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

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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
Jan 27, 2016	2015_299559_0023	030595-15	Resident Quality Inspection

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), DIANE BROWN (110), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 6, 9,10,12,13,16,17,19, 20, 23 and 24, 2015.

During the course of this inspection Critical Incident log #'s 027462-15 and 026376-15 were inspected.
During the course of the inspection the inspectors(s) conducted a tour of the home, observed staff interaction with residents, observed the provision of care to residents, observed medication administration and meal service, reviewed clinical records and relevant policy and procedures related to the inspection.

During the course of the inspection, the inspector(s) spoke with the administrator, director of resident care (DRC), nurse manager (NM), environmental services manager (ESM), program support service manager, quality development home coordinator, dietary supervisor, registered nurse (RN), registered practical nurse (RPN), personal support worker (PSW), activation aide, RAI coordinator, Residents' Council President and Family Council chair, families and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Pain
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

6 WN(s)
3 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

Record review of PointClickCare (PCC) notes identified resident #012 as having responsive behaviours towards co-residents and staff.

Record review of a Critical Incident reports for identified dates, revealed the resident exhibited responsive behaviours towards two co-residents.

On two identified dates, resident #012 was observed to have a physical altercation with resident #013 that resulted in injury.

Review of the written plan of care revealed when the resident exhibits responsive behaviours staff are directed to commence dementia observational screening (DOS) charting.

An interview with RPN #106, PSWs #107 and #109 revealed DOS charting was not initiated.

An interview with nurse manager #100 revealed it is the expectation DOS charting would be initiated when the resident exhibited physical responsive behaviours and confirmed the care set out in the plan of care was not provided. [s. 6. (7)]

2. The licensee failed to ensure that the following is documented: the provision of the care set out in the plan of care.

Resident #009's Minimum Data Set (MDS) identified the resident had worsening skin and wound issues and four different treatment plans were initiated.

1-The skin and wound dressing was to be changed every fifth day or more often if required.

Review of the resident's electronic treatment administration record (eTAR) revealed the treatment was not documented as being administered on 9 occasions during an identified period.

2-An appliance to be applied to his/her lower identified areas of the body every evening.

Review of the eTAR revealed the treatment was not documented as being applied on 26 occasions during an identified period.

3-A prescription cream was to be applied three times per day to identified areas of the body. Review of the eTAR revealed the treatment was not documented as being applied on 38 times for an identified period of time.

4-A second prescription cream was to be applied three times per day on the resident until resolved.

Review of the eTAR revealed this treatment was not documented as being applied on 17 identified dates.

Interviews with RPN #128 and the DRC confirmed the eTARs were not documented as providing the treatment/care to resident #009, as set out in the plan of care. [s. 6. (9) 1.]

3. The licensee failed to ensure that the following is documented: the provision of the care set out in the plan of care.

Resident #010's Minimum Data Set (MDS) identified the resident had worsening skin and wound issues, the following treatment plan was initiated:

1- Apply a treatment to the wound after cleansing, cover and change every three days.

Review of the eTAR revealed this treatment was not documented on for an identified period.

The treatment plan was subsequently changed and the order was as follows:

2 – Apply a treatment to the wound after cleansing, cover and change every three days.

Review of the eTAR revealed the treatment was not documented on 9 occasions during an identified period of time.
Interviews with RPN #124 and the DRC confirmed the eTARs were not documented as providing the treatment to the resident as directed by the physician. [s. 6. (9) 1.]

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. 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 failed 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.

1-The home's policy in the Nursing and Personal Care Policy Manual, subject Self-Medication, Policy #NPC J-20, effective date November 2011, indicated medications that are self-administered by the resident must be stored in a secure area or kept on his/her person.

Record review and an interview with RPN #128 confirmed resident #039 as being able to self-medicate two identified medications.

The inspector and PSW #129, observed on an identified date in November, 2015, at resident #039's bedside, one of the medications on top of the bedside table and was not secured in the locked bedside drawer or kept on his/her person.

2-The home's policy in Medical Pharmacies Manual, subject Physician's Medication Review, Policy #8-5, dated January 2014, revealed when checking a new medication review, the nurse must go back to the previous medication review and check all orders written since that review and update the new medication review form to reflect all orders as being current. The policy indicates once the review is signed by the physician; any order not included in the medication review is automatically discontinued.

Record review of resident #039's ability to self-medicate order, which had been initially ordered in May, 2015, revealed two medication reviews had been completed and processed on two identified dates. Resident #039's self-medicate order had not been transcribed onto the medication reviews and the resident continued to self-medicate.

3-The home's policy in Medical Pharmacies Manual, subject Handling of Medications, Policy #5-1, dated January 2014, indicated eye drops must be dated when opened and removed when expired and medications with an identified stop date ordered by a physician must be removed from use.

On November 19, 2015, the following expired medications were found on the medication cart in an identified home area:
Resident #040's and #041's eye medications had not been discarded after being opened for 28 days and resident #042's medication was not discarded after seven days.

Interviews with RPN #128 and the DRC confirmed:
1-the home's policy for Self-Administration had not been followed and the resident's

medication was not stored in a secure area or kept on his/her person,
2- the home's policy for processing Physician Medication Reviews had not been followed and the order for the Resident to self-medicate had not been transcribed to the Physician Medication Review to determine if the order to self-medicate was to be renewed or discontinued,
3- the home's policy for the Handling of Medications was not followed and the medications should have been discarded as directed. [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 have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the following policies are complied with: Self-Medication, Physician's Medication Review, and Handling of Medications, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

On November 6, 2015, during the Resident Quality Inspection tour of the building, the inspector observed six windows that were fully opened.

1-In an identified home area in both resident lounge areas four windows were fully opened and in one of the lounge areas there were five residents.
2-In a second identified home area in both resident lounge areas two windows were opened fully.

An interview with the ESM confirmed the windows were opened more than 15 centimeters and accessible to the residents. [s. 16.]

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 every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required.

In an interview a resident revealed he/she had dentures and pain on the lower gum where the lower denture rubbed on the root of a tooth. The resident recalled an appointment with the dental hygienist over a year ago.

Record review failed to locate a dental assessment for 2015.

An interview with the NM confirmed the resident had not been offered the annual dental assessment for 2015. [s. 34. (1) (c)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home responds in writing within 10 days of receiving Residents' Council advice related to food concerns.

Review of the Residents' Council meeting minutes revealed the Residents' Council addressed food related concerns and questions in the July 13, 2015, meeting.

An interview with the Administrator and Dietary Supervisor revealed a written response within 10 days of receiving the Residents' Council food concerns was not provided to Residents' Council and to date a written response had not been provided. [s. 57. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food is served at a temperature that is both safe

and palatable to the residents.

On November 6, 2015, at lunch, in an identified dining room, three pans: pureed quiche, pureed peas and minced peas were observed placed on top of a lid covering a steam table well and not within the steam table well.

At 12:28 an identified resident was served a pureed entree with the pureed quiche probed at 39.9 degrees Celsius and pureed peas at 40.4 degrees Celsius.

At 12:32 the temperatures of the three pans of food held on top of the steam table well were taken. The temperatures were identified as follows: pureed quiche was 39.0 degrees Celsius; pureed peas 40.4 degrees Celsius and minced peas 40.7 degrees Celsius. The temperatures were confirmed by dietary aide #114.

Observation of the identified steam table well, containing the hot foods, was not turned on.

Dietary aide #114 confirmed the steam table well dial had not been turned on.

The home's policy DM-F-10 Food Service Temperatures - stated hot foods are to be held and served at 60 degrees Celsius or hotter.

An interview with the dietary supervisor confirmed all hot food pans are to be held within the steam table well and the pureed food temperatures identified were not held and served at the appropriate temperature of a minimum 60 degrees Celsius. [s. 73. (1) 6.]

2. The licensee has failed to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs.

At 12:22 on November 6, 2015, in an identified dining room, a resident was observed being totally assisted with his/her soup by staff member #113 with the resident's second course of a pureed entree in front of him/her. Staff member #113 continued to totally assist resident #026 with his/her soup until completion at 12:28. Staff member #113 confirmed the meal service was not served course by course.

An interview with the dietary supervisor revealed the home has a "Live to Eat" dining program and staff are expected to serve the residents course by course. The dietary supervisor further confirmed there was no indication for the resident to receive both

courses at the same time. [s. 73. (1) 8.]

Issued on this 29th day of January, 2016

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

Original report signed by the inspector.