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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 24, 2019	2019_747725_0001	025695-17, 026749-17, 027914-17, 024889-18, 028184-18, 032434-18	Critical Incident System

Licensee/Titulaire de permis

S & R Nursing Homes Ltd.
265 North Front Street Suite 200 SARNIA ON N7T 7X1

Long-Term Care Home/Foyer de soins de longue durée

Trillium Villa Nursing Home
1221 Michigan Avenue SARNIA ON N7S 3Y3

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

CASSANDRA TAYLOR (725), ALICIA MARLATT (590)

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): Janurary 21 and 22, 2019.

The following intakes were completed within this inspection;

Critical Incident Systems (CIS) inspection: Log #027914-17/CIS #2217-000012-17 was related to injury resulting in hospitalization,
Critical Incident Systems (CIS) inspection: Log #028184-18/CIS #2217-000014-18 was related to falls prevention and management,
Critical Incident Systems (CIS) inspection: Log #026749-17/CIS #2217-000010-17 was related to falls prevention and management,
Critical Incident Systems (CIS) inspection: Log #025695-17/CIS #2217-000009-17 was related to falls prevention and management,
Critical Incident Systems (CIS) inspection: Log #032434-18/CIS #2217-000017-18 was related to falls prevention and management,
Critical Incident Systems (CIS) inspection: Log #024889-18/CIS #2217-000012-18 was related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, two Managers of Resident Care (MRC), one Resident Assessment Instrument (RAI) Coordinator, one Registered Nurse (RN), four Registered Practical Nurse (RPN) and two Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) reviewed residents' clinical records, Critical Incident System (CIS) reports and Risk Management reports.

During the course of the inspection, the inspector(s) observed the provision of resident care including resident specific routines and staff and resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

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

1 WN(s)
0 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. (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).

Findings/Faits saillants :

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

A Critical Incident System (CIS) Report #2217-000010-17 was submitted to the Ministry of Health and Long-Term Care for resident #002 relating to a fall with injury.

Information contained within the CIS report stated that resident #002 had self-transferred and fell as a result. The resident was assessed and transferred to the hospital where they were diagnosed with a specific fracture.

During a record review of resident #002's plan of care it indicated the resident was a falls risk and that falls interventions were in place.

During staff interviews with Registered Nurse (RN) #106 and Registered Practical Nurses (RPN) #107 and #108 they indicated that the resident was a falls risk. RPN's #107 and #108 also indicated that resident #002 was to have specific falls interventions in place.

During a staff interview with RPN #108, Inspector #725 asked where the specific fall interventions were documented. RPN #108 indicated in Point of Care (POC) and on review no interventions was found. RPN #108 confirmed that the specific intervention was not initiated.

During resident observations on January 22, 2019 at 0930 and 1130 hours the resident did not have a specific intervention in place. Inspector #725 asked RPN #108 to observe resident #002 on January 22, 2019 at 1330 hours. On observation it was confirmed by RPN #108 that resident #002 was not wearing the specific intervention as documented in the care plan.

During an interview with Administrator #100 it was confirmed that the specific interventions should have been in place as specified in the plan of care or documentation that resident refused the intervention.

The licensee has failed to ensure that the specific interventions were in place for resident #002 as specified in the plan. [s. 6. (7)]

Issued on this 24th day of January, 2019

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

Original report signed by the inspector.