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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 1, 2015	2015_299559_0019	T-2991-15	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26 Midhurst ON L0L 1X0

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

TRILLIUM MANOR HOME FOR THE AGED
12 GRACE AVENUE ORILLIA ON L3V 2K2

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

ANN HENDERSON (559)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 10, 2015.

During the course of the inspection, the inspector(s) spoke with the administrator, nurse manager, registered nurse, personal support worker (PSW) and residents.

During the course of the inspection, the inspector(s) reviewed clinical records, investigation notes, relevant policies and procedures, observed staff interaction with residents and conducted a tour of two home areas.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan.

Review of a critical incident report and electronic progress notes revealed on an identified date, resident #001 drank an identified substance from a Dixie cup which had been left on the treatment cart adjacent to the resident.

An interview with nurse manager #101 revealed the resident had returned from the hospital following a procedure and was not to consume food or fluids orally as per the physician's order. The nurse manager revealed he/she had been teaching the afternoon registered staff about a new process for the resident's care using normal saline and the identified substance dispensed into Dixie cups.

An interview with resident #001 at the time of the inspection, revealed he/she remembered the incident but could not remember if he/she took the Dixie cup from the cart or if it was given to him/her. The resident then indicated to the inspector his/her mouth was dry and asked for some ice chips.

An interview with PSW #103 revealed he/she had answered the resident's call bell at an identified time, and observed an open bottle of the identified substance on the cart and noted the resident's throat was significantly swollen compared to earlier in the evening. The PSW further revealed resident #001 had frequently used the call bell during the evening at least every 10 minutes to request a drink and was informed he/she was not allowed to consume fluids by mouth.

An interview with night RN #102 revealed resident #001 was sent to hospital immediately after the incident and subsequently returned in the morning with no further directions and to continue avoiding the consumption of food and fluids orally.

Record review revealed on an identified date, the resident was observed in his/her bathroom trying to get a drink of water from the tap and the resident was reminded he/she was could not consume fluids orally; the resident grabbed and attempted to drink the hand sanitizer. The home removed all liquids from the room and turned off the water faucet. A notice had been placed on the wall above the resident's bed indicating the resident was not to consume food or fluids orally.

On an identified date, a physician's order was received directing staff to give the resident finely chopped ice chips as required.

An interview with the resident on the date of the inspection, revealed he/she had not been given ice chips after requesting them two hours earlier.

The administrator confirmed the staff had not followed the plan of care by keeping the resident from eating or drinking orally and then later with the exception of ice chips. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

Review of a critical incident report and electronic progress notes revealed on an identified date and time, resident #001 drank an identified substance from a Dixie cup which had been left on the treatment cart adjacent to the resident.

An interview with nurse manager #101 revealed the resident was not to consume food or fluids orally as per the physician's order.

An interview with PSW #103 revealed he/she had answered the resident’s call bell on an identified date and time, and noticed resident #001’s eyes were big, and the resident was pointing at the treatment cart with multiple Dixie cups with liquids and suction secretions in them. The PSW revealed he/she had asked the resident if he/she had drunk from a Dixie cup and the resident motioned his/her head "yes". The PSW further revealed there was an open bottle of the identified substance on the cart. The PSW observed the resident’s throat was significantly swollen compared to earlier in the evening.

A review of the material safety data sheet(MSDS)- for the identified substance revealed the substance may be harmful if swallowed and should be stored in a clean, cool, well ventilated dark area.

The administrator confirmed the home had failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times. [s. 91.]

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 all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

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Issued on this 19th day of October, 2015

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

Original report signed by the inspector.