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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Apr 29, 2022	2022_906687_0003	018326-21, 019148-21, 019756-21, 020786-21, 002026-22, 002077-22	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

LOVIRIZA CALUZA (687), KAREN HILL (704609)

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): March 21-25 and March 28-31, 2022.

The following intakes were inspected upon during this Critical Incident System (CIS) Inspection:
- Three logs related to fall incidents that resulted in resident injuries;
- One log related to an alleged financial abuse of a resident;
- One log related to an environmental incident from a resident room, and
- One log related to a physical altercation between two residents.

A follow-up (FU) Inspection #2022_906687_0004, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Infection Prevention and Control (IPAC) Lead, Maintenance Manager, Environmental Support Services Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Social Worker, Maintenance Coordinator, Administrative Assistants (AAs), Physiotherapy Assistant (PTA), Personal Support Workers (PSWs), Housekeepers, Recreation Aide, COVID-19 Screener, family members and residents.

The Inspectors conducted daily observations of the provision of care to the residents, staff to resident interactions, Infection Prevention and Control (IPAC) practices, and reviewed health care records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

6 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	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 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 a resident's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A resident fell and sustained an injury. A falls intervention was implemented as a falls prevention strategy at that time.

The resident's electronic care plan was reviewed and identified that the falls intervention that was implemented was not included.

Registered staff members and management confirmed that the resident required a falls intervention as a safety strategy and that the plan of care was supposed to be reviewed and revised.

Sources: CIS reports; resident observations; review of resident's health record; the home's policy titled "Falls Management Program", interviews with Personal Support Worker (PSW), Registered Practical Nurse (RPN), Registered Nurse (RN), Physiotherapy Assistant (PTA), the DOC, the Administrator, and other staff members. [s. 6. (10) (b)]

2. A resident requested assistance to use the washroom. Two staff members were observed assisting the resident to a nearby washroom.

The resident's electronic care plan, under the focus "Continence Care", indicated that the

resident was unable to use the washroom due to an injury.

The RPN confirmed that the resident’s condition had since improved and they were currently able to use the washroom with the assistance from staff.

The Administrator verified that when a resident’s care needs had changed or when the plan of care was no longer required or relevant, the plan of care was supposed to be updated to reflect the resident's current care needs.

Sources: CIS reports; observation with resident and staff members; review of resident’s health record, and interviews with the RPN, and the Administrator. [s. 6. (10) (b)]

3. An isolation signage was observed in front of a resident's bedroom door. The resident’s electronic care plan did not indicate an isolation focus for the resident.

Staff members indicated that resident was on isolation related to an infection. The RPN and the Infection Prevention and Control (IPAC) Lead both verified that the resident’s care plan was not updated to reflect this change.

Sources: Resident and staff observations; review of resident's health care records, and interviews with the RPN, the IPAC Lead and other staff members. [s. 6. (10) (b)]

4. A resident had three separate fall incidents in the home within a two month period. The resident's post fall risk assessment record indicated a specific risk level for falls.

The resident's electronic care plan under the focus for “Safety”, indicated that the resident was at a different risk level for falls.

The home’s policy titled “Falls Management Program”, dated September 2019, indicated that registered staff were responsible to update the care plan with resident specific information and interventions to reflect the resident's care needs.

The RPN acknowledged that resident’s electronic care plan was not reviewed and revised after their fall incident. The DOC and the Administrator both verified that when a resident's care needs had changed, the plan of care was supposed to be updated to reflect the change.

Sources: A CIS report; review of resident’s health record; the home’s policy titled “Falls

Management Program”; and interviews with staff members, the DOC, and the Administrator. [s. 6. (10) (b)]

5. A review of the home's high risk rounds documentation record indicated that on two separate dates, a resident's falls intervention was ineffective and another intervention was initiated.

The resident’s electronic care plan under the focus for “Safety”, indicated two interventions.

Observation of the resident and discussion with staff members confirmed that one of the resident's fall interventions in their room was no longer current.

Staff members and the DOC all confirmed that the falls prevention strategies in resident's electronic care plan record were confusing. The resident's care plan was supposed to be updated to reflect the current care needs of the resident.

Sources: A CIS report; observations of the resident and staff members; review of resident’s health record; the home’s policy titled “Falls Management Program”, review of high risk rounds; and interviews with staff members, the DOC, and the Administrator. [s. 6. (10) (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 ensure that a resident's plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, 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 has failed to ensure that the resident's post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls prevention.

A resident had four separate fall incidents and it was identified that two of the fall incidents had no post fall assessments completed.

The home’s policy titled “Falls Management Program” dated September 2019, indicated that the post fall management of residents included the completion of a post fall assessment.

Registered staff members and management all verified that a post fall assessment must be completed by a registered staff member for every resident fall incident.

The post fall assessment not being completed by the registered staff after every fall incident posed an increased risk to the resident, related to lack of clinical assessment and information gathered after the fall incident and any appropriate falls prevention interventions that should have been implemented.

Sources: A CIS report; review of resident’s health care records; the home’s policy titled “Falls Management Program”, and interviews with staff members, the DOC, and Administrator. [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 a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls prevention, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an organized program of maintenance services were in place for routine and preventative maintenance in the home.

A resident in a home (HA) area was identified with equipment where multiple electrical devices were plugged in. Another resident's room was also identified with two pieces of equipment where several electrical devices were also plugged in.

The home’s policy titled “Preventative Maintenance”, effective date January 2020, indicated that "Each piece of equipment would be inspected as outlined by the preventative maintenance to ensure that everything would be in good repair, condition, and correct any deficiencies. Extension cords were prohibited and were not to be used".

The Maintenance Coordinator stated that they had checked the resident home areas and they were not made aware of the resident's equipment. The Maintenance Manager acknowledged that no extension cords or power bars were allowed in the home due to risk of resident's safety.

Sources: A CIS report, observation of residents' rooms; review of residents' health care records; review of home’s policy titled “Preventative Maintenance”, and interviews with the Maintenance Coordinator, the Maintenance Manager, and other staff members. [s. 90. (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 ensure that an organized program of maintenance services are in place for routine and preventative maintenance in the home, to be implemented voluntarily.

WN #4: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and

ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day regarding an incident that caused an injury to a resident which resulted in a significant change in their health status.

A resident had a fall incident; sustained an injury, and was transferred to the hospital for treatment and follow-up care the same day.

The Inspector reviewed the Long-Term Care Home (LTCH) portal and was unable to locate a Critical Incident System (CIS) Report that had been submitted to the Director regarding the resident's fall incident.

The DOC confirmed that a CIS report was not submitted to the Director regarding the resident's fall incident.

Sources: Review of the LTCH portal; resident's health care records, and interview with the DOC. [s. 107. (3)]

2. The licensee has failed to ensure that the Director was provided with the outcome after a fall incident that resulted in an injury and transfer to the hospital involving two residents.

A resident had a fall incident; sustained an injury, and was transferred to the hospital the same day.

Another resident had a fall incident; was transferred to the hospital the same day and subsequently diagnosed with an injury.

The Inspector reviewed the CIS reports and identified that there were no updates to include the resident's status upon return from the hospital.

The Administrator verified that it was the responsibility of the staff member who completed the CIS report to provide an update about the outcome of the fall incident including the resident's status, and that the update was not provided as required.

Sources: CIS reports; review of the residents' health care records; the homes policy titled "Critical Incident Reporting", and interview with the Administrator. [s. 107. (4) 3.]

3. The licensee has failed to ensure that the Director was provided with a written report of the fall incident analysis of the three residents that had fall incidents which included any long-term action plans to prevent recurrence.

It was identified that there were three residents who were involved in four separate fall incidents which resulted in hospital transfers.

The CIS reports that involved the residents were reviewed and it was identified that they did not include any long-term action plans to correct the situation or prevent the recurrence of the fall incidents.

The DOC acknowledged that when a resident had a fall incident that resulted in a significant change, the CIS report must be updated along with the long-term action plans to prevent recurrence of fall incidents. The Administrator verified that the CIS reports were supposed to be amended to include the required information.

Sources: CIS reports; review of residents' health care records; the homes policy titled "Critical Incident Reporting", and interviews with the DOC and the Administrator. [s. 107. (4) 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 Director was informed no later than one business day of an incident that caused an injury to a resident resulting in a significant change in their health status; to ensure that the Director is provided with the outcome after a resident's fall incident requiring transfer to the hospital, and to ensure that the Director is provided with a written report of the analysis and findings of their investigation that caused an injury to a resident, to be implemented voluntarily.

WN #5: 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 has failed to ensure that where the Act or this Regulation required, the licensee of a long-term care home to have, institute or otherwise put in place any system, and that the system was complied with.

In accordance with O. Reg. 79/10, s. 49 (1), the licensee was required to ensure that the Falls Prevention and Management Program provided strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home’s policy titled “Head Injury", which indicated that, “Any resident who potentially may have sustained an injury to the head would be promptly assessed and have a head injury routine (HIR) initiated”.

A resident had three unwitnessed fall incidents in the home in a two month period. The HIR documentation record on two separate dates revealed that the resident was not assessed as they were sleeping. In another HIR documentation record, it was revealed that the resident was sleeping again and was not assessed. By the time the resident was assessed, the resident had a significant change in their health status which required transfer to hospital.

The DOC acknowledged that the registered staff were expected to follow the home's HIR policy and should have completed the assessments on the HIR tool as required.

Sources: A CIS report; review of resident’s health record; resident's HIR monitoring tools;

review of the home’s policy titled “Head Injury", and interview with the DOC. [s. 8. (1)]

2. A resident was identified with six (6) fall incidents within a two month period. The post fall HIR documentation record indicated that either the resident was sleeping at that time or no HIR documentation was completed.

The RPN stated that when a resident had a fall incident and they were identified with a head injury, their responsibility was to initiate the post fall HIR as stated in the home's HIR policy.

The DOC acknowledged that the registered staff were expected to follow the home's HIR policy and were supposed to complete the assessments on the post fall HIR tool as required.

Post fall HIR not being initiated or completed can potentially increase the actual risk for a resident by delaying the identification of changes in their health condition and implementation of additional care interventions as needed.

Sources: A CIS report; resident’s health record; resident’s HIR monitoring tools; review of the home’s policy titled "Head Injury", and interviews with the RPN, the DOC, and the Administrator. [s. 8. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to inform the Director of the description of the individuals involved in an incident, including the names of any staff members or other persons who were present at or discovered the incident.

A CIS report indicated that a staff member reported an environmental incident coming from resident's room. The CIS report did not indicate the name of the staff member who discovered the incident.

The home’s policy titled “Critical Incident Reporting” effective date February 2022, indicated that, “In making a report to the Director, the names of the staff member who responded to the incident were to be included”.

During an interview with staff members, a PSW stated that they had discovered the environmental incident from the resident's room and reported this to the RPN. The Administrator was interviewed and stated that they were supposed to include the names of the staff members who discovered the incident in the CIS report but they did not.

Source: A CIS report; review of resident's health care record; the home’s policy titled “Critical Incident Reporting", observation of resident and residents’ rooms, and interviews with PSW, RPN, the Administrator and other staff members. [s. 104. (1) 2. ii.]

Issued on this 30th day of May, 2022

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

Original report signed by the inspector.