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
Mar 31, 2017	2017_414110_0004	031100-16	Complaint

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

DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 22, 23, 24, 27, 2017

Complaint log #031100-16 was the focus of this inspection.

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

The following Inspection Protocols were used during this inspection:

Personal Support Services
Recreation and Social Activities

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

- **4 WN(s)**
- **1 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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the 24-hour admission care plan was based on the resident's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co-ordinator.

A complaint was received by the Ministry of Health and Long Term Care, related to the lack of proper hygiene care during resident #001's respite stays.

Record review identified that resident #001 had two separate respite stay in an identified time frame.

Record review identified two separate documents entitled 24-hour Plan of Care Form, policy #NPC D-95-5 in resident #001's archived chart. One form package was dated resident #001's first stay and the other was dated his/her second stay. The 24 hour plan of care form included areas to identify residents diagnosis, any behavioural/emotional needs, cognition, allergies, pain, communication and hearing, vision and activities of daily living (ADL's) for front line staff. The plan did not include customary routines and comfort requirements.

Resident's first stay plan of care was incomplete and second stay plan of care was blank.

Interview with RPN #106 revealed the PSWs are to refer to this 24 hour care plan to direct what care to provide the resident and he/she further revealed that the admitting RPN was required to complete the form during admission. RPN #106 confirmed that the he/she had admitted resident #001 on an identified date although could not recall or place him/her. RPN #106 further confirmed that he/she did not complete the 24hour plan of care form.

Interviews with PSW #109 and #108 revealed that a care plan is usually not in place for respite stay residents.

Interview with the DRC revealed that the 24 hour plan of care was not complete in identifying resident #001's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co-ordinator, including ADL's and customary routines and comfort requirements. [s. 24. (4)]

2. Record review identified resident #003's last respite stay had been for an identified eight day period.

Record review identified one document entitled 24-hour Plan of Care Form, policy #NPC D-95-5 in the resident's archived chart. The package was dated according to the resident's last stay. A review of the plan of care revealed it was incomplete including sections related to activities of daily living.

Interviews with PSW #109 and #108 revealed that a care plan is usually not in place for respite stay residents.

Interview with the DRC revealed that the 24 hour plan of care was not complete in identifying resident #003's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co-ordinator, including ADL's and customary routines and comfort requirements. [s. 24. (4)]

3. Record review identified resident #004's respite stay over a four day period in an identified month.

Record review identified one documents entitled 24-hour Plan of Care Form, policy #NPC D-95-5 in the resident's chart. The package was dated according to the residents four day stay. A review of the plan of care revealed it was blank including sections related to activities of daily living.

Interviews with RPN #106 and #112 revealed the PSWs are to refer to this 24 hour care plan to know what care to provide and that the admitting RPN was required to complete the form during admission.

Interviews with PSW #109 and #108 revealed that a care plan is usually not in place for

respite stay residents.

Interview with RPN #112 revealed that the 24 hour plan of care was not complete in identifying resident #004's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co-ordinator, including ADL's and customary routines and comfort requirements. [s. 24. (4)]

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 care set out in the 24-hour admission care plan is based on the resident's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co-ordinator, 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 :

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's organized program of nursing services included a policy # NPC D-95, entitled 24-Hour Plan of Care, effective date: September 2012.
The purpose of the policy stated was to ensure a comprehensive assessment is completed on each new Resident admitted to a County of Simcoe Long Term Care Home in order to ensure all required information is received, all Ministry of Health Standards are met and a Care Plan is initiated within 24 hours of a Resident's admission.
The policy directs registered staff as follows:
C. When the Resident is admitted, the Registered Staff on duty at the time of admission will obtain, confirm or amend the information with the Resident and / or the Family. An "Admission Note" will be completed on PointClickCare®.
D. The 24-Hour Plan of Care, once completed, will be made available for PSW. The Multidisciplinary Team will consult and amend as necessary. Any changes added will be dated and signed by the Staff Member who made the change.

Record review of resident #001, #003 and #004 confirmed the 24 hour plan of care's were blank or incomplete.

Interview with RPN #112 confirmed that the 24 hour care plans were not always being completed.The RPN further identified that the admission process including respite admissions needs to be revisited to ensure completion of forms and proper communication with the families.

Interview with the DRC confirmed the home's policy was not followed with respect to completing the 24 hour plan of care. [s. 8. (1) (b)]

WN #3: 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 failed to ensure that the resident bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was received by the Ministry of Health and Long Term Care, related to the lack of proper hygiene care during resident #001's respite stay.

Record review identified that resident's first respite stay was for a period of nine days in an identified month.

Progress notes revealed the day of discharge the resident's POA called the home to report his/her concern that resident #001 appeared unclean, stating it was clear that he/she did not get a bath. The note revealed that staff informed the resident's POA that resident #001 had refused both his/her baths, and the POA stated this was due to the fact that they were not being offered according to his/her preference.

Record review of the 24 hour plan of care failed to identify resident's bathing choice.

Record review of the activities of daily living (ADL) flow sheets identified the resident's two scheduled bath days during his/her respite stay but the ADL form was blank failing to confirm if a bath or shower was offered or provided.

Record review of the progress notes identified an afternoon PSW offered resident a bath or shower on a separate day and that the resident refused.

Staff interviews with PSW's #110, #108 and #109 revealed they were either unable to recall the resident; recall his/her bathing preference or if the resident had a bath or shower during his/her nine day stay.

Interview with the DRC confirmed that staff are expected to document in the ADL flow sheet when a bath was provided or refused and that there was no evidence that the resident was bathed, at a minimum, twice a week by the method of his or her choice. [s. 33. (1)]

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 each resident receives oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

A complaint was received by the Ministry of Health and Long Term Care, related to the lack of proper hygiene care during resident #001's respite stay.

Record review identified that resident #001's first respite stay was for an identified nine day period.

Progress notes revealed that on an identified date, four days following resident's admission, resident #001's POA approached PSW #110 twice at different times and told PSW #110 that resident #001 needed his/her teeth brushed. The note revealed that PSW #110 apologized to the POA, was unsure of why it had not being done and assured the POA that care would be provided that night. PSW #110 documented that a new tube of toothpaste was opened up that night, the toothpaste that the POA had brought at the beginning of the resident's stay and that the foil was still on the tube. The progress note further revealed that staff #110 gave resident his/her tooth brush loaded with paste and the resident brushed his/her own teeth.

Record review of the 24 hour plan of care identified resident #001required extensive assistance for personal hygiene.

Interview with PSW #110 revealed knowledge of the incident and stated that the resident's teeth appeared unbrushed and that he/she was upset when he/she peeled off the foil on the toothpaste as it appeared the resident had not been assisted with brushing his/her teeth since admission.

Record review of the Follow-up Question Report, AM/PM Care, whereby PSWs document when oral care was provided, identified that PM mouth care or brushing was not documented as provided three days during his/her stay, leading up to the POA's observation and concern.

An interview with the DRC confirmed that mouth care was expected to be provided to resident #001 twice a day and staff are expected to document when care was provided or refused. The DRC acknowledged that there was no indication that resident #001 received mouth care twice a day. [s. 34. (1) (a)]

Issued on this 31st day of March, 2017

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

Original report signed by the inspector.