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 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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 21, 2017	2017_493652_0013	022066-17	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

NATALIE MOLIN (652), ADAM DICKEY (643), STELLA NG (507)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28, and 29, 2017

The following critical incident (CI) inspections were conducted concurrently with the RQI:#030632-16 (related to plan of care); #032953-16; (related to falls prevention and management) and #009621-17 (related to medication management system)

The following complaint inspections were conducted concurrently with the RQI: #022066-17 (related to continence care and bowel management, skin and wound care, nutrition care and hydration programs); and #018467-17 (related to plan of care, falls prevention and management, food production, dining and snack service, oral care, personal care, skin and wound care)

During the course of the inspection, the inspector(s) spoke with The Administrator, business manager, director of care (DOC), associate directors of care (ADOC), nursing clerk, facility charge nurse, consultant pharmacist, food service supervisor, food service worker, registered nursing staff, personal support workers (PSWs), Residents' Council president and Family Council representative,residents, substitute decision makers (SDMs), and complainants.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

7 WN(s)
4 VPC(s)
1 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A) Critical Incident System Report was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, in regards to an incident. The CIS revealed that on an identified date and time, resident #005 was given resident #008's scheduled medication on an identified time and resident #008 was administered resident #005's scheduled medication on an identified time during an identified medication pass. 2 hours later, resident #005 was observed to have change in his/her health status and resident #005 was transferred to hospital for further assessment.

Review of the medication administration record (MAR) for resident #005 revealed that the resident was scheduled for an identified medication on an identified date and time. Review of the MAR for resident #008 revealed that the resident was scheduled for an identified medication on an identified date and time.

In interview, RPN #112 stated that on an identified date and time, he/she was administering medication at an identified medication pass on the unit. While RPN #112 was preparing the identified medication for resident #005, resident #008 approached him/her and requested his/her medication for an identified time. Resident #008 continued to ask for the medication despite being told by RPN #112 to wait as he/she was preparing the identified medication for resident #005. Due to the persistent request of resident #008, RPN #112 decided to administer the medication to resident #008's prior to resident #005. RPN #112 then placed the medication cup containing two tablets of an identified medication on top of the empty pouch aside on the medication cart. RPN #112 then proceeded to prepare resident #008's medication by pouring the identified medication into a medication cup. RPN #112 picked up resident #005's medication and

gave it to resident #008, then gave resident #008’s medication to resident #005. RPN #112 further stated that he/she was in a hurry to complete the medication pass as he/she was required to supervise the meal service at an identified time in the dining room. RPN #112 stated that he/she was aware that he/she might have given the wrong medication to residents #005 and #008, and he/she monitored resident #005 closely during an identified meal. At an identified time, resident #005 expressed feeling unwell, and his/her health status changed. The doctor was notified and resident #005 was transferred to hospital for further assessment. RPN #112 acknowledged that on and identified time, during an identified medication pass, he/she had administered resident #005 with an identified medication which had not been prescribed for resident #005, and he/she had administered an identified medication which had not been prescribed for resident #008.

In interview, DOC #121 confirmed that on an identified date, residents #005 and #008 were administered medication which had not been prescribed for them. DOC #121 stated that RPN #112 was provided education on safe practice of medication administration, home’s medication administration policy and College of Nurses of Ontario (CNO) standards after the above mentioned medication incident.
B) On an identified date inspector #643 observed a bottle of an identified medication were kept in resident #004’s room. On an identified date inspector #507 observed a bottle of an identified medication was kept in resident #022’s room.

On an identified date, the inspector and RPN #124 observed a bottle of an identified medication in resident #004’s room. In interview, resident #004 stated that the medication was brought to him/her by his/her family member #1, and he/she has been taking the identified medication at a specific time.

On an identified date, the inspector and RPN #110 observed a bottle of an identified medication in resident #022’s room. In interview, resident #022 stated that the medication was brought to him/her by his/her family member #2, and he/she has been taken the identified medication at specific times a day for a few weeks.

Review of the physician’s orders for resident #004 failed to reveal an order for taking the identified medication. Review of the physician’s orders for resident #022 failed to reveal an order for the identified medication.

In interview, DOC #121 stated that if a resident wanted to take an identified medication, staff would notify the doctor and prescribe the medication to the resident, and the medication would be kept and administered by the registered staff unless self-

administration of the medication was approved by the prescriber in consultation with the resident.

The severity of the non-compliance and the severity of the harm were actual as it relates to residents #005 and #008. The scope of the non-compliance was isolated. A review of the compliance history revealed that there was a written notification (WN) issued in inspection 2014_252513_001 dated September 17, 2014. As a result of the severity, scope and the licensee's previous compliance history, a compliance order is warranted. [s. 131. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

During stage two of the resident quality inspection (RQI) falls prevention was triggered

for resident #007 related to staff interview during stage one.

Review of resident #007's health records revealed that he/she had two fall incidents in an identified period prior to the staff interview on an identified date. One fall occurred on an identified date, and a previous fall occurred on another identified date. Review of resident #007's progress notes revealed that after the identified date, resident #007 was complaining of pain on an identified body part and swelling was observed. An x-ray of resident #007's identified body part was ordered on an identified date, and the results received on an identified date, revealed injury to resident #007's identified body part.

Review of the current written plan of care accessed on an identified date revealed that staff were instructed to provide assistance to resident #007 with two persons transferring using and identified equipment. This method was revised on an identified date, and was indicated in order to prevent resident #007 from pivoting on his/her identified body part until a follow-up x-ray was completed. Observations by the inspector on identified dates, revealed a transfer logo posted above the bed for resident #007 indicating one person minimum assistance transfer.

In an interview, PSW #105 stated that the method of transfer for resident #007 was for one person to provide physical assistance with resident #007 being able to weight bear. When asked if the method of transfer for resident #007 had been changed after the injury of his/her body part, he she stated it had not changed. PSW #105 stated that direct care staff are able to access the care plan on the point of care (POC) terminals in addition to the card above a resident bed indicating transfer method. PSW #105 further stated that he/she was unaware that the transfer method for resident #007 had been changed to two person transfer with an identified equipment. The transfer logo indicated one person minimal assistance transfer and the written plan of care indicated two person with the identified equipment.

In an interview, RPN #123 who was the lead for the falls prevention and management program in the home stated that it was the responsibility of the registered staff on the unit to update the card above the resident bed indicating transfer method. In an interview, RPN #124 stated that it was the responsibility of the restorative staff or falls lead to update the card indicating transfer method.

In an interview, the DOC stated that it was the responsibility of registered staff on the unit to update the card above the resident bed indicating transfer method. The DOC further stated that the card above the resident bed indicating transfer method was part of the

plan of care and should match the written plan of care. The DOC acknowledged that the plan of care did not set out clear direction to staff and others that provide care for resident #007. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the substitute decision maker (SDM) been given an opportunity to participate fully in the development and implementation of the plan of care.

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a complaint in regards to resident #042's care.

Record review of resident #042's medication administration record for an identified date, revealed an identified medication was on hold during an identified period for resident #042.

Record review of resident #042's multidisciplinary progress notes on an identified date revealed the physician held his/her identified medication.

Record review of resident #042's three months medication review revealed his/her identified medication was held by the physician on an identified date.

Interview with RPN #110 revealed resident #042's substitute decision maker (SDM) was not informed that the identified medication was held for resident #042 on an identified date.

Interview with RN/Facility Charge Nurse/Acting ADOC #109 revealed resident #042's identified medication was on hold by the physician on an identified date on a three months medication review and he/she was informed of this by the resident #042's SDM. [s. 6. (5)]

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 written plan of care set out clear directions to staff and others who provide direct care to the 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 that the licensee is required by the Act or Regulation to have instituted or otherwise put into place was complied with.

As required by the Regulation (O. Reg. 79/10, s. 48. (1) 1) every licensee shall ensure that an interdisciplinary program for falls prevention and management to reduce the incidence of falls and the risk of injury is developed and implemented in the home.

Review of the home’s policy titled “Resident Falls” policy number LTC-CA-WQ-200-07-08, under the section titled “Resident Safety and Risk Management” revealed that falls where there is a suspicion of head injury are to include resident assessment and documentation of this assessment for 72 hours following the fall. Review of Chartwell's Head Injury Flow Sheet document revealed head injury routine (HIR) is to be completed every 15 minutes for the first hour, every 30 minutes for the following two hours, hourly

for the next four hours and if stable every four hours until 72 hours have been reached.

During stage two of the resident quality inspection (RQI) falls prevention was triggered for resident #007 related to staff interview during stage one.

Review of resident #007’s health records revealed that he/she had two fall incidents in an identified period prior to the staff interview on an identified date. One fall occurred on an identified date, and a previous fall occurred on another identified date, both falls were un-witnessed by staff.

In interviews, RPNs #122, #123, #124, #125 and RN #106 stated that HIR would be initiated whenever a resident has an un-witnessed fall, and should be completed for 72 hours after the fall.

Review of resident #007’s chart revealed HIR monitoring records for the fall incident occurring on an identified date. The head injury flow sheet documented monitoring at two specified times on an identified date. The remaining 72 hour monitoring was not completed on the flow sheet. Review of the head injury flow sheet for the fall on an identified date, revealed monitoring every 15 minutes at specified times. Monitoring was completed every 30 minutes at specified times. No further monitoring was documented for the 72 hour period after the fall.

In an interview, the DOC stated that it was the expectation of the home for HIR to be completed for any un-witnessed fall, as well as for falls with evidence of head injury. The DOC further stated that the HIR should be completed on the hard copy for the 72 hour period following the fall. The DOC acknowledged that the head injury flow sheets for resident #007 had not been completed as per the home’s policy. [s. 8. (1) (a), s. 8. (1) (b)]

2. A complaint was received by the MOHLTC regarding concerns related to a fall incident on an identified date, involving resident #042.

Review of resident #042’s progress notes revealed that on an identified date, at an identified time, resident #042 was found on his/her identified body part on the floor by PSW #137 and RPN #138 came to resident #042’s room and found him/her sitting on the floor at a specified location. RPN #138 assessed resident #042 and no injury was noted at time of assessment. The progress note further indicates that HIR continued for

resident #042.

Review of resident #042's health records failed to reveal documentation of HIR being completed for the fall incident occurring on an identified date.

In interviews, RPN #138 and RN #114 stated that when a resident has an unwitnessed fall that head injury routine should be completed for 72 hours post fall and documentation should be placed in the resident's chart. RN #114 further stated that resident #042's fall on an identified date was un-witnessed and should have had HIR completed for this fall incident. [s. 8. (1) (a), s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise related to the completion of head injury monitoring is complied with,, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a complaint in regards to resident #023's nail care.

On an identified date, the inspector observed resident #023's toe nails were long.

Interviews with PSWs #128 and #133 revealed PSWs did not have the training to cut residents, toenails. RPN #110 stated that resident #023's substitute decision maker (SDM) initiated the foot care service once when the resident was admitted. The SDM made another request two days prior to have resident #023's toenails to be cut, and the resident had his/her toenails cut the day before. RPN #110 further stated that when a resident's toenails needed to be cut, they would refer the resident or SDM to the Office Manager.

Interview with Office Manager #135 stated that the home offered the arrangement of chiropodist service to residents with charge.

Interview with DOC #121 revealed there was no staff who had foot care training in the home at this time, and PSWs do not cut the residents' toenails; therefore, basic foot care service was not provided to residents. [s. 35. (1)]

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 each resident of the home received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinical appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #005 was triggered for continence care and bowel management during stage 1 of the Resident Quality Inspection (RQI) due to the use of a specialised treatment device.

Record review of the admission resident assessment instrument – minimum data set (RAI-MDS) assessment for resident #005 completed on an identified date, revealed that the resident was incontinent of bladder frequently.

Record review of the most recent RAI-MDS assessment for resident #005 completed on an identified date revealed that the resident has a specialised treatment device in place.

Record review of the assessments for resident #005 failed to reveal a bladder continence assessment since admission.

Interviews with ADOC #109 and DOC #121 revealed a bladder continence assessment was required for all residents on admission, every quarter and when the resident’s condition changed by using the bladder continence assessment on the computer. ADOC #109 confirmed that resident #005 has never been assessed for his/her bladder continence by using the bladder continence assessment template on admission, quarterly and when his/her bladder continence condition changed. [s. 51. (2) (a)]

2.The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinical appropriate assessment instrument that was specifically designed for assessment of incontinence.

On an identified date, the Ministry of Health and Long Term care (MOHLTC) received a complaint in regards to resident #023’s continence care.

Review of the admission resident assessment instrument –RAI-MDS assessment for resident #023 completed on an identified date, revealed that the resident was incontinent of bladder frequently.

Review of the most recent RAI-MDS assessment for resident #023 completed on an identified date, revealed that the resident was incontinent of bladder frequently.

Review of the assessments for resident #023 failed to reveal a bladder continence assessment had ever been completed for this resident.

Interviews with ADOC #109 and DOC #121 stated that bladder continence assessment was required for all residents on admission, every quarter and when the resident’s condition changed by using the bladder continence assessment on the computer. ADOC #109 confirmed that resident #023 has never been assessed for his/her bladder continence by using the bladder continence assessment template on admission. [s. 51. (2) (a)]

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 each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinical appropriate assessment instrument that was specifically designed for assessment of incontinence,, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of the personal assistance service device (PASD) has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Record review of resident #012's written plan of care on an identified date, revealed he/she use quarter bed rails bilaterally as a personal assistance service device (PASD) for repositioning while in bed. This written plan of care also revealed that resident #012's wheel chair is tilted while he/she is in the chair as a PASD for comfort and pressure relief.

Resident #012 was observed sitting with his/her wheel chair tilted on four occasions and the bed rails engaged bilaterally while in bed on these same occasions during the inspection.

Record review of resident #012's health care records revealed a consent has not been obtained for his/her use of the PASDs

Interviews with PSW #139.and RPN #117 revealed a consent has not been obtained from the substitute decision maker of resident #012 for the use of the PASDs.

Interview with the RN/Facility Charge Nurse #114 revealed a consent has not been obtained from the substitute decision maker of resident #012 for the use of the PASDs.

Interviews with DOC#121 revealed the expectation is that an updated consent is received from the resident or substitute decision maker for the use of the PASD on an annual basis [s. 33. (4) 4.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On an identified date, at an identified time, the inspector observed RPN #102 perform an assessment on resident #022 by using an identified equipment, administered medication to residents #022 and #023 without performing hand hygiene prior to and after the identified testing for resident #022, and administering medication to residents #022 and #023.

On an identified date, at an identified time, the inspector observed RPN #112 administered medication to residents #021 and #024 without performing hand hygiene prior to and after administering medication to both residents.

Record review of the home's Hand hygiene program, policy #LTC-CA-WQ-205-02-04, revised March 2016, indicated that hand hygiene is to be performed

- before putting on and after taking off gloves,
- before initial contact with the resident, and
- before performing an aseptic procedure, include glucometer testing.

Interviews with RPNs #102 and 112 stated that they should perform hand hygiene prior to and after administering medication to a resident.

Interview with DOC #121 revealed the home's expectation was for staff to perform hand hygiene prior to and after medication administration to a resident. [s. 229. (4)]

Issued on this 4th day of December, 2017

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NATALIE MOLIN (652), ADAM DICKEY (643), STELLA NG (507)
Inspection No. / No de l'inspection :	2017_493652_0013
Log No. / No de registre :	022066-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 21, 2017
Licensee / Titulaire de permis :	TRILOGY LTC INC. 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	Chartwell Trilogy Long Term Care Residence 340 McCowan Road, SCARBOROUGH, ON, M1J-3P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christine Maragh

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To TRILOGY LTC INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

Upon receipt of this report the licensee shall prepare a plan to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.
The plan should include, but not limited to ensure the following:
1. Registered Staff administer medications, in accordance with the College of Nurses of Ontario Professional Practice Standards and Guidelines:
a) The right resident
b) The right medication/drug
c)The right dose/amount
d) The right route/method
e) The right time
f) The right reason
g) The right site
h) The right frequency

2) Registered Staff avoid communication and attempt to minimize distractions when preparing and administering medications as per safe medication administration practices.
3) All registered staff in the home receive education in the administration of medications in accordance with the College of Nurses of Ontario Professional Practice Standards and Guidelines and the
Home policies and procedures related to Medication Administration.
4) Develop and implement a process to monitor staff compliance with safe medication administration practices.

This plan is to be submitted via email to inspector natalie.molin@ontario.ca by December 01, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [Reg. s. 131 (1)]

A) Critical Incident System Report was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, in regards to an incident. The CIS revealed that on an identified date and time, resident #005 was given resident #008's scheduled medication on an identified time and resident #008 was administered resident #005's scheduled medication on an identified time during an identified medication pass. 2 hours later, resident #005 was observed

to have change in his/her health status and resident #005 was transferred to hospital for further assessment.

Review of the medication administration record (MAR) for resident #005 revealed that the resident was scheduled for an identified medication on an identified date and time. Review of the MAR for resident #008 revealed that the resident was scheduled for an identified medication on an identified date and time.

In interview, RPN #112 stated that on an identified date and time, he/she was administering medication at an identified medication pass on the unit. While RPN #112 was preparing the identified medication for resident #005, resident #008 approached him/her and requested his/her medication for an identified time. Resident #008 continued to ask for the medication despite being told by RPN #112 to wait as he/she was preparing the identified medication for resident #005. Due to the persistent request of resident #008, RPN #112 decided to administer the medication to resident #008's prior to resident #005. RPN #112 then placed the medication cup containing two tablets of an identified medication on top of the empty pouch aside on the medication cart. RPN #112 then proceeded to prepare resident #008's medication by pouring the identified medication into a medication cup. RPN #112 picked up resident #005's medication and gave it to resident #008, then gave resident #008's medication to resident #005. RPN #112 further stated that he/she was in a hurry to complete the medication pass as he/she was required to supervise the meal service at an identified time in the dining room. RPN #112 stated that he/she was aware that he/she might have given the wrong medication to residents #005 and #008, and he/she monitored resident #005 closely during an identified meal. At an identified time, resident #005 expressed feeling unwell, and his/her health status changed. The doctor was notified and resident #005 was transferred to hospital for further assessment. RPN #112 acknowledged that on and identified time, during an identified medication pass, he/she had administered resident #005 with an identified medication which had not been prescribed for resident #005, and he/she had administered an identified medication which had not been prescribed for resident #008.

In interview, DOC #121 confirmed that on an identified date, residents #005 and #008 were administered medication which had not been prescribed for them. DOC #121 stated that RPN #112 was provided education on safe practice of medication administration, home's medication administration policy and College

of Nurses of Ontario (CNO) standards after the above mentioned medication incident.
B) On an identified date inspector #643 observed a bottle of an identified medication were kept in resident #004's room. On an identified date inspector #507 observed a bottle of an identified medication was kept in resident #022's room.

On an identified date, the inspector and RPN #124 observed a bottle of an identified medication in resident #004's room. In interview, resident #004 stated that the medication was brought to him/her by his/her family member #1, and he/she has been taking the identified medication at a specific time.

On an identified date, the inspector and RPN #110 observed a bottle of an identified medication in resident #022's room. In interview, resident #022 stated that the medication was brought to him/her by his/her family member #2, and he/she has been taken the identified medication at specific times a day for a few weeks.

Review of the physician's orders for resident #004 failed to reveal an order of taking the identified medication. Review of the physician's orders for resident #022 failed to reveal an order for the identified medication.

In interview, DOC #121 stated that if a resident wanted to take an identified medication, staff would notify the doctor and prescribe the medication to the resident, and the medication would be kept and administered by the registered staff unless self-administration of the medication was approved by the prescriber in consultation with the resident.

The severity of the non-compliance and the severity of the harm were actual as it relates to residents #005 and #008. The scope of the non-compliance was isolated. A review of the compliance history revealed that there was a written notification (WN) issued in inspection 2014_252513_001 dated September 17, 2014. As a result of the severity, scope and the licensee's previous compliance history, a compliance order is warranted. [s. 131. (1)]

(507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 01, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 21st day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Natalie Molin

Service Area Office / Bureau régional de services : Toronto Service Area Office