Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 12, 13, 14, 15, 21, 22, 2012	2012_035124_0011	Complaint

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

LYNDA HAMILTON (124)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, Director of Clinical Services, Assistant Director of Care, Nurse Practitioner and Registered Practical Nurse.

During the course of the inspection, the inspector(s) reviewed the health records of three residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Pain

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 subsections:

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 failed to comply with LTCHA, 2007, s. 6, (7) in that the resident did not receive care as specified in the plan of care.
The resident had diagnoses of diabetes and cancer.
A progress note stated the resident had skin breakdown in the coccyx area, query stage two. Nine days later, the physician ordered the dressing for the stage 2 ulcer on the resident's coccyx be changed every three to four days or sooner as needed.
Review of the resident's Treatment Administration Record indicated that the dressing was not changed for six days.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

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;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s.50. (2) (b) (iv) in that the resident's skin breakdown/pressure ulcer was not reassessed at least weekly by a member of the registered nursing staff as demonstrated by the following finding.
A resident had diagnoses of diabetes and cancer.
The resident was readmitted to the home from hospital and the admission progress note stated the resident had skin breakdown in the coccyx area, query stage two.
Nine days later, the physician ordered dressing changes to the resident's stage two pressure ulcer.
There were no documented weekly assessments of the resident's stage two pressure ulcer for fifteen days.

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 subsections:

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 failed to comply with O.Reg.79/10, s. 131,(2) in that the residents did not receive drugs in accordance with the directions specified by the prescriber as demonstrated by the following findings.

A resident had diagnoses of diabetes and arthritis.
The resident's RAI-MDS assessment stated that the resident had moderate pain on a daily basis.

The physician prescribed a new dose of analgesic. The resident's Medication Tracking Record for the analgesic showed that the resident did not receive the newly prescribed dose of analgesic.
This information was reviewed with the Director of Clinical Services and she agreed that the resident did not receive the prescribed dose of analgesic for these two mornings.
2. Another resident had diagnoses of arthritis and cancer.
-It is documented in the Health Outcomes for Better Information and Care assessment that the resident had daily pain that was at times horrible or excruciating.
-The physician's order stated the resident was to receive analgesic every eight hours (0800, 1600, 2400).
It was documented in the resident's progress notes that the resident's analgesic was not administered at 1600 hours on the previous day.
-The resident's Medication Administration Record (MAR) had no initials to indicate that the analgesic was given at 1600 hours.

-Another physician's order stated that analgesic was to be given every eight hours and the MAR reflected that the resident received doses of analgesic at 0600, 1400 and 2000 hours.

On a specific date, the resident's MAR and Individual Narcotic Medication Record reported that the analgesic was administered at 0600 and 1700.
The physician was advised that the resident missed the 1400 hours dose of analgesic.
The resident did not receive analgesic as directed by the physician on two occasions.

Issued on this 30th day of March, 2012

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

Lynda Hamilton