Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2020	2020_772691_0013	024293-19, 011773-20	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

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

JENNIFER NICHOLLS (691)

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): July 6-10, 2020.

The following intakes were inspected upon during this Critical Incident System inspection:

-Two intakes submitted to the Director regarding an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, Associate Director of Resident Care (ADRC), Registered Nurses (RNs), Registered Practical Nurse (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector also conducted a daily walk through of resident care areas, observed the provision of care towards residents, reviewed relevant health care records, and internal investigation documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

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	Légende 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care was based on, at a minimum, an interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A (CI) report was submitted to the Director on an identified dated related to an injury to a resident for which the resident was taken to hospital. The CI report also indicated that resident #002 was identified near resident #003.

Inspector #691 conducted a review of resident #002’s identified health care records which indicated that resident #002 had a history of identified responsive behaviors.

Inspector #691 reviewed resident #002’s care plan and identified a focus of behaviors but there were no identified responsive behaviors with specific interventions. A further review of resident #002's clinical records, including specified progress notes, revealed that the resident had a history of identified responsive behaviors. Progress notes identified that resident #002 had exhibited these behaviours on multiple separate incidents since an identified date.

During separate interviews with PSW #105, PSW #107, RPN #104 and RPN #106, which all indicated that resident #002 had exhibited specified responsive behaviors on multiple occasions.

Inspector #691 reviewed the home's policy titled “Nursing and Personal Care Policy Manual-Responsive Behavior Program policy" D-20 -Responsive Behavior Program last revised September 2019. The policy stated that the plan of care should adopt strategies for the causes and responses to triggers and responsive behaviors and minimize the risk of altercations and to update care plan to reflect potential risks and support strategies that may be used. The policy further identified using high risk rounds to discuss residents with identified behaviors and to trial new interventions. The policy further indicated that the nursing team will ensure that the plan of care has identified risk and strategies with clear interventions for staff that is updated and evaluated for effectiveness.

Inspector #691 reviewed the home’s policy titled “Nursing and Personal Care Policy Manual, Orientation and Routines” NPC B-20 effective February 2020. The policy stated that the responsibility of the RN was to ensure that the residents plan of care had been updated to include behaviors and interventions.

During separate interviews with PSW #105, PSW #108, RPN #104 and RPN#107, they indicated that the care plan for resident #002 identified responsive behaviors but did not identify responsive behaviors indicating specified interventions to respond to those behaviors.

During an interview with RN #106, they indicated that the care plan for resident #002 identified a focus of responsive behaviors but indicated that there should be more indicators to alert staff of the identified specified responsive behaviors.

During an interview with the ADRC, Inspector #691 reviewed the care plan for resident #002, the ADRC confirmed that there was a focus of behaviors but did acknowledge that the care plan was a “bit light” on identifying resident #002 had specified responsive behaviors. [s. 26. (3) 5.]

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 plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. 1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours,
(c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the residents responses to interventions were documented.

A (CI) report was submitted to the Director on an identified dated related to an injury to a resident for which the resident was taken to hospital. The CI report also indicated that resident #002 was identified near resident #003.

Inspector #691 conducted a record review of resident #002's progress notes, which indicated resident #002 had a specified type of assessment initiated on a identified date.

A) Inspector #691 reviewed resident #001's specified type of assessment, for a period of seven days.The Inspector identified missing documentation on three occurrences during the specified period of time.

B) Inspector #691 reviewed resident #001's specified type of assessment, for a period of seven days.The Inspector identified missing documentation on three occurrences during the specified period of time.

C) Inspector #691 reviewed resident #001's specified type of assessment, for a period of seven days.The Inspector identified missing documentation on four occurrences during the specified period of time.

D) Inspector #691 reviewed resident #001's specified type of assessment, for a period of seven days.The Inspector identified missing documentation on three occurrences during the specified period of time.

E) Inspector #691 reviewed resident #001's specified type of assessment, for a period of seven days.The Inspector identified missing documentation on three occurrences during the specified period of time.

F) Inspector #691 reviewed resident #001's specified type of assessment, for a period of seven days.The Inspector identified missing documentation on four occurrences during the specified period of time.

G) Inspector #691 reviewed resident #001's specified type of assessment, for a period of seven days.The Inspector identified missing documentation on five occurrences during the specified period of time.

Inspector #691 reviewed a specific policy last revised September 2019. The policy indicated that staff would participate in the documentation that was required for any assessment of the resident.

Inspector #691 reviewed a specific policy effective February 2020. The policy indicated that staff would ensure that all documentation was completed for their shift.

The Inspector interviewed PSW #102, PSW #105, and PSW #108, and RN # 106 whom all confirmed that residents who required the specified type of assessment had documentation completed for an identified period of time, and further indicated that there was missing documentation.

Inspector #691 interviewed the ADRC, who verified that all staff were trained on documentation and could document on the specified type of assessment. The ADRC confirmed that it was the expectation that any staff member that worked on the unit, were to document for the entire shift. The ADRC acknowledged that the specified type of assessment for resident #002 was not completed as required. [s. 53. (4) (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 ensure that all provisions of care, is documented as required for each resident, to be implemented voluntarily.

Issued on this 21st day of July, 2020

[redacted]

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

Original report signed by the inspector.