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

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

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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
Dec 12, 2016	2016_334565_0015	030187-16	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

MATTHEW CHIU (565), SIMAR KAUR (654)

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): October 18, 19, 20, 21, 24, 25, 26, 31, November 1, 2, and 3, 2016.

During the course of the inspection, Critical Incident Intakes #025132-16 and #031217-16 related to falls prevention and management were inspected.

During the course of the inspection, inspectors #565 and #654 conducted complaint inspection #2016_432654_0007 concurrently. Finding of non-compliance was identified under O. Reg. 79/10, s. 49 (2) related to resident #020 is issued together with the non-compliances of this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care, Dietary Supervisor, Resident Assessment Instrument - Minimum Data Set Coordinator, Wound Care Nurses, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Physiotherapist, Physiotherapy Aide, Residents, and Family Members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining services, record review of relevant resident and home records, meeting minutes for Residents' Council, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

7 WN(s)
4 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. (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 plan of care was reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

Review of two Critical Incident System (CIS) reports revealed resident #007 fell in the summer of 2016, sustained an identified injury, and two months later the resident fell again and sustained another identified injury. Both injuries caused a significant change in the resident’s health condition.

Review of resident #007’s progress notes and plan of care indicated the resident had both physical and cognitive impairments and was at risk for falls. Further review of the resident's health record identified a history of multiple falls since he/she was admitted to the home. As a result of the multiple falls, the resident sustained multiple identified injuries within a five-month period.

Further review of resident #007’s plan of care indicated that during this five-month period, the falls prevention interventions had not been revised after three identified falls, and the resident fell again subsequently.

Interviews with Personal Support Worker (PSW) #109, #110, Registered Nurse (RN) #113, and the Physiotherapist (PT) indicated the resident was at risk for falls due to impaired cognition and physical function. The staff members indicated after the resident returned from hospital in the summer of 2016, he/she kept falling multiple times and the above mentioned falls prevention interventions were ineffective in preventing the resident from falling. RN #113 and the PT further indicated the falls prevention plan of care was not revised after the three identified falls as mentioned above.

Interview with the Director of Resident Care (DORC) confirmed the falls prevention plan of care for the resident was not revised when the care set out in the plan had not been effective. [s. 6. (10) (c)]

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 plan of care is reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident has fallen, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls if required.

a. Review of two CIS reports revealed resident #007 fell in the summer of 2016, sustained an identified injury, and two months later, the resident fell again and sustained another identified injury. Both injuries caused a significant change in the resident's health condition.

Review of resident #007's progress notes and plan of care indicated the resident had both physical and cognitive impairments and was at risk for falls. Further review of the resident's fall history indicated the resident fell on multiple identified dates in 2016 since he/she was admitted to the home.

The home's practice is when a resident has fallen, a post-fall assessment should be conducted using the home's Post Fall Assessment on Point Click Care (PCC). Review of

the assessment records indicated no post-fall assessment was completed for resident #007's falls on two identified falls in 2016.

Interview with RN #113 indicated the resident fell on an identified date and sustained an identified injury. When he/she returned from hospital, the resident fell again several times. On another identified date about one month later, the resident was found sitting on the foot rest of the wheelchair and sustained no injury. The staff member further indicated no post-fall assessment was conducted for these two falls.

b. A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to the provision of care for resident #020 including concerns related to falls.

Review of resident #020’s progress notes and plan of care indicated the resident had both physical and cognitive impairments and was at risk for falls. On an identified date, the resident was found sitting on the floor in his/her room. The incident was unwitnessed and the resident had no injury. Review of the assessment records indicated no post-fall assessment was completed for this fall.

Interview with PSW #116 who discovered the incident stated he/she did not recollect the details. By reading the staff member’s own record in progress notes, he/she indicated it was a fall. Interview with Registered Practical Nurse (RPN) #118 indicated the home would have considered the incident as a fall, and no post-fall assessment was conducted for the resident’s fall.

Interview with the DORC confirmed that post-fall assessments were required for the above mentioned falls for resident #007 and #020, and they were not conducted as required. [s. 49. (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 when the resident has fallen, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls if required, to be implemented voluntarily.

WN #3: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During stage one of the Resident Quality Inspection (RQI), Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment revealed resident #001 had a worsening altered skin integrity.

Record review of an identified clinical assessment revealed that resident #001 was noted to have a specified altered skin integrity. Further review of the assessment records indicated two other skin assessments were conducted on two identified dates later. There was no skin assessment record for about two months since the first identified assessment and no skin assessment record for a two-week period between the second and the third assessments.

Interview with PSW #123 revealed that the resident had the specified altered skin integrity and had been using an identified equipment for the last two months for his/her condition. Interviews with RPN #124 and Wound Care Nurse #125, confirmed that resident #001 was not reassessed on a weekly basis by a registered staff member during the above mentioned periods.

Interview with the DORC indicated that residents with altered skin integrity are required to be reassessed at least weekly by a member of the registered nursing staff using the Wound Assessment Tool in PCC. The DORC confirmed that resident #001 was not being reassessed weekly as required. [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, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstance of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

a. During stage one of the RQI, staff interview revealed a specified medical intervention was put in place for resident #003.

Review of resident #003's RAI-MDS admission assessment revealed the resident had been continent of bowel and frequently incontinent of bladder. Further review of the RAI-MDS assessments revealed the resident's continence status had changed and the resident had become incontinent of bowel since the summer of 2015.

Review of resident #003's assessment records indicated the resident had received an assessment using the home's Admission/Comprehensive Continence Assessment tool in PCC on an identified date in 2013. The assessment did not include the type of incontinence and the potential to restore function with specific interventions.

Interviews with PSW #109, #110, RPN #112, and RN#113 indicated the resident's bowel continence status had changed from continent to incontinent in the summer of 2015. RPN #112 and RN #113 further indicated the resident had not received a comprehensive

continence assessment when he/she became incontinent of bowel at that time, and the comprehensive continent assessment tool did not include types of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

2. b. During stage one of the RQI, the RAI-MDS assessment data revealed resident #007 had a decline in his/her continence status.

A review of resident #007's RAI-MDS admission assessment revealed the resident was continent of bowel and usually continent of bladder. The RAI-MDS assessment further revealed the resident's continence status had changed to incontinent of both bowel and bladder about three months later.

A review of the assessment records indicated upon admission, the resident had received a continence assessment using the home's Admission/Comprehensive Continence Assessment tool, but it did not include the type of incontinence and the potential to restore function with specific interventions.

Interviews with PSW #109 and RN #113 indicated the resident had been incontinent of both bowel and bladder. RN #113 indicated the resident had not received the comprehensive continence assessment when he/she became incontinent.

Interview with the DORC indicated the home had been using the Admission/Comprehensive Continence Assessment tool in PCC for continence assessment and it did not include identification of type of incontinence and potential to restore function with specific interventions. The DOC confirmed that when resident #003 became incontinent of bowel, and that when resident #007 became incontinent of bowel and bladder, they did not receive a continence assessment as required. [s. 51. (2) (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 each resident who is incontinent received an assessment that includes type of incontinence and the potential to restore function with specific interventions, and that where the condition or circumstance of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the copies of the inspection reports from the past two years for the long-term care home are posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

During the RQI inspection initial tour on October 18, 2016, and subsequent observations on October 18 and 26, 2016, a binder was observed at the main entrance of the home with the information available for the public including public copies of the inspection reports. Inspection report #2015_299559_0023 dated January 27, 2016, was not posted.

Interview with the Administrator revealed that the home posted the above mentioned inspection report in the binder at the main entrance in January 2016. The Administrator stated the report could have been taken by a family or staff member, and confirmed that the inspection report was not posted in the home at the time of this inspection. [s. 79. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed, of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

Review of an identified CIS report and progress notes revealed resident #007 fell on an identified date. The resident was transferred to hospital and diagnosed with a specified medical condition on the same day, and it resulted in a significant change in the resident's health condition. The CIS report was submitted to the Director two days after the fall.

Interviews with RN #113 and the DORC indicated the home was aware of the resident's diagnosis as result of the fall on the same day. The DORC confirmed that the incident was not reported until two business days after the occurrence of the incident. [s. 107. (3) 4.]

WN #7: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

The RQI stage one observations of two resident shared bathrooms revealed unlabelled personal care items:
- October 19, 2016, a kidney basin and a toothbrush in an identified bathroom,
- October 20, 2016, two baskets of toiletries in another identified bathroom.

Interview with PSW #120 confirmed that the above mentioned kidney basin and toothbrush belonged to resident #021, and they were not labelled.

Interview with PSW #122 indicated that the above mentioned two baskets of toiletries, one belonged to resident #022 and another belonged to resident #023. The staff member confirmed both baskets and the personal care items in the baskets were not labelled.

Interview with the RPN #121, PSW #120 and #122 revealed that the personal care items in residents shared bathrooms should be labelled for infection control purposes. RPN #121 further indicated that PSWs should label the personal care items for the resident by using a permanent marker.

Record review of the home’s policy entitled "Infection Control Policy Manual" (Policy #IFC B- 50, effective date December 2015) revealed the following:
- Personal care supplies, e.g. lotions, creams, soaps, razors, combs, soaps, brushes, etc. should NOT be shared with other residents. These items must be labelled if:
a. They are stored in a common area such as spa rooms.
b. The resident does not have a private accommodation.

Interview with the DORC indicated that the personal care supplies are required to be labelled and not to be shared with the other residents who share accommodation and bathrooms. The DORC confirmed that the staff did not participate in implementation of infection prevention and control program. [s. 229. (4)]

Issued on this 12th day of January, 2017

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

Original report signed by the inspector.