s plan of care.

As outlined in WN #1, resident #001 sustained an injury on an identified date during the provision of morning care. The resident’s Power of Attorney (POA) was not notified of the resident injury until three days after the injury.

ADOC #119 was interviewed in regards to the expectation of notifying this residents POA in regards to an injury. The ADOC indicated the POA should have been notified the same day. The ADOC indicated they recalled the POA had expressed upset that they had not been notified of the injury for three days. [s. 6. (5)]

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure no drug was administered to resident #001 unless prescribed for the resident.

On an identified date, RPN #118 was administering morning medications. In error, medications prepared for resident #003 were given to resident #001.

ADOC #119 was interviewed and indicated they recalled being made aware of the incident. ADOC #119 stated the RPN notified the RN in charge of the home and the Nurse Practitioner (NP) at the time of the error, as well as the resident and POA. According to the documentation in the resident health care record, resident #001 was monitored in accordance with the NP’s direction and the resident sustained no untoward outcomes as a result of the error. [s. 131. (1)]

WN #4: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure 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.

As outlined in WN #3, a medication incident occurred involving resident #001. When a copy of the medication incident was requested, ADOC #119 indicated they were unable to find documentation of the incident. The ADOC stated RPN #118 was notified and stated they had not completed the medication incident report. The ADOC indicated all medication incidents are required to be documented. [s. 135. (1)]

Issued on this 22nd day of October, 2018

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

Original report signed by the inspector.