Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Aug 13, 2019	2019_533115_0020	011129-19, 014483-19	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

TERRI DALY (115)

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 25 & 29, 2019

The following Critical Incidents related to falls prevention were inspected:
Log #011129-19/Critical Incident #2217-000012-19
Log #014483-19/Critical Incident #2217-000016-19

During the course of the inspection, the inspector(s) spoke with the Administrator, two Managers of Resident Care, Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) reviewed clinical records, critical incidents, the homes investigative notes, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 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	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 was submitted to the Ministry of Long-Term Care on a specific date, related to improper/incompetent treatment of a resident that resulted in harm or risk to a resident.

The report indicated that resident #002 had been involved in an incident resulting in injury.

A review of their clinical record showed resident #002 had been assessed a number of times post falls the past few months and was a high risk for falling.
The resident had some cognitive impairment noted on their most recent MDS assessment and their RAPS indicated: Short and long term memory loss. Poor decision making.

A further review of the clinical record, specifically resident #002's most recent care plan showed specific interventions related to Toilet use/Elimination:
Do not leave resident on toilet - requires 1 staff present for safety.

Under Risk for falls related to: Cognitive impairment, Impaired balance.
Interventions include:
"Falling Leaf" logo indicator on door frame to alert staff of the high potential fall risk.

The investigative notes and critical incident report noted that the Personal Support Worker (PSW) left resident #002 in the bathroom, that they provided resident #002 with the call bell and told them to ring when they were done. When they returned to resident #002's room the Registered Practical Nurse (RPN) was exiting indicating that there had been an incident. The resident was transferred to hospital.

A review of the home's policy RCM 11-01 AM PM Care last revised August 12, 2018 states:
POLICY:
1. Each resident will receive care and services consistent with his/her plan of care and with the resident's rights outlined in the Resident's Bill of Rights.

3. Toileting - Assist as indicated on care plan.

7. Safety - Ensure all safety measure identified on the resident care plan are initiated.

An interview with PSW #105 and RPN #106, both stated that resident #002 was frail, at a high risk for falls, and required staff to stay with them during toileting, per the care plan.

An interview with Manager of Resident Care #101, they stated that staff did not follow the care plan for resident #002 and that this would be expected of all staff in the home.

The licensee had failed to ensure that the care set out in the plan was provided to resident #002 as specified in the plan. [s. 6. (7)]

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 plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 13th day of August, 2019

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

Original report signed by the inspector.