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

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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
Aug 13, 2018	2018_755728_0001	012549-18	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Trillium Court
550 Philip Place KINCARDINE ON N2Z 3A6

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

MARIA MCGILL (728), GLORIA KOVACH (697), JANETM EVANS (659), NUZHAT UDDIN (532)

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): June 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, 2018.

The following follow up and intakes were completed in conjunction with the RQI:
Log #004661-18/SAC 18863 / 2773-000003-18 critical incident related to alleged resident to resident abuse
Log #004886-18/ IL-55927-LO complaint related to admissions of residents to the home
Log #005434-18/ IL-55996-TO complaint related to admissions of residents to the home

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), a LHIN Coordinator, the Office Manager, the Administrative Assistant, a Union Representative, the Resident Assessment Instrument Coordinator (RAI Coordinator), the Environmental Services Manager, the Program/Recreation Manager, a Psychogeriatric Nurse, a Restorative Care Aide, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Housekeepers.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **10 WN(s)**
- **9 VPC(s)**
- **2 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. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week, by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) During an interview, with an identified resident, they said that they had missed three baths in the past two weeks. The identified residents plan of care stated that the resident is to receive baths as per the bath schedule. The Daily Bath Schedule list states that this resident is to receive two baths weekly. A review of the Point of Care (POC) documents that the resident received a bath on four specified dates over a thirty day period. There were no documented resident refusals during this time period. This resident received four baths over four weeks when they should have received eight.

B) A record review of an identified five residents plan of care stated that the residents were to receive baths as per the bath schedule. The Daily Bath Schedule list stated that the residents were to receive two baths weekly. A review of POC documents that the residents received a bath on four or five specified dates over a period of thirty days, inclusive of resident refusals. These residents received four or five baths over a four week period when they should have received eight.

A Personal Support Worker and registered staff member said that baths are documented in POC by care staff.

The RAI coodinator confirmed that baths were not completed twice weekly for these specified residents.

During an interview, the Executive Director stated that the expectation for baths was that residents would be bathed twice weekly and that they were unaware that baths were not being completed.

The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week, by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [s. 33. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to review the assessments and information that were required to be taken into account, under subsection 43(6), and approve the applicant's admission to the home unless, (a) the home lacks the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances exist which

are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Two complaints were received regarding the home withholding approval for admission for two identified applicants.

A record review of the Resident Assessment Instrument (RAI) application for one applicant indicated that the applicant had specified medical diagnosis. A review of the physical and history indicated that the applicant had behaviours. Review of the RAI and the behaviour assessment tool indicated that the applicant had specific behaviours.

A review of the RAI assessment for another identified applicant stated that the applicant was a specified age with a specified medical diagnosis. The applicant had specified behaviours and resisted care for specified reasons.

During an interview, a complainant said that an applicant was not accepted to Trillium Court. They said that the applicant had specified behaviours and they received a letter from Trillium Court indicating that the applicant was not accepted to the home due to lack of physical facilities.

In an interview a complainant said that two applicants were looking for Long Term Care (LTC) and they both wanted to go to this LTC home. These applicants needed LTC and seemed like they were being denied because of mental health reasons. The complainant explained that the applicants were not aggressive or uncooperative. The complainant said that it seemed as though anyone that had a mental health diagnosis was not being accepted to the home and no explanation was provided.

A Psycho Geriatric Nurse Consultant shared that they were involved with one of the applicants in the community. The Psycho Geriatric Nurse Consultant said that they initiated the LHIN application for an applicant at a specified time. They reported that the initial assessment was completed during a specified time and the second assessment followed. They stated that both times the application for admission was withheld.They said that the the letter was generic and referred to the applicant with the incorrect gender pronoun.

Review of the refusal letter indicated that the grounds for withholding approval for the applicants was that the home “lacked physical facilities”.

The Director of Care said that they were responsible for reviewing the applications for admissions. The DOC said that they review the assessment first followed by reviewing the two RAI assessments and the assessment from the physician. They said that they sometimes review the behavioral assessment. The DOC said that they looked for triggers which included wandering. They said that their budget only allows for one PSW and registered staff at night which makes wandering unmanageable. They also stated that they were not a secure unit. The DOC said that if the applicants were wandering into other resident rooms it may be a trigger for other residents. The DOC reported that they also looked at any aggressive behaviours and reviewed the medication list to determine if the applicant was on antipsychotics. The DOC said that if the list was full of antipsychotics then that was a flag for them as one of their clinical programs strived to minimize antipsychotics in the home. They also said that as part of their admission application review they would consider the behavioural assessment as one of the tools for acceptance or refusal. They said that they review the application to see if there was a safety risk and said that since the home is attached to a retirement home, the home cannot guarantee security as people were going in and out of the LTC area.

The DOC acknowledged that if the applicants were coming with "red flags" then they would refuse them. They added that they would allow the potential applicants to go somewhere first where they can have their health concerns addressed and they may then become safe to reapply to Trillium Court.

In an interview, the DOC said that they were withholding admissions more regularly now as they were getting applications from all over (i.e., cities further away, etc.). They said that they were not a psychiatric unit, and that they have been getting applications where the hospital or community had not stabilized the residents. When asked why they withhold acceptance of applicants with behaviours, such as wandering, the DOC explained that they were not a secure unit because many residents and families know the code to the locked door. They said that they were near a highway and ravine which could be dangerous for people who wander and that the home could not supervise a resident that wanders.

Observation and interview with the Executive Director (ED) confirmed that the home had a Wander Guard system in place. The ED showed the system and shared that the system locks the door to the home area when the residents with a wander guard walk within close proximity to the door. They said that that there was a separate code to unlock the system and a separate code for the door. They stated that once the resident leaves the home area there was no code on the main door.

A LHIN Placement Coordinator said that they had spoken with the DOC about the fact that the letters were the same for all refusals. They said that in the last few weeks there were three to four refusals. The LHIN Placement Coordinator reported that in many cases applicants who were refused by Trillium Court were accepted by the other four homes on their list. They said the reason that was provided for not accepting the specified applicants was that the home lacked the "physical facilities for the resident's care" and indicated that this was usually the reason for denial from Trillium Court. They said that the reasons for denying the application included wandering because they don't have a designated secure unit for those with mental health issues and those on psychotropic medications.

They stated that recently they denied admission to a client who required specified medical treatments because the home felt that they would require complex care. They said that despite an explanation that the resident would leave the home for the required treatments and would not require a lot of extra care, the DOC refused to accept them.

The ED stated that they do not participate in reviewing the admission application. They shared that they were aware of who was on the list but did not look at the clinical side. They stated that the DOC looked at the behavior assessments and clinical complexity and they would share with the team if the resident was accepted or rejected and the DOC was responsible for drafting up the letters. They stated that the DOC was the sole person to review the applications and to determine if the residents were to be admitted to the home.

The Executive Director said that they were not aware of the specified applicants being declined. They stated that behaviours was one of the main concerns as it comes down to the safety of the other residents in the home. When asked regarding wandering the Executive Director indicated that it was not wandering but exit seeking that they were concerned about.

The applications for applicants were reviewed by the Executive Director. The Executive Director reviewed the RAI and Behaviours Assessments to review for a specified resident which included documents that were submitted for both applications.

The Executive Director stated that based on reviewing the application for a specified applicant, they did not see any reason to withhold admission. They shared that going forward they would review the applications to ensure that both the DOC and the ED were

involved and understand the concerns from the application.

The Executive Director was provided with the RAI and Behaviors Assessments to review for another specified applicant and notes from the home where they were currently residing. The ED reviewed the notes and shared that there were identified concerns that could be the reasons why the applicant was declined admission.

The ED shared that they did not want to decline difficult applicants but if they take a bed somewhere else then they would be willing to reassess their application. The ED shared that the initial application for a specified applicant did not have anything that led to a refusal; however, could understand the reason for refusal of the other specified applicant. The ED said that the home's staffing complement, especially on nights, was insufficient to care for behavioral residents; and, therefore, they were not able to accept applicants that other homes accepted.

2. The licensee has failed to ensure that where the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out, (a) the ground or grounds on which the licensee is withholding approval; (b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; (c) an explanation of how the supporting facts justify the decision to withhold approval; and (d) contact information for the Director. 2007, c. 8, s. 44. (9).

Two complaints were received regarding the home withholding approval for admission for two identified applicants.

Record review indicated that a written notice (refusal letter) was sent out to the applicants, the Director, and the appropriate placement co-ordinator.

Further review of the refusal letter indicated that the grounds for withholding approval for the two applicants was that the home "lacked physical facilities" necessary for their care and it stated that the team decided to withhold acceptance for admission as the home was unable to meet the family member's needs.

In an interview, the Director of Care said they were withholding admissions more regularly now as they were getting applications from all over (i.e., cities outside of the area). The DOC said that this was not a psychiatric unit and they were getting unreasonable applications. They said that they provide a written notice and give the

piece of the legislation that would pertain to why they could not admit an applicant (i.e., “lack of physical facilities” or "lack of nursing expertise"). They said that they were advised by the LHIN Coordinator that this was how the letter should be so it was not wordy. They said that they used to give a clear explanation as to why they were not able to admit the applicants but not anymore.

In an interview the LHIN Coordinator shared that it was quite common for Trillium Court to withhold admissions. They said that they had spoken with the Director of Care (DOC) about the fact that the letters were the same for all refusals. The family, clients, and hospital do not understand the reasons that applicants were being denied. LHIN Coordinator shared that they identified this as being an issue for the last six months. They said that the reason for withholding admission usually was that the home “lacks the physical facilities” and did not include detailed explanation of the supporting facts.

In an interview, the ED reviewed the letters and said that they used to provide more detail in written notices. The regulations were reviewed with the ED and they acknowledged that the written notice did not include a detailed explanation of the supporting facts, as they relate both to the home and to the applicant’s condition and requirements for care and the contact information for the Director.

The licensee has failed to ensure that where the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out, (a) the ground or grounds on which the licensee is withholding approval; (b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant’s condition and requirements for care; (c) an explanation of how the supporting facts justify the decision to withhold approval; and (d) contact information for the Director. 2007, c. 8, s. 44. (9). [s. 44. (9)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 where the licensee withholds approval for admission, the licensee gives to persons described in subsection (10) a written notice setting out, a) the ground or grounds on which the licensee is withholding approval; b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; c) an explanation on how the supporting facts justify the decision to without approval; and, d) contact information for the Director., to be implemented voluntarily.

WN #3: 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. (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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(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 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 the resident's care needs change or care set out in the plan is no longer necessary.

Review of the Resident Assessment Instrument Minimum Data Set (RAI MDS), for a specified resident showed the resident's bowel continence status had changed from frequently incontinent to incontinent and the resident's bladder continence status had changed from occasionally incontinent to incontinent.

Review of the clinical record for the identified resident did not show evidence of a

continence assessment being completed on Point Click Care for over one year.

Review of the current care plan for the specified resident documented the resident received specified toileting care.

The home's policy called Continence Care –Change of Continence (CARE2-010-01) effective date August 31, 2016 and review date March 31, 2018 stated:
“The Nurse will initiate the 3-Day Continence Diary with the change in continence status. If based on the nurse’s clinical judgement it was determined not to complete the 3-day Continence Diary. The rational will be documented in the IDPN and Continence Assessment.
Complete the Continence Assessment (PCC) which will include the evaluation of the 3-day Continence Diary. The interdisciplinary Care Team assesses all Residents using a clinical assessment instrument and develops personalized plan of care. Continence care treatments and interventions include:
Promotion of continence
Prevention of constipation
Nutrition and hydration protocols
Toileting programs for bowel and bladder management.
Incontinent care products are not an alternative to toileting
There is an annual evaluation of continence care products in consultation with our, Residents, their SDM and direct care staff."

Twp Personal Support Workers (PSW) stated that the identified resident was not receiving the specified toileting care identified in the care plan.

A Registered Practical Nurse (RPN) stated continence assessments were to be completed on a resident's admission and when there is a change in continence status; a voiding diary and assessment were to be completed. A RPN reviewed the current care plan for the specified resident and acknowledged it was not reflective of the resident's current continence care needs.

The Director of Care (DOC) stated that the expectation when a resident's continence status had worsened was that staff complete a continence assessment and update the care plan. The DOC reviewed the clinical record for the specified resident and acknowledged that a continence assessment had not been completed and the care plan had not been updated to reflect the resident's current continence status.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

2. Review of the Resident Assessment Instrument Minimum Data Set (RAI MDS) dated early 2018, for an identified resident showed the resident had specific worsening behaviours.

Review of the clinical record for a specified resident did not show evidence of a behaviour assessment or Dementia Observation Systems (DOS) being completed for the resident since a specified time.

The clinical record showed the identified resident had been followed by BSO Geriatric Behaviour Response team at a specified time.

Review of a specified residents current care plan documented specific responsive behaviours and interventions.

Review of the home's policy LTC Dementia Care - Assessment and Care Planning, effective August 31, 2016, reviewed March 31, 2018, documented procedure:
-Applicable RAI-MDS outcome measures will be reviewed on move-in and quarterly
-Care planning will reflect individualized and flexible approaches that include consideration of both non-pharmacological and pharmacological interventions and referrals to specialists
-Specialized dementia assessment, interventions, and programming will be considered and implemented in appropriate Resident situations (eg Dementiability Methods the Montessori way, U-First, Gentle Persuasive Approaches).

Responsive Behaviours
-The Responsive Behaviour Care Pathway in the Dementia and Behavioural Care Guidelines resource binder will be used to determine interventions to manage responsive behaviours.
-Monitoring of responsive behaviours will be completed using an objective systematic tracking tool such as the Dementia Observations System (DOS).

A Personal Support Worker (PSW) stated the resident had identified behaviours. A PSW stated if the resident may exhibit a behaviour alongside a particular medical concern, but otherwise denied the resident had behaviours.

A Registered Practical Nurse (RPN) stated an identified resident had specific behaviours with cares. The RPN stated that the resident had been started on a related medication. A RPN stated that the resident no longer exhibited a lot of behaviours.

The Director of Care (DOC) stated that the specified resident did not have any behaviours at this time. The DOC stated that the expectation for assessing and documenting resident behaviours included that the RAI-MDS assessment would be completed, including the Resident Assessment Protocol (RAP); then the care plan would be updated. The DOC reviewed the current care plan and stated that it did not reflect the resident's current status and that the specified behaviours should have been removed from the care plan.

The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

3. Review of the most recent Resident Assessment Instrument Minimum Data Set (RAI-MDS) documented specified behaviours. Another behaviour was documented as occurring every four to six days but less than daily and was not easily altered. It was indicated that there had been a deterioration in the resident's behavioural symptoms.

Review of progress notes from specified dates showed one incident where the resident declined a meal and documentation indicated the resident was confused at times.

Review of the hard copy of the resident chart from specified dates showed the resident was treated with medications for identified medical concerns.

Review of the Behavioural Resident Assessment Protocol (RAP) for a specified date, documented "a plan of care with interventions to avoid complications and minimize risks will be put into place".

Review of the current care plan for a specific resident did not show documented evidence of behaviours. Review of "resolved" care plan items showed prior responsive behaviours.

Observations completed during the inspection did not show evidence of any behaviours.

A Personal Support Worker (PSW) and Registered Practical Nurse (RPN) stated a specified resident did not exhibit responsive behaviours.

Resident Assessment Instrument Coordinator (RAI-C)/ Behavioural Support Ontario (BSO) nurse stated the specified resident was not on their BSO list. They stated when the specified resident had pain, they had some issues with behaviours but otherwise they did not exhibit responsive behaviours. The RAI-C/BSO nurse stated that usually the home would complete DOS charting to look at the root cause of the issue. They looked at the clinical record and acknowledged that DOS charting had not been completed. In addition to this they acknowledged that a behaviour care plan had not been completed for the specified resident.

The licensee failed to ensure the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

4. Review of the Resident Assessment Instrument on a specified date, for an identified resident documented their bowel continence status had changed from being occasionally incontinent to frequently incontinent. There was no relevant continence assessment completed for the specified resident. The plan of care for the specified resident documented a prompted bowel program for incontinence.

Review of the home's policy Continence Care –Change of Continence (CARE2-010-01) effective date August 31, 2016 and review date March 31, 2018 stated:
"The Nurse will initiate the 3-Day Continence Diary with the change in continence status. If based on the nurse's clinical judgement it was determined not to complete the 3-day Continence Diary. The rational will be documented in the IDPN and Continence Assessment.
Complete the Continence Assessment (PCC) which will include the evaluation of the 3-day Continence Diary. The Interdisciplinary Care Team assesses all Residents using a clinical assessment instrument and develops personalized plan of care."

Two Personal Support Workers (PSW) and a Registered Practical Nurse (RPN) stated the specified resident was incontinent of both bowel and bladder. A PSW stated the specified resident's bowel incontinence had worsened in the last three to six months.

A RPN stated that the home's process was to complete a voiding diary and continence assessment upon admission to the home and with any change in continence status.

They were uncertain if the resident had a change in their continence status.

The Director of Care (DOC) stated the expectation was that a three day voiding diary be completed and a continence assessment with a change in a resident's continence status. The DOC acknowledged that a bowel continence assessment should have been completed for the specified resident with a change in their bowel continence status, but it had not been done.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff of the home is on duty and present at all times unless there is an allowable exception to this requirement.

A review of the nursing schedule dated June 9 to July 6, 2018 showed that June 16, 17, 23, 24, 25, 2018 from 1800-2300 hours there was no Registered Nurse (RN) coverage in the home. This accounted for five shifts out of 60 shifts or approximately eight percent.

In an interview, office manager said that the home did not have a RN in the building for evenings on June 16, 17, 23, 24, and 25, 2018 from 1800-2300 hours.

An interview with the Executive Director (ED), indicated that the Director of Care (DOC) acts as the RN on duty outside of the DOC role duties and hours when no RN is available. In an interview, the ED said that there had not been a RN present in the home on June 16, 17, 23, 24, and 25, 2018 from 1800hours-2300hours.

The licensee has failed to ensure that at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff of the home is on duty and present at all times unless there is an allowable exception to this requirement. [s. 8. (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 to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided in the regulations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy, or system instituted or otherwise put in place was complied with. In accordance with Regulation, s. 48 requires the licensee to ensure that the interdisciplinary programs, including a continence care and bowel management program, are developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48

Policy called Continence Care –Change of Continence (CARE2-010-01) effective date August 31, 2016 and review date March 31, 2018 stated:
"The Nurse will initiate the 3-DAY continence Diary with the change in continence status. If based on the nurse's clinical judgement it was determined not to complete the 3day Continence diary. The rational will be documented in the IDPN and Continence Assessment.
Complete the Continence Assessment (PCC) which will include the evaluation of the 3-day Continence Diary."

Clinical record review indicated that a specified resident had a medical intervention during hospitalization related to identified medical concerns.

The plan of care for the specified identified they had the medical intervention started in hospital due to diagnosed medical concerns during hospitalization during a specified time period. It further identified the residents continence needs.

Clinical record review indicated that there was no relevant continence assessment completed in the assessment tab in Point Click Care (PCC).

A RN stated that the continence assessments was completed as a hard copy dated for a specified date; however, there was no continence assessment that was completed since the resident's return from the hospital and it should have been.

The DOC shared that the continence assessment should have been done and it was not completed for the resident after they returned from the hospital.

On a specified date, the ED reviewed the PCC and agreed that there was no continence assessment completed after the resident returned from the hospital. They reviewed the policy and acknowledged that the nurse was to do the Continence assessment in PCC which was inclusive of the evaluation of the 3-day Continence Diary, and this was not done. The ED shared that staff was expected to do the continence assessment with improvement and with decline in the resident's continence status.

The licensee has failed to ensure that the continence policy related to continence assessment put in place was complied with. [s. 8. (1) (b)]

2. The licensee failed to ensure that written policies and procedures related to disposal of discontinued medication were implemented.

Review of the medication incident report (MIR) form, for an identified resident documented an omission of a specified medication, by mouth every morning and the medication strip was found in the medication cart.

Review of the orders for a specified resident documented that this medication was discontinued by the physician on a specified date and that a different dose of the medication was ordered every morning on a specified date.

Review of the medication administration record (eMAR) for a specified resident documented that the medication was administered to the resident on a specified date.

The progress notes for a specified resident as documented by the Director of Care (DOC) stated that when the DOC spoke with the substitute decision maker (SDM) regarding the possible medication error. It was identified that the error was related to not removing the old medication pouch.

In an interview with the DOC, they stated that the error was that the discontinued

medication was left in the medication cart and that it should have been removed when it was discontinued.

During an interview with a Registered Nurse (RN), they stated that the home's policy for drug destruction directed them to discard discontinued medication right away and they should not be left on the medication cart.

Review of the Drug Inventory Control documented that medications that were no longer required due to being discontinued be identified, destroyed, and disposed of.

The licensee failed to ensure that written policies and procedures related to disposal of discontinued medication were implemented. [697] [s. 8. (1) (b)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan provides for a staffing mix that is consistent with the residents' assessed care and safety needs.

During an interview on June 27, 2018, the Director of Care (DOC) said that the homes staffing complement included:

Day Shift: 4 Personal Support Worker (PSW), 1 RN, 1 RPN
Evening Shift: 3 PSW, 1 RN
Night Shift: 1 RN, 1 PSW

A review of the staff schedule for the time period of June 9, 2018 to June 28, 2018 identified six PSW shifts out of sixty shifts (ten percent) where the home did not have a full staffing complement. This was confirmed by the Office Manager. The Office Manager and Administrative Assistant stated that when they were short of staff they would call staff to see if a shift could be filled or ask a staff on the previous shift to stay. In an interview with Executive Director (ED), they said that the home is currently in a "staffing crisis" with respect to filling the positions and that it is difficult to cover time off for staff.

A) During an interview with a Personal Support Worker (PSW), they said that on the night shift they were concerned about resident safety because many of the residents required two staff for assistance and that it was physically impossible to be at both ends of the hallway at one time.

A review of the staffing plan titled "Staffing Plan Annual Evaluation" dated February 22, 2018, stated, "due to decreased funding second night PSW has been temporarily laid off. Working to develop new PSW day/evening and night job routines to pick up baths for residents".

A PSW said that staff were unable to take breaks on the night shift because that would leave residents left waiting for required care. A PSW stated that when there were two PSW staff on the night shift, the RN was better able to focus on their role, residents waited less time to get required care, and there were less falls as the RN was also able to answer resident call bells.

During an interview with a registered staff they said that if a resident had a fall or if a resident was not sleeping, it was difficult to provide others with the needed care and challenging to prioritize the residents care.

The ED stated that different staffing complements on the night shift were trialed when the home's Case Mix Index (CMI) supported it and that it was successful having two PSWs on the night shift. The ED said that the added value was related to falls prevention, increase in safety checks, and improved response to residents' needs; however, they said that the shift was not filled consistently and statistics on the improvements to care could not be tracked.

B) A review of the plan of care for a specified resident identified that the resident required a specific assistance level for toileting. During an interview, a specified resident said that they required specified assistance for toileting and that on the night shift they had to wait to get up to use the washroom given the number of residents that staff had to help.

A review of the plan of care for a specified resident stated that the resident required a specified assistance for toileting. During an interview, this resident said that they had to wait to be toileted and that on one occasion they were unable to make it to the washroom on time and they were incontinent.

A review of the plan for care for an identified resident stated that the resident required a

specified assistance with toileting. During an interview, the resident said they had to wait when there was not enough staff.

C) During an interview with a specified resident, they stated that they had missed three baths in the past two weeks. Review Point of Care (POC) documentation related to baths showed that six specified residents did not receive two baths weekly as identified in their plan of care. The RAI coordinator confirmed that the baths were not completed twice weekly for the identified residents during a thirty day time period.

During an interview a PSW stated that baths were not being completed because of being short staffed. Two registered staff said that baths were likely not being completed due to being short of staff. A PSW said that if they were short on days the baths would get missed and there was not enough staff in general to provide residents' with the care they needed.

The ED stated that they did not know the reasons that baths were not being completed when most days they had the full staff complement. There were only six shifts from June 9, 2018 to July 6, 2018 where they were short. The ED said they were unaware that residents were not receiving a minimum of two baths weekly.

D) A review of a medication incident, documented that a specified resident was not given two specific ordered medications by mouth at bedtime as ordered. The medication that was to be given on a specified date was found in the medication strip in the medication cart by the night shift. The Director of Care's (DOC) investigation of the medication error stated that having one registered staff on the night shift who provided medications to forty residents was a factor in this medication error.

E) During an interview with a specified resident, they said that when the home was short of staff they had to wait between thirty to sixty minutes to attend breakfast. This resident stated that they would prefer to be up at a specific time; however, they said that it was difficult because of their specified care requirements.

A record review for the resident showed that they required a specified level of assistance with transfers and care. This resident was observed lying in bed after the breakfast meal had started. The resident said that staff were aware that they would have liked to get up and staff would likely get them up later.

A review of the Staffing Plan dated 2018, in the section titled Alternate Staffing

Contingency Plan, it stated that the home used agency workers in the event of an emergency situation where adequate staffing was not available. In an interview with the ED, they said that agency would not be used and when asked if this was part of their staffing plan, they said no. The ED stated that their staffing plan was determined based on the way it had always been and would be revisited if the funding was there to support changes.

The licensee failed to ensure that the staffing plan provides for a staffing mix that is consistent with the residents' assessed care and safety needs. [s. 31. (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 to ensure that the staffing plan provides for a mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation, to be implemented voluntarily.

WN #7: 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 that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds 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.

A progress note on a specified date, stated that an identified resident had a skin integrity concern on a specified area of their body. A specified treatment was provided and the plan stated to monitor the area of altered skin integrity.

A review of the clinical record found that no initial wound assessment was completed when it was first noted.

An initial wound assessment was documented on a specified date after the initial progress note, which identified the same skin integrity concern on the specified area of the resident.

In an interview, a registered staff member said that the reddened area would be considered a skin integrity concern and an initial wound assessment should have been completed when it was first identified. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

A progress note on a specified date documented that an identified resident was observed and treated for a skin integrity concern on a specified area.

A review of the clinical record indicated an initial wound assessment completed at a later date that documented worsening of the skin integrity concern.

In an interview a registered staff member said the resident had a concern related to skin integrity. They said that treatment was not provided for the area after the initial documentation, as it was missed and that it later progressed. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure that that a resident exhibiting altered skin integrity,

including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered staff, if clinically indicated.

Review of a specified residents clinical record identified that the resident was observed to have a skin integrity concern to a specified area and a treatment was provided with the plan documented to monitor the skin concern.

The residents plan of care indicated that no weekly assessments were completed between the initial date when the area of concern was identified, and the identified date when an initial wound assessment was completed for the same area.

In an interview, a registered staff member said that area should have been assessed weekly. A registered staff member said that the skin integrity concern was not assessed weekly. [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 that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds: a) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate instrument that is specifically designed for skin and wound assessment; b) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required; and, c) is assessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there are schedules and procedures in place for routine and preventative maintenance.

It was observed that a grab bar in the shared bathroom of an identified room was loose and that it moved when grabbed.

During an interview, a PSW stated that they were not aware that the grab bar in the specified room was loose. The PSW stated that they would have it fixed right away.

A record review of the care plan dated for an identified resident who resides in the specified room documented that the resident required support for mobility and that they require an assistive device to self-transfer.

In an interview with a PSW they stated that two residents would use the grab bar in their bathroom to steady themselves.

During interviews with the residents who resided in the room, they stated that they used the grab bar beside the toilet to help with transfers.

A review of the Trillium Court Seniors Community by Revera Maintenance Log for the identified time period, there were no maintenance request forms or documentation related to the loose bar in the shared bathroom of the specified room.

During an interview, the Environmental Services Manager (ESM) stated that they were not aware of the loose grab bar in the specific room and there had been no maintenance request to fix the loose grab bar in this room.

During interviews with Executive Director (ED) and the ESM, they stated that preventative maintenance was to be completed for the rooms and bathrooms and that it had not been completed. The ESM said that there is no documentation for previous years room maintenance audits.

The licensee failed to ensure that there are schedules and procedures in place for routine and preventative maintenance. [s. 90. (1) (b)]

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 there are schedules and procedures in place for routine, preventative, and remedial maintenance, to be implemented voluntarily.

WN #9: 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 that drugs were administered to an identified resident in accordance with the directions for use specified by the prescriber.

A medication incident form documented that a specified resident was not given two specified medications at bedtime as ordered and that the medication that was to be given was found in the medication strip in the medication cart during the night shift.

Review of the Director of Care's (DOC) report on medication errors to the Professional Advisory Committee from the meeting, documented that there was one medication omission in January.

A RN stated that they had missed giving the resident two medications that were ordered for them in the evening.

In an interview with the DOC they stated that the resident should have received two specified medications in the evening on a specified date and that the medication had been signed for as being given, but the medication was not given to the resident as the medication in the package was found in the medication cart on the night shift.

The licensee has failed to ensure that drugs were administered to resident #023 in accordance with the directions for use specified 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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that staff monitored the symptoms of infection for an identified resident on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A review of the progress notes for a specified resident documented in a physician's note that the resident had a a specified medical diagnosis. The physician further documented symptoms to the resident. The resident was diagnosed with a specific medical diagnosis.

A doctor's note on an specified date, documented that the specified resident was ordered a specific medication for concerns including pneumonia.

A Registered Nurse (RN) stated that when a resident has pneumonia they would monitor the effectiveness of the medication by oxygen saturations and chest assessments. An RN said that the standard for what needed to be monitored for a resident with pneumonia, was that the resident would be constantly monitored and oxygen saturations and temperatures once a shift.

A Registered Practical Nurse (RPN) stated they would have taken a temperature and check the resident's chest daily and document in the progress notes.

Review of the progress notes for a specified resident from a specified time period, documented vital signs on one specified date and time, the resident's temperature on one specified date and time and the resident's temperature on one specified date and time. There were no oxygen saturations, chest assessments, or chest auscultations documented in the progress notes from a specified time period. There was no further documentation of temperatures or vital signs for a specified resident in progress notes between the specified time period.

The Director of Care (DOC), stated the Home's policy for monitoring symptoms of infection in residents included monitoring the resident every shift, and for pneumonia they would expect that an oxygen saturation, chest auscultation, temperature and vital signs done every shift.

The licensee failed to ensure that staff monitored the symptoms of infection for resident #036 on every shift in accordance with evidence-based practices and the practice of the home. [s. 229. (5) (a)]

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 on every shift symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

Issued on this 13th day of September, 2018

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

Original report signed by the inspector.

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

Ministére 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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIA MCGILL (728), GLORIA KOVACH (697), JANETM EVANS (659), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2018_755728_0001
Log No. / No de registre :	012549-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 13, 2018
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Trillium Court 550 Philip Place, KINCARDINE, ON, N2Z-3A6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Deborah Kraft

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, s 33. (1).

Specifically, the licensee must:
a) ensure the specified residents, and any other resident, are provided a minimum of twice weekly bathing, by a method of their choice, unless contraindicated by a medical condition.
b) ensure there is a process of tracking, monitoring, and auditing bathing for the five specified residents and any other resident. The process of tracking, monitoring, and auditing should be documented.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of this issue was a level 3 as it related to five out of the five residents reviewed. The home had a level 2 compliance history as they had previous unrelated non-compliance with the LCTHA.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week, by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) During an interview, with an identified resident, they said that they had missed three baths in the past two weeks. The identified residents plan of care stated that the resident is to receive baths as per the bath schedule. The Daily Bath Schedule list states that this resident is to receive two baths weekly. A review of the Point of Care (POC) documents that the resident received a bath on four specified dates over a thirty day period. There were no documented resident refusals during this time period. This resident received four baths over four weeks when they should have received eight.

B) A record review of an identified five residents plan of care stated that the residents were to receive baths as per the bath schedule. The Daily Bath Schedule list stated that the residents were to receive two baths weekly. A review of POC documents that the residents received a bath on four or five specified dates over a period of thirty days, inclusive of resident refusals. These residents received four or five baths over a four week period when they should have received eight.

A Personal Support Worker and registered staff member said that baths are documented in POC by care staff.

The RAI coodinator confirmed that baths were not completed twice weekly for these specified residents.

During an interview, the Executive Director stated that the expectation for baths was that residents would be bathed twice weekly and that they were unaware that baths were not being completed.

The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week, by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [s. 33. (1)] (728)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 10, 2018

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. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Order / Ordre :

The licensee must be compliant with s. 44(7) of the LTCHA.
Specifically, the licensee must:

a) review the admission applications for two specified applicants, if they remain on the waiting list, and approve their applications for admission unless: a) the home lacks the physical facilities necessary to meet the applicant's care requirements; b) the staff at the home lack the nursing expertise necessary to meet the applicant's care requirements; or, c) circumstances exist which are provided for in the regulations as being a ground for withholding approval;

b) review the admission applications for any other applicant and approve their applications for admission unless: a) the home lacks the physical facilities necessary to meet the applicant's care requirements; b) the staff at the home lack the nursing expertise necessary to meet the applicant's care requirements; or, c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

The severity of this issue was determined to be a level 3 as there was actual harm to the applicant. The scope of the issue was a level 3 as it related to two of the two applicants reviewed. The home had a level 2 history as there was previous unrelated non-compliance.

Grounds / Motifs :

1. The licensee has failed to review the assessments and information that were required to be taken into account, under subsection 43(6), and approve the applicant's admission to the home unless, (a) the home lacks the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Two complaints were received regarding the home withholding approval for admission for two identified applicants.

A record review of the Resident Assessment Instrument (RAI) application for one applicant indicated that the applicant had specified medical diagnosis. A review of the physical and history indicated that the applicant had behaviours. Review of the RAI and the behaviour assessment tool indicated that the applicant had specific behaviours.

A review of the RAI assessment for another identified applicant stated that the applicant was a specified age with a specified medical diagnosis. The applicant had specified behaviours and resisted care for specified reasons.

During an interview, a complainant said that an applicant was not accepted to Trillium Court. They said that the applicant had specified behaviours and they received a letter from Trillium Court indicating that the applicant was not accepted to the home due to lack of physical facilities.

In an interview a complainant said that two applicants were looking for Long Term Care (LTC) and they both wanted to go to this LTC home. These applicants needed LTC and seemed like they were being denied because of mental health reasons. The complainant explained that the applicants were not aggressive or uncooperative. The complainant said that it seemed as though anyone that had a mental health diagnosis was not being accepted to the home and no explanation was provided.

A Psycho Geriatric Nurse Consultant shared that they were involved with one of the applicants in the community. The Psycho Geriatric Nurse Consultant said that they initiated the LHIN application for an applicant at a specified time. They reported that the initial assessment was completed during a specified time and the second assessment followed. They stated that both times the application for admission was withheld.They said that the the letter was generic and referred to the applicant with the incorrect gender pronoun.

Review of the refusal letter indicated that the grounds for withholding approval for the applicants was that the home “lacked physical facilities”.

The Director of Care said that they were responsible for reviewing the applications for admissions. The DOC said that they review the assessment first followed by reviewing the two RAI assessments and the assessment from the physician. They said that they sometimes review the behavioral assessment. The DOC said that they looked for triggers which included wandering. They said that their budget only allows for one PSW and registered staff at night which makes wandering unmanageable. They also stated that they were not a secure unit. The DOC said that if the applicants were wandering into other resident rooms it may be a trigger for other residents. The DOC reported that they also looked at any aggressive behaviours and reviewed the medication list to

determine if the applicant was on antipsychotics. The DOC said that if the list was full of antipsychotics then that was a flag for them as one of their clinical programs strived to minimize antipsychotics in the home. They also said that as part of their admission application review they would consider the behavioural assessment as one of the tools for acceptance or refusal. They said that they review the application to see if there was a safety risk and said that since the home is attached to a retirement home, the home cannot guarantee security as people were going in and out of the LTC area.

The DOC acknowledged that if the applicants were coming with "red flags" then they would refuse them. They added that they would allow the potential applicants to go somewhere first where they can have their health concerns addressed and they may then become safe to reapply to Trillium Court.

In an interview, the DOC said that they were withholding admissions more regularly now as they were getting applications from all over (i.e., cities further away, etc.). They said that they were not a psychiatric unit, and that they have been getting applications where the hospital or community had not stabilized the residents. When asked why they withhold acceptance of applicants with behaviours, such as wandering, the DOC explained that they were not a secure unit because many residents and families know the code to the locked door. They said that they were near a highway and ravine which could be dangerous for people who wander and that the home could not supervise a resident that wanders.

Observation and interview with the Executive Director (ED) confirmed that the home had a Wander Guard system in place. The ED showed the system and shared that the system locks the door to the home area when the residents with a wander guard walk within close proximity to the door. They said that that there was a separate code to unlock the system and a separate code for the door. They stated that once the resident leaves the home area there was no code on the main door.

A LHIN Placement Coordinator said that they had spoken with the DOC about the fact that the letters were the same for all refusals. They said that in the last few weeks there were three to four refusals. The LHIN Placement Coordinator reported that in many cases applicants who were refused by Trillium Court were accepted by the other four homes on their list. They said the reason that was provided for not accepting the specified applicants was that the home lacked the

"physical facilities for the resident's care" and indicated that this was usually the reason for denial from Trillium Court. They said that the reasons for denying the application included wandering because they don't have a designated secure unit for those with mental health issues and those on psychotropic medications.

They stated that recently they denied admission to a client who required specified medical treatments because the home felt that they would require complex care. They said that despite an explanation that the resident would leave the home for the required treatments and would not require a lot of extra care, the DOC refused to accept them.

The ED stated that they do not participate in reviewing the admission application. They shared that they were aware of who was on the list but did not look at the clinical side. They stated that the DOC looked at the behavior assessments and clinical complexity and they would share with the team if the resident was accepted or rejected and the DOC was responsible for drafting up the letters. They stated that the DOC was the sole person to review the applications and to determine if the residents were to be admitted to the home.

The Executive Director said that they were not aware of the specified applicants being declined. They stated that behaviours was one of the main concerns as it comes down to the safety of the other residents in the home. When asked regarding wandering the Executive Director indicated that it was not wandering but exit seeking that they were concerned about.

The applications for applicants were reviewed by the Executive Director. The Executive Director reviewed the RAI and Behaviours Assessments to review for a specified resident which included documents that were submitted for both applications.

The Executive Director stated that based on reviewing the application for a specified applicant, they did not see any reason to withhold admission. They shared that going forward they would review the applications to ensure that both the DOC and the ED were involved and understand the concerns from the application.

The Executive Director was provided with the RAI and Behaviors Assessments to review for another specified applicant and notes from the home where they were currently residing. The ED reviewed the notes and shared that there were

identified concerns that could be the reasons why the applicant was declined admission.

The ED shared that they did not want to decline difficult applicants but if they take a bed somewhere else then they would be willing to reassess their application. The ED shared that the initial application for a specified applicant did not have anything that led to a refusal; however, could understand the reason for refusal of the other specified applicant. The ED said that the home's staffing complement, especially on nights, was insufficient to care for behavioral residents; and, therefore, they were not able to accept applicants that other homes accepted. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 21, 2018

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 13th day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére 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

Name of Inspector /
Nom de l'inspecteur : Maria McGill

Service Area Office /
Bureau régional de services : Central West Service Area Office