Ontario

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

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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
May 4, 7, 8, 2012	2012_049143_0023	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

PAUL MILLER (143)

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 Administrator, the Director of Clinical Services, the Assistant Director of Nursing, Registered Practical Nurses, Personal Support Workers and family members.

During the course of the inspection, the inspector(s) Reviewed resident health care records, observed medication administration and reviewed policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Critical Incident Response

Falls Prevention

Medication

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The following findings are in respect of log # O-000789-12:

On February 7, 2012, Registered Practical Nurse (Staff # 111) documented that new orders were received from Doctor to start hydromorphone, decrease calcium and order received from NP (Nurse Practitioner)to change colace. A review of the health care record did not indicate that the Power of Attorney for Personal Care was informed of this change and given an opportunity to participate in the revised plan of care.

The licensee has failed to ensure that the Long Term Care Act, 2007 section 3 (1) 11. i that every resident has the right to participate in the plan of care.

2. The following findings are in respect of log O-000623-12:

On March 2, 2012 resident # 1 requested a basin complaining of not feeling well. A Personal Support Worker, staff # S103, advised a Registered Practical Nurse (staff # S104) that the resident was not feeling well. Staff # S104 advised staff # S103 not to provide the resident with a basin. The resident became ill and vomited a small amount of emesis.

The licensee has failed to met the requirement sec. 3. (1) 3 by ensuring that every resident is not neglected.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

Findings/Faits saillants :

1. The following findings are in respect of log # O-000789-12

The resident was transferred to Kingston General Hospital (KGH). A Registered Practical Nurse documented that KGH attending physician called informing the home that the resident had passed away.

On February 21st, 2012 staff # S101 submitted a Critical Incident Report to the Ministry of Health and Long Term Care Ottawa Service Area office.

On May 4, 2012 staff # S101 reported to the inspector that the Ministry of Health was not immediately notified of the unexpected or sudden death. Staff # S101 indicated that the home did have access to the after hours number for the Ministry of Health and Long Term Care.

The licensee has failed to comply with O. Reg. 79/10 sec. 107 (2) where a licensee is required to make a report immediately and it is after normal business hours, the home is required to report using the Ministry's emergency contact.
2. The following findings are in respect of log # O-000789-12

Resident # 2 fell. The resident was transferred to Kingston General Hospital (KGH). A Registered Practical Nurse documented that KGH attending physician called informing the home that the resident had passed away.

On February 21st, 2012 staff # S101 submitted a Critical Incident Report to the Ministry of Health and Long Term Care Ottawa Service Area office.

On May 4, 2012 staff # S101 reported to the inspector that the Ministry of Health was not immediately notified of the unexpected or sudden death. Staff # S101 indicated that the home did have access to the after hours number for the Ministry of Health and Long Term Care and that a Duty Inspector with the Ottawa Service Area had not been called to inform of the unexpected or sudden death.

The licensee has failed to comply with O. Reg. 79/10 sec. 107 (1) 2. the requirement to inform the Director immediately of an unexpected or sudden death.

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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The following findings are in respect of log # O-000789-12:

On May 4th, 2012 interviewed staff #S105 who reported that at times Personal Support Workers (PSW) would administer medications that were crushed and mixed with food to residents. # S105 identified three PSW's (Staff # S108, S109 and S110) who have given medications to residents. The complainant reported to the inspector that a PSW (S107) was observed administering medication to resident # 2.

The licensee has failed to met the requirements of O. Regulation 79/10 sec. 131. (3) to ensure that no persons administers a drug to a resident unless that person is a physician, dentist, registered nurse or a registered practical nurse.

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 Personal Support Workers do not administer medications to residents,, to be implemented voluntarily.

Issued on this 8th day of May, 2012

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