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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 13, 2016	2016_179103_0001	002221-15, 030470-15, 000440-16, 007369-16	Complaint

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 4-8, 11-13, 2016

The following logs were included in this inspection: 002221-15 (fall resulting in injury), 030470-15 (alleged staff to resident abuse), 000440-16 (alleged staff to resident abuse), 007369-16 (alleged resident abuse/neglect),

During the course of the inspection, the inspector(s) spoke with residents, Registered Practical Nurses (RPN), Registered Nurses (RN), Personal Support workers (PSW), Business Manager, Assistant Director of Care (ADOC), and the Administrator.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **8 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	Legendé 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. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The following finding relates to Log #000440-16:

The licensee has failed to ensure a written complaint concerning the care of a resident was immediately forwarded to the Director.

On an identified date, resident #002's family member forwarded an email to the Administrator outlining concerns related to the care of resident #002. The home failed to forward this written complaint to the Director (MOHLTC).

A critical incident was submitted on an identified date and amended eight days later outlining the home's investigation into the allegation. To date of this inspection, the written letter of complaint has not been forwarded to the Director. [s. 22. (1)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The following finding relates to Log #030470-15:

The licensee has failed to ensure a verbal complaint that alleged financial abuse of resident #003 was immediately investigated.

O. Reg 79/10 s. 2 (1) defines financial abuse as any misappropriation or misuse of a resident's money or property.

On an identified date, the family member of resident #003 approached the business manager and reported personal items were missing.

The business manager was interviewed and indicated she reported the information immediately to the Administrator and indicated the family member believed the items were missing as a result of a theft.

The Administrator was interviewed and indicated she was advised of the incident by the business manager and that the home took no action at that time to investigate the missing items. She indicated the resident had a cognitive impairment and may have been responsible for the misplaced or lost items.

Two days later, the home met with the family members in regards to their concerns. Later that day, the home was contacted by the police who had been notified by the family.

At the time of this inspection, a compliance order was issued under inspection #2016_179103_0002 to ensure the home's abuse policy reflects the legislated requirements for reporting incidents of abuse. [s. 23. (1) (a)]

2. The following finding relates to Log #000440-16:

The licensee has failed to ensure the results of an alleged abuse investigation was reported to the Director.

On an identified date, the home submitted a critical incident reporting an alleged staff to resident physical abuse involving resident #002. The home completed an internal investigation with inconclusive results and then requested a third party investigator to review the incident.

To date of this inspection, there has been no amendments made to the critical incident report in regards to the outcome of the third party investigation. The home failed to

ensure the results of the alleged abuse investigation was reported to the Director (MOHLTC).

At the time of this inspection, a compliance order was issued under inspection #2016_179103_0002 to ensure the home's abuse policy reflects the legislated requirements for reporting incidents of abuse. [s. 23. (2)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The following finding relates to Log #030470-15:

The licensee failed to ensure an allegation of financial abuse was immediately reported to the Director.

As outlined in WN #2, the alleged financial abuse was not reported to the Director (MOHLTC). To date of this inspection, there has been no notifications made in regards to the alleged abuse.

At the time of this inspection, a compliance order was issued under inspection

#2016_179103_0002 to ensure the home's abuse policy reflects the legislated requirements for reporting incidents of abuse. [s. 24. (1)]

2. The following finding relates to Log #000440-16:

The licensee has failed to ensure that the Director was immediately notified of an alleged physical abuse involving resident #002.

O. Reg 79/10 s. 2 (1) defines physical abuse as:

(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose or,
(c) the use of physical force by a resident that causes physical injury to another resident.

On an identified date, the family member of resident #002 approached RN #101 and informed her of of an injury that the family member believed may have been the result of a physical abuse.

RN #101 was interviewed and indicated the family member was very upset at that time and she accompanied the family member to the resident's room to assess the situation. The RN stated she provided support to the family member and advised the home would investigate.

RN #101 indicated she immediately contacted the Assistant Director of Care (ADOC). The RN indicated she did not notify the police or the MOHLTC and she did not receive any instructions from the ADOC to do so.

ADOC #107 was interviewed and indicated she was notified of the family member's allegation of physical abuse. She further indicated the ministry was notified for the first time by means of the critical incident which was submitted three days after the home became aware of the alleged physical abuse. The ADOC indicated she was aware the notification to the ministry should have been immediate.

At the time of this inspection, a compliance order was issued under inspection #2016_179103_0002 to ensure the home's abuse policy reflects the legislated requirements for reporting incidents of abuse. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The following finding relates to Log #007369-16:

The licensee has failed to ensure a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

Resident #001's current plan of care, was reviewed and indicated the resident was at risk of skin impairment due to fragile skin. On an identified date, resident #001 was transferred to the hospital for assessment of a change in condition. The resident returned to the home approximately twelve hours later.

The resident health care record was reviewed and there was no documented skin assessment completed following the resident's return from hospital. [s. 50. (2) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The following finding relates to Log #030470-15:

The licensee has failed to ensure there is a written process to report and locate residents' lost personal items.

The Administrator was interviewed in regards to the home's process to report and locate residents' missing personal items. She indicated the home utilizes the complaints process and provided the inspector with "Complaints" policy, # LTC-CA-WQ-100-05-08. The Administrator further indicated the "Missing Clothing Report Form" is used to describe the residents' missing personal items and that the form would be circulated to the nursing units upon the report of missing items.

The Missing Clothing Report Form, NESM/Form-E-01.01.05 was reviewed and referred only to the process for reporting and locating missing resident clothing. There was no indication in either the Complaints policy or the Missing clothing process to address the process for locating residents' personal items. [s. 89. (1) (a) (iv)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The following finding relates to Log #030470-15:

The licensee has failed to ensure that the appropriate police force was immediately notified of an alleged financial abuse of resident #003.

As outlined in WN #2, the home failed to immediately notify the police of allegations of financial abuse upon becoming aware of the incident. The family notified the police two days after the allegation was brought to the attention of the Administrator.

At the time of this inspection, a compliance order was issued under inspection #2016_179103_0002 to ensure the home's abuse policy reflects the legislated requirements for reporting incidents of abuse. [s. 98.]

2. The following finding relates to Log #000440-16:

The licensee has failed to ensure the police were immediately notified of an alleged abuse of resident #002.

As outlined in WN #3, the home failed to immediately notify the police of an allegation of physical abuse involving resident #002. ADOC #107 was interviewed and indicated despite being made aware of the incident on an identified date, the police were not notified by the home until two to three days later. The ADOC indicated she is aware the notification should have been immediate.

At the time of this inspection, a compliance order was issued under inspection #2016_179103_0002 to ensure the home's abuse policy reflects the legislated requirements for reporting incidents of abuse. [s. 98.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The following finding relates to log 000440-16:

The licensee has failed to ensure the documented record of complaints included a written complaint received from resident #002's family.

On an identified date, resident #002's family member sent an email to the Administrator outlining concerns related to the resident's care. The home's documented record of written and verbal complaints was reviewed and failed to reflect this written complaint. The Administrator indicated the home had not previously acknowledged emails as a written form of complaint. [s. 101. (2)]

WN #8: 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. (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:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any 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. 107 (4).
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).
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).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The following finding relates to Log #002221-15:

The licensee has failed to ensure a report in writing was submitted to the Director within 10 days in regards to a reportable incident.

On an identified date, staff noted resident #004 was having difficulty ambulating and assessed the resident for injuries. The resident was unable to provide any insight due to a cognitive impairment and there had been no witnessed incidents of a fall. The resident was transferred to the hospital and assessed for an injury.

The home contacted the after hours pager to notify the ministry of the incident the following day, but failed to submit the critical incident report until fourteen days later. [s. 107. (4)]

Issued on this 28th day of April, 2016

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

Original report signed by the inspector.