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 soins 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
Nov 3, 2016	2016_235507_0014	030026-16	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

Chartwell Trilogy Long Term Care Residence
340 McCowan Road SCARBOROUGH ON M1J 3P4

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

STELLA NG (507), ROMELA VILLASPIR (653)

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 13, 14, 17, 18, 19, 20, 21 and 24, 2016.

The following Follow-Up Inspection was inspected:
Log #013316-16 related to Abuse Prevention

The following Critical Incident System Inspection was inspected:
Log #026721-16 related to Fall Prevention and Management

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Dietician, (RD), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSW), Environmental Services Manager (ESM), Resident(s) and Substitute Decision Maker (s) (SDM).

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection control prevention and practice, reviewed clinical health records, minutes of Residents' Council meetings, staff training records, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (2)	CO #001	2016_179103_0002	653

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. 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).

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 the care set out in the plan of care was provided to the resident as specified in the plan.

During stage one of the Resident Quality Inspection (RQI), resident #002 was triggered related to minimizing of restraining.

During observations on two identified dates at identified times, resident #002's side rail on one side of the bed was noted to be in the up position.

Review of resident #002's written plan of care on an identified date indicated that the resident used two side rails for repositioning.

Interviews with PSW #113 and RPN #114 stated that resident #002 only used one side rail on one side for self reposition in bed.

During an interview, the DOC acknowledged that the care set out in resident #002's written plan of care was not provided as specified in his/her plan of care. [s. 6. (7)]

2. The license has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

The following finding relates to Log #026721-16.

Review of resident #022's current care plan on an identified date indicated the resident required total assistance of two people with mechanical lift for transfer.

Interview with the resident revealed that he/she required one person assist for transfer from bed to wheelchair when he/she was at the foot of the bed, and was not able to hold on to the side rails. Otherwise, the resident was independent in transfer.

Interview with PSW #107 revealed the resident required limited assistance for transfer. Interview with PSW #109 revealed the resident was able to transfer independently. Interview with RN #110 revealed the resident required one person assistance for transfer. RN #110 further confirmed resident #022's care plan was not revised when his/her condition improved.

Interview with DOC confirmed that the home's expectation was to update the care plan immediately when the resident's condition changed. [s. 6. (10) (b)]

3. During stage one of the RQI, resident #003 was triggered related to nutrition and hydration.

Review of resident #003's Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessments in an identified year, revealed the resident's speech deteriorated in an identified month. RAI-MDS assessments on two identified dates of the mentioned year indicated resident #003 was not able to make speech. Review of the resident's current plan of care on an identified date indicated the resident was at risk for choking.

During the course of the inspection, the inspector observed resident #003 made gestures, but no speech.

Interviews with PSWs #100 and #106, and RPN #102 revealed that resident #003 was not able to talk. RPN #102 confirmed resident #003's care plan was not revised when the care set out in the plan is no longer necessary.

Interview with DOC confirmed that the home's expectation was to update the care plan immediately when the resident's condition changed. [s. 6. (10) (b)]

4. During stage one of the RQI, resident #005 was triggered related to a new alteration in skin integrity.

Review of resident #005's significant change in status assessment completed on an identified date indicated that resident had alteration in skin integrity.

Review of resident #005's written plan of care on an identified date, completed three and a half months after the mentioned assessment was completed, indicated under potential for skin alteration, that resident had alteration in skin integrity. The interventions also directed staff to complete skin treatments to the alteration in skin integrity as per the Treatment Administration Record (TAR).

Review of progress notes on Point Click Care (PCC) on an identified date, documented five weeks after the mentioned assessment was completed, indicated that resident #005's alteration in skin integrity was healed.

Interview with PSW #107 on an identified date, six months after the mentioned assessment completed, revealed that resident #005 did not have alteration in skin integrity.

During an observation on the same day, the Inspector and RPN #111 observed resident #005's did not have alteration in skin integrity.

Interview with RPN #111 revealed that the alteration in skin integrity was healed. He/She further indicated that resident # 005's written plan of care should have been updated, as resident no longer had alteration in skin integrity.

Interview with the DOC stated that the home's expectation was for registered staff to immediately update resident #005's written plan of care after his/her alteration in skin integrity had been resolved. [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 the care set out in the plan of care is provided to the resident as specified in the plan and the resident is reassessed and the plan of care 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. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remained in the original labeled package provided by the pharmacy service provider until administered to a resident.

On an identified date, during observation of resident #005's 0800 hrs medication pass, on an identified floor, it was noted that the resident's 0800 hrs medication pouch had a tear, and was already open before administration. After RPN #111 had taken out the medication pouch from the cart, the pills scattered in the cassette. RPN #111 had then taken the pills from the cassette and administered the medications to resident #005.

Review of the pharmacy service provider's policy titled "Medication System – Multidose Strip Index Number: 04-01-10" last reviewed July 1, 2010, under multidose medication system item #11, indicated the following:

"All medications should remain in the multidose strip provided by the pharmacy until administered to the resident".

Interview with the DOC stated that the medications in the torn pouch were already considered wasted medications, and that the home's expectation was for the registered staff to immediately discard the medication pouch once he/she noticed that it was already open before administration. [s. 126.]

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 drugs remain in the original labeled package provided by the pharmacy service provider until administered to a resident, to be implemented voluntarily.

WN #3: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

a) Review of the home's policy titled "Policy No: LTC-CA-WQ-200-06-02 Delivery of Medications and other Pharmaceuticals" revised November 2014, under procedures item #2, indicated the following:

"If the medications cannot be located, the Registered Staff is to contact the pharmacy to advise the pharmacy or on-call pharmacist of the missing medication. The on-call pharmacist is then responsible for arranging delivery either through the contracted pharmacy or thru the back up pharmacy".

On an identified date during observation of resident #005's 0800 hrs medication pass, on an identified floor, RPN #111 noted that the resident's medication pouch was already open and that an identified medication was missing from the pouch. He/She further noted that resident #005 did not have another identified medication available.

RPN #111 documented on the electronic Medication Administration Record (eMAR), that both mentioned medications were not available at the time of administration. Resident #005 did not receive both medications during the 0800 hrs medication pass.

Six hours later on the same day, the inspector interviewed RPN #111 in regards to resident #005's medications that were not available during the 0800 hrs medication pass. RPN stated that he/she had forgotten to notify his/her charge nurse, and that both medications were not ordered or administered to the resident.

Interview with the DOC indicated that the home's expectation was for registered staff to call pharmacy right away when medications were not available, so that the medications can be sent to the home. [s. 8. (1) (b)]

2. b) Review of the home's policy titled "Policy No: LTC-CA-WQ-200-06-14 Narcotics" revised July 2015, under policy, indicated the following:

"The Registered Staff going off shift and the Registered Staff coming on shift will count and sign for all resident narcotics at each shift change. Irrespective of type of sheet selected, it is imperative that on coming shift and off going shift Registered Staff complete at the same time the end/beginning of shift narcotic count".

On an identified date at an identified time, on an identified floor, RPN #111 and the inspector reviewed the narcotic count documentation in conjunction with the current narcotic supply of medication. The inspector and RPN #111 observed that four residents' narcotic and controlled drug administration record sheets were already signed for the count which was scheduled to take place an hour later.

Interview with RPN #111 revealed that he/she signed the scheduled narcotic count as he/she already administered the standard narcotics for his/her shift. He/She further indicated that signing the narcotic sheets in advance was not in accordance to the home's policy.

Interview with the DOC, indicated that registered staff were not supposed to sign the narcotic sheets in advance. He/She further indicated that the narcotic count was supposed to be done with the incoming registered staff. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the copy of the inspection report from the past two years for the long-term care home was posted in the home.

During the tour of the home on an identified date, the inspector reviewed the binder located in the "MOH Reports" section near the home's main entrance. It was noted that inspection #2014_285546_0031 Report Date: December 12, 2014, was not included in the binder.

During an interview, the Administrator confirmed that the inspection report mentioned above, was not posted in the home as required. [s. 79. (3) (k)]

Issued on this 9th day of November, 2016

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

Original report signed by the inspector.