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
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
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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
Jun 26, 27, 28, 29, 2012	2012_038197_0018	Critical Incident

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Corporate Registered Dietitian, the Registered Dietitian, the Food Service Supervisor, a Registered Nurse (RN), a Restorative Care Nurse, Registered Practical Nurses (RPN), Personal Support Workers (PSW) and food service workers.

During the course of the inspection, the inspector(s) reviewed a health care record, the regular minced menu, the minced diet guidelines and the Dysphagia Screening policy.

The following Inspection Protocols were used during this inspection:

Hospitalization and Death

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 6(10)(b) in that resident #1 was not reassessed and the plan of care was not reviewed and revised when the resident's care needs changed.
On June 27, 2012 staff members S102, S103, S104, S105 and S106 all stated during individual interviews that resident #1 aspirated at breakfast on a specified date.
RN #S102 stated during the interview on June 27, 2012 that on another date she observed resident #1 at the nursing station to be coughing while drinking nectar thick fluids, however, no one had mentioned to her that the resident was having difficulty with fluids. When asked if she knew resident #1 had aspirated at breakfast she said that she did not know that day but that she heard about it after the resident had already passed away.
RPN #S106 worked from 0700 - 1100 hours on the unit where resident #1 resided the date of the incident. During an interview on June 27, 2012 she stated that she assessed resident #1 after breakfast and noted a physical change in the resident's condition. RPN #S106 stated that she informed RPN #S105 at shift change (1100 hours) that she was concerned about the resident due to possible aspiration during the breakfast meal and asked her to get a blood pressure since she was unable to. She said she also mentioned her concern to RN #S102.
RPN #S105 worked from 1100 - 1500 hours on the same unit the date of the incident. During a telephone interview on June 27, 2012 she stated that staff did report to her that resident #1 had aspirated at breakfast. RPN #S105 stated that she knew resident #1 needed to have a blood pressure reading but by the time she got to it the resident was already in the dining room for lunch and so her plan was to do the resident's vitals after lunch.
PSW #S104 reported in an interview on June 27, 2012 that even before resident #1 started eating lunch that day the resident wasn't doing well. She went on to say that she thought the resident may have also aspirated on nectar thickened juice at lunch before eating the pizza. She said that she cut up the resident's pizza, but felt it was the wrong thing to give the resident for lunch since the resident had aspirated at breakfast.
Upon review of resident #1's health care record there was no documentation related to the resident having difficulty with fluids and no documentation related to the resident aspirating at breakfast or having a change in condition.
Even though resident #1 was known to be having difficulty with the current diet order, the resident was not reassessed and the plan of care was not reviewed and revised to reflect a change in the resident's care needs.
2. The licensee has failed to comply with LTCHA 2007, s. 6(7) in that resident #1 did not receive the diet as specified in the plan of care.
The plan of care dated June 19, 2012 for resident #1 indicates the diet order as regular minced with nectar thick fluids.
On a specified date resident #1 was served a piece of pizza for lunch that was not an approved regular minced menu item.
Resident #1 was noted to be in distress while eating the pizza and PSW #S103 stated that she cleared a piece of pizza out of the resident's mouth, however, the resident was still drooling so the PSW felt that there could be another piece stuck in the resident's throat. PSW #S103 noted the pizza crust to be thick and hard and not appropriate for the resident and so took the pizza back to the dietary aid to ensure is was meant for residents on a regular minced diet.
RN #S102 was called to assess the resident and later noted in a referral note to the Registered Dietitian that resident #1 had aspirated at lunch and had a change in condition. RN #S102 stated in an interview on June 27, 2012 that she did not feel the pizza was appropriate for resident #1.
Resident #1 passed away early the next day. The coroner's report indicated that the immediate cause of death was asphyxia due to food aspiration.
During an interview with the Corporate Registered Dietitian #S101 on June 27, 2012 she stated that the pizza that was served the date of the incident to resident #1 was not the Nestle Food Services pizza with the crust cut off that was tested and approved for the regular minced menu.
During an interview with the Food Service Supervisor on June 27, 2012 she stated that the home decided to make their own pizza for the regular minced menu rather than bring in the approved Nestle Food Services pizza. She further indicated that the crust of the pizza that the home made was not tested to ensure it was appropriate for residents receiving a regular minced diet and also stated that dietary staff had not been removing the crust from the pizza before serving it to residents.

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 72(2)(c) in that there are not standardized recipes for all menus.
The SS 2012 Trillium master menu for Sunday of week 3 states there is a no crust cheese pizza for residents on a regular minced diet.
During an interview with the Food Service Supervisor she stated that the home does not have a standardized recipe for this menu item.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 129(1)(a)(iv) in that drugs were not stored in a way that complied with manufacturer's instructions.
On a specified date resident #1 received an as needed dose of hydromorphone administered by RPN #S107. Early the next morning the same resident received another as needed dose of hydromorphone administered by RPN #S114.
During an interview with RPN # S107 on June 27, 2012 she stated that the hyrdromorphone administered to resident #1 comes in a 2mg/mL ampoule and has a snap off lid. RPN #S107 stated that usually their practice is to discard the rest of the ampoule after each use. However, due to the fact that there has been a shortage of hydromorphone in the home the decision was made to store the open ampoule of hydromorphone in a medication cup in resident #1's slot in the medication cart in case that resident needed another dose. RPN #S107 indicated that the open ampoule of hydromorphone could not be put back into the double locked box in the medication cart since it could not be stored properly.

Issued on this 29th day of June, 2012

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

Jessica Pattin, RD

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PATTISON (197)
Inspection No. / No de l'inspection :	2012_038197_0018
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Jun 26, 27, 28, 29, 2012
Licensee / Titulaire de permis :	SPECIALTY CARE EAST INC. 400 Applewood Crescent, Suite110, VAUGHAN, ON, L4K-0C3
LTC Home / Foyer de SLD :	TRILLIUM CENTRE 800 EDGAR STREET, KINGSTON, ON, K7M-8S4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~JENNIFER POWLEY~~ Dawn Black

To SPECIALTY CARE EAST INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that residents requiring texture modification receive their diet as specified in the plan of care.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA 2007, s. 6(7) in that resident #1 did not receive the diet as specified in the plan of care.
The plan of care dated June 19, 2012 for resident #1 indicates the diet order as regular minced with nectar thick fluids.
On a specified date resident #1 was served a piece of pizza for lunch that was not an approved regular minced menu item.
Resident #1 was noted to be in distress while eating the pizza and PSW #S103 stated that she cleared a piece of pizza out of the resident's mouth, however, the resident was still drooling so the PSW felt that there could be another piece stuck in the resident's throat. PSW #S103 noted the pizza crust to be thick and hard and not appropriate for the resident and so took the pizza back to the dietary aid to ensure is was meant for residents on a regular minced diet.
RN #S102 was called to assess the resident and later noted in a referral note to the Registered Dietitian that resident #1 had aspirated at lunch and had a change in condition. RN #S102 stated in an interview on June 27, 2012 that she did not feel the pizza was appropriate for resident #1.
Resident #1 passed away early the next day. The coroner's report indicated that the immediate cause of death was asphyxia due to food aspiration.
During an interview with the Corporate Registered Dietitian #S101 on June 27, 2012 she stated that the pizza that was served the date of the incident to resident #1 was not the Nestle Food Services pizza with the crust cut off that was tested and approved for the regular minced menu.
During an interview with the Food Service Supervisor on June 27, 2012 she stated that the home decided to make their own pizza for the regular minced menu rather than bring in the approved Nestle Food Services pizza. She further indicated that the crust of the pizza that the home made was not tested to ensure it was appropriate for residents receiving a regular minced diet and also stated that dietary staff had not been removing the crust from the pizza before serving it to residents. (197)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 06, 2012

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that residents requiring texture modification are reassessed and their plan of care reviewed and revised when their care needs change.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA 2007, s. 6(10)(b) in that resident #1 was not reassessed and the plan of care was not reviewed and revised when the resident's care needs changed.
On June 27, 2012 staff members S102, S103, S104, S105 and S106 all stated during individual interviews that resident #1 aspirated at breakfast on a specified date.
RN #S102 stated during the interview on June 27, 2012 that on another date she observed resident #1 at the nursing station to be coughing while drinking nectar thick fluids, however, no one had mentioned to her that the resident was having difficulty with fluids. When asked if she knew resident #1 had aspirated at breakfast she said that she did not know that day but that she heard about it after the resident had already passed away.
RPN #S106 worked from 0700 - 1100 hours on the unit where resident #1 resided the date of the incident. During an interview on June 27, 2012 she stated that she assessed resident #1 after breakfast and noted a physical change in the resident's condition. RPN #S106 stated that she informed RPN #S105 at shift change (1100 hours) that she was concerned about the resident due to possible aspiration during the breakfast meal and asked her to get a blood pressure since she was unable to. She said she also mentioned her concern to RN #S102.
RPN #S105 worked from 1100 - 1500 hours on the same unit the date of the incident. During a telephone interview on June 27, 2012 she stated that staff did report to her that resident #1 had aspirated at breakfast. RPN #S105 stated that she knew resident #1 needed to have a blood pressure reading but by the time she got to it the resident was already in the dining room for lunch and so her plan was to do the resident's vitals after lunch.
PSW #S104 reported in an interview on June 27, 2012 that even before resident #1 started eating lunch that day the resident wasn't doing well. She went on to say that she thought the resident may have also aspirated on nectar thickened juice at lunch before eating the pizza. She said that she cut up the resident's pizza, but felt it was the wrong thing to give the resident for lunch since the resident had aspirated at breakfast.
Upon review of resident #1's health care record there was no documentation related to the resident having difficulty with fluids and no documentation related to the resident aspirating at breakfast or having a change in condition.
Even though resident #1 was known to be having difficulty with the current diet order, the resident was not reassessed and the plan of care was not reviewed and revised to reflect a change in the resident's care needs. (197)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 06, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and more about the HSARB on the website www.hsarb.on.ca.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 29th day of June, 2012

Signature of Inspector / Signature de l'inspecteur : Jessica Pattison, RD

Name of Inspector / Nom de l'inspecteur : Jessica Pattison

Service Area Office / Bureau régional de services : Ottawa Service Area Office