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**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 12, 2014 | 2014_285546_0031 | O-001085-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

TRILOGY LTC INC.
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

TRILOGY LONG TERM CARE
340 McCowan Road SCARBOROUGH ON M1J 3P4

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

SUSAN WENDT (546), ANANDRAJ NATARAJAN (573), MARIA FRANCIS-ALLEN (552), MEGAN MACPHAIL (551)

**Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): October 20, 21, 22, 23, 24, 27, 28, 29, 30 and 31, 2014**

**The following Critical Incident Inspections were conducted as part of this Resident Quality Inspection:**
**001069-14**
**001082-14**
**001956-14**

**During the course of the inspection, the inspector(s) spoke with Residents, Family members, the President of the Residents' Council, the Chair of Family Council, the Regional Director of Operations, the acting Director of Care (Acting DOC), the assistant Director of Care (ADOC), the RAI Coordinator, the Director of Social Services, the Business Manager, the Programs and Support Services Manager, several activity aides, the Environmental Services Manager, several Housekeeping aides, the Food Services Manager, several dietary aides, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), one restorative care attendant, one Physiotherapist, one OT/PT Assistant, one Corporate Nurse Consultant.**

**The following Inspection Protocols were used during this inspection:**

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
7 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

## NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 is provided to the resident as specified in the plan.

On a specific date in July 2014, Resident #009 was diagnosed and treated for aspiration pneumonia by the in-home Nurse Practitioner who referred Resident #009 for chest physiotherapy. On the same day, Resident #009 was kept on isolation by Registered Staff and the Infection Control Coordinator for Respiratory precautions. Resident #009 was assessed by Registered Physiotherapist #114 on a specific date in July 2014, who recommended chest physiotherapy for 3 times a week for 12 weeks. Inspector #573 reviewed Resident #009's physiotherapy daily attendance sheets for the month of July 2014 and observed that Resident #009 was seen once in July 2014 only for chest physiotherapy. On a specific date in March 2014, Resident #016 had a fall and sustained a hip fracture. The resident was admitted to hospital and was surgically treated. Resident #016 returned to the LTCH in April 2014, was assessed by Registered Physiotherapist #114 on a specific date in April 2014, who recommended physiotherapy exercise and ambulation for 3 times a week for 12 weeks. Inspector #573 reviewed Resident #016's physiotherapy daily attendance sheets for the month of May 2014 and observed that Resident #012 was not seen for Physiotherapy treatments from the beginning of May 2014 to mid-May 2014. Inspector #573 reviewed the progress notes which indicated that Resident #016 had been on isolation for an infection at the beginning of May 2014, and upon further reviewing the progress notes, noted that Resident #012 had sustained a fall in mid-May 2014 and was hospitalised. On a specific date in October 2014, the Registered Physiotherapist #114 mentioned during an interview with Inspector #573 that Resident #009 was not seen for chest physiotherapy while on respiratory isolation and that Resident #016 had not been seen for ambulation while on contact isolation. The Physiotherapist stated that it was his own discretion not to provide physiotherapy treatments for residents who were on Isolation in the home.

On a specific date in October 2014, Inspector #573 spoke with the Acting Director of Care who mentioned that residents could be seen for physiotherapy treatments while on isolation with the use of proper Personal protective equipment (PPE) and further stated that being unaware that residents had not been receiving physiotherapy treatments while on isolation. For Resident #009 and Resident #016, the physiotherapy treatments set out in the plan of care were not provided as specified in the plan. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to Resident #022.

On a specific date in October 2014, Inspector #573 observed Resident #022 seated in a tilt wheelchair with no foot rest. The resident's legs were observed to be dangling without any leg support when the wheelchair was in a tilted position and on another date in October 2014, Inspector #573 observed Resident #022 sleeping in a tilted position in the tilt wheelchair, without any foot rest supporting both legs.

Resident #022's plan of care indicated that the resident required the wheelchair at all times and required extensive assistance for locomotion around unit by one staff. Furthermore, the plan of care indicated that the resident, required the assistance of 2 staff to sit in the wheelchair.

On a specific date in October 2014, Inspector #573 brought to a PSW Staff #119's attention that Resident #022's legs were not supported in the tiled position; the PSW Staff applied the foot rest in the tilt wheel chair, so that resident was positioned comfortably. Further PSW Staff #119 stated that when the resident was in the wheelchair, the staff usually applied the foot rest to support both legs.

On a specific date in October 2014, Inspector #573 spoke with RPN #120 who stated that resident was not capable of foot propelling in the tilt wheelchair by self and that the legs should be supported with the foot rest at all times.

On a specific date in October 2014, Inspector #573 spoke with the person in charge of the Restorative Care Program, who mentioned that all nursing staff were trained in positioning residents and further indicated that when a resident was positioned in a tilt position in a tilt wheelchair, the expectation was that nursing staff apply both foot rest. [s. 30. (1) 2.]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.**

**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg 79/10, s. 32 in that the home did not ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

Resident #002 was observed by Inspector #573, on several dates in October 2014, to have long jagged nails on the fingers of both hands and un-groomed long facial hair on the upper lip and chin. Resident #002's plan of care indicated that the resident required extensive assistance for personal hygiene by one staff to assist the resident with daily shaving. Furthermore, the plan of care indicated that the resident fingernails were to be cleaned and trimmed by nursing staff on spa days.

Resident #005 was observed by Inspector #573, on several dates in October 2014, to be un-groomed with excessive thick facial hair. Resident #005's plan of care indicated that the resident required assistance with personal hygiene such as shaving and mouth care daily due to decreased range of motion and impaired voluntary movement on one side due to a cardiovascular accident.

Inspector #573 spoke with PSW #117 who stated that both Resident #002 and Resident #005 required one person physical assistance with daily personal care and grooming. PSW #117 reported that both residents did not have any behavioural concerns where staff would not be able to cut fingernails or shave; furthermore,PSW #117 indicated that shaving for both residents was not done on daily basis.

On a specific date in October 2014, Inspector #573 spoke with RPN #109 who confirmed that both residents required assistance from the PSW for daily shaving since they were not capable of doing it on their own; RPN #109 also agreed with Inspector #573 that Resident #002's nails were unclean and untrimmed and confirmed that Resident #002 had not received fingernail care on assigned shower days. [s. 32.]

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council**

**Specifically failed to comply with the following:**

**s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).**

**Findings/Faits saillants :**

The licensee has failed to ensure that the Home did not respond in writing within 10 days of receiving Resident Council advice related to concerns or recommendations.

On a specific date in October 2014, Inspector #573 spoke with the Residents' Council (RC) President who indicated that being unsure if the licensee responded in writing within 10 days with regards to any advice related to concerns from the Residents' Council.

Inspector #573 reviewed the minutes of the Residents' Council Meetings from June to September 2014. It was observed by Inspector #573 that the licensee responded in writing with regards to the Concerns/Recommendations from the Residents' Council, but not within 10 days.

- For June 30, 2014, the RC meeting issued Dietary concerns (steamed vegetables often overcooked) and issues related to bus transportation for residents with powerchairs; the response date was dated as July 15, 2014.

- For July 28, 2014, the RC meeting issued Laundry concerns (residents getting other residents' clothing on weekly basis); the response date was dated as August 11, 2014.

- For August 25 2014, the RC meeting regarding 6th floor residents with concerns in regards to nursing staff speaking in different language to each other while providing care to the residents; the response date was dated September 12, 2014.

- For September 29 2014, the RC meeting issued recommendations for more social entertainment for residents and issued concerns related to a particular day program that was not available in the activity calendar; the response date was dated October 14, 2014.

Inspector #573 spoke with the Program & Support Services Manager who stated being aware to responding in writing with regards to Concerns/Recommendations from the Residents' Council and further stated that it was the Home's policy to respond in 10 days.

On a specific date in October 2014, Inspector #573 spoke with the Director of regional Operations who stated that the written response with regards to Concerns and Recommendations to the Residents' Council was not given within 10 days and agreed with the Inspector that it had to be within 10 days upon receiving from the Residents' Council. [s. 57. (2)]

**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).**

**Findings/Faits saillants :**

On a specific date in October 2014, Physiotherapist S#114 mentioned during an interview with Inspector #573 that Resident #009 was not seen for chest physiotherapy since the resident had been on respiratory isolation and that Resident #016 was not seen for ambulation since that resident had been on contact isolation. Furthermore, S#114 stated that it was at his own discretion not to provide physiotherapy treatments for the residents who were on isolation precautions in the Home.

During a conversation with Inspector #573 on a specific date in October 2014, the Acting DOC confirmed that residents could be seen for physiotherapy treatments while on isolation, as long as proper infection prevention and control (IPC) precautions were used, including the use of personal protective equipment (PPE); the Acting DOC further confirmed not being made aware that residents, who were on isolation precautions, were not receiving physiotherapy treatments as set out in their plan of care.

In addition, the Acting DOC stated that every staff, including registered physiotherapist and physiotherapy assistants must undergo annual mandatory training in the Home regarding IPC, including the use of PPE.

On a specific date in October 2014, Inspector #573 spoke with Home's Corporate Nurse Consultant who, after reviewing the Home's training and retraining records, confirmed that S#114 had not received IPC retraining since 2012. [s. 76. (4)]

**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

**s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).**

**Findings/Faits saillants :**

On a specific date in October 2014, in a conversation with Inspector #573, the Residents' Council President confirmed that the licensee had not sought the advice of Residents' Council regarding the development of the Home's annual satisfaction survey.

Minutes of Residents' Council Meetings, from January 2014 to September 2014 reviewed by Inspector #573, indicated that Residents' Council's advice had not been requested in the development of the satisfaction survey. Inspector #573 interviewed the Programs & Support Services Manager, who confirmed that Residents' Council had not been consulted with respect to the development and carrying out of the residents' satisfaction survey.

During an interview with Inspector #573 on a given day in October 2014, the Family Council Chair indicated that the licensee had not sought the advice of Family Council regarding the development of Home's annual satisfaction survey.

Inspector #573 interviewed the Director of Social Services who stated that the Family Council had not been consulted with respect to developing and carrying out of the satisfaction survey.

During a conversation with Inspector #573 on a given date in October 2014, the Regional Director of Operations stated that the Home conducted a satisfaction survey every year but that the Home had not sought the advice of Residents' Council and of Family Council in developing and carrying out the Home's annual satisfaction survey. [s. 85. (3)]

**WN #7: 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:**
**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. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident 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. 104 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure that the report to the Director included the following action taken in response to the incident:
ii. whether a physician or Registered Nurse in the Extended Class was contacted

Regarding Log #001081-14 related to Resident #018:
A Critical Incident report was received from the licensee indicating that on a specific date in June 2014, Resident #018 was hit on the hand with a picture frame and kicked by the spouse of a co-resident. The report did not indicate that the MD was notified of the incident.

The clinical health record for Resident #018 as well as the MD/nurse communication binder were reviewed and there was no documented evidence found to support that the MD was notified of the incident.

The registered staff, ADOC and Acting DOC were interviewed and were unable to confirm whether the MD had been informed of the critical incident. [s. 104. (1) 3.]

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**Issued on this 12th day of December, 2014**

| Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs |
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**Original report signed by the inspector.**