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 # / No de registre	Type of Inspection / Genre d'inspection
Jul 23, 2018	2018_486653_0012	005361-18	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

ROMELA VILLASPIR (653), SARAN DANIEL-DODD (116), SHIHANA RUMZI (604)

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): May 22, 23, 24, 25, 28, 29, 30, 31, June 1, 4, and 5, 2018.

The following intakes were inspected concurrently during this inspection: Complaint Log #002191-18 related to bed refusal, and Follow-up Log #028116-17 related to medications.

During the course of the inspection, the inspectors conducted a tour of the home, observed medication administration, observed staff to resident interactions, reviewed staff schedule, training records, clinical health records, and relevant home policies and procedures.

Inspectors Adelfa Robles (#723) and Miko Hawken (#724) attended this inspection during orientation.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Dietary Aides (DAs), Assistant Food and Nutrition Manager (AFNM), Food and Nutrition Manager (FNM), Registered Dietitian (RD), Pharmacy Transition Lead, Assistant Director of Care (ADOC), Director of Care (DOC), and the Administrator.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
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
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **6 VPC(s)**
- **1 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
O.Reg 79/10 s. 131. (1)	CO #001	2017_493652_0013	604

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. (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).

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 had failed to ensure that the resident, the SDM, if any, and the designate of the resident/ SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

During stage one of the Resident Quality Inspection (RQI), resident #011 triggered for no notice of change, as per the family interview.

In an interview, resident #011's Substitute Decision-Maker (SDM) indicated they had never been contacted when resident #011 had changes in medication, and the SDM stated they were aware that the home was required to contact the SDM when there where changes made to the resident's medication.

A review of resident #011's "Prescriber Order Form" from an identified period, indicated new orders on three identified dates.

In a follow up interview, the resident's SDM was informed by the inspector of the orders from the three identified dates, and the SDM stated that they were not made aware of the orders at the time they had been prescribed.

Interviews held with RPNs #112 and #121 stated that when a new order for change in medication or addition of medication had been received, the nurses were expected to document the date and time on the prescriber order form, dock the Electronic Pen (E-Pen), and call the SDM to inform them of the order. The RPN stated the SDM was to be called for any change or addition in orders, and staff were to check off the boxes for progress notes and consent obtained for new medication, on the prescriber order form. The RPN reviewed resident #010's 2018 prescriber order form and acknowledged that

the consent obtained box in the prescriber order form was not checked off. The RPN further reviewed resident #010's progress notes and stated there was no note to indicate that the family was informed of the orders from the three identified dates.

An interview with the Director of Care (DOC) indicated that once a medication order was received, the nurses were required to process the order, carry out first and second checks, and ensure that the SDM was called for any new or change in medication, update the progress note, and check off the prescriber order form indicating that the SDM had been called for consent. The DOC reviewed resident #010's 2018 prescriber order form and acknowledged that the consent obtained box in the prescriber order form was not checked off, indicating that the SDM had not been contacted to inform them of the three orders. [s. 6. (5)]

2. The licensee had failed to ensure that the care set out in the plan of care had been provided to the resident as specified in the plan.

During stage one of the RQI, resident #009 triggered related to altered skin integrity from both a staff interview and census record, as well as from the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) previous to most recent.

A review of resident #009's written plan of care on an identified date, indicated they had an identified area of altered skin integrity.

A review of resident #009's prescriber order form indicated that on an identified date, RPN #115 received a telephone order from the physician confirming an outside provider's health treatment recommendation.

An observation conducted by inspector #653 on an identified date and time, noted that RPN #101 removed the previous treatment from the resident's identified part of the body, which was different from the prescribed treatment. Afterwards, RPN #101 carried out the treatment procedure as ordered.

An interview with RPN #101 indicated that the previous registered staff had applied an identified treatment to resident #009's identified part of the body, instead of the treatment that was ordered. An interview with RPN #115, confirmed that they had applied the identified treatment instead of the one prescribed, on the resident's area of altered skin integrity on an identified date, and acknowledged that they had not provided care to resident #009 as specified in the plan.

An interview with the DOC acknowledged the above mentioned information and indicated that the registered staff had not provided care to resident #009 as specified in the plan and as per the treatment recommendation. [s. 6. (7)]

3. Due to an area of non-compliance found related to resident #009's skin and wound care, the sample size had been extended to two more residents.

A review of resident #032's written plan of care on an identified date, indicated they had two areas of altered skin integrity. A review of the outside provider's health treatment recommendation that was approved by the physician on an identified date, indicated the treatment for one area of altered skin integrity.

A review of resident #032's electronic Treatment Administration Record (eTAR) for an identified month, revealed the treatment started on an identified date, and the treatment was slightly different from the treatment that was ordered.

An interview with RPN #115 acknowledged that they had incorrectly transcribed the treatment order to the eTAR for the one area of altered skin integrity, and did not write the treatment exactly as it had been ordered.

Further review of resident #032's eTAR from an identified month, revealed that RPN #116 completed the identified treatment on seven identified dates. An interview with RPN #116 indicated that they had been applying the treatment to resident #032 as per the instructions on the eTAR. The inspector read out the outside provider's health treatment recommendation that was approved by the physician, and RPN #116 acknowledged they had not provided care to the resident as prescribed.

An interview with the DOC acknowledged the above mentioned information and indicated that the registered staff had not provided care to resident #032 as specified in the plan, in regards to the treatment on the identified area of altered skin integrity. [s. 6. (7)]

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. 58. Residents' Council assistant

Specifically failed to comply with the following:

s. 58. (1) Every licensee of a long-term care home shall appoint a Residents' Council assistant who is acceptable to that Council to assist the Residents' Council. 2007, c. 8, s. 58. (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that an assistant who was acceptable to the Council, had been appointed to assist the Residents' Council.

A review of the Residents' Council Minutes binder for the period of January – May 2018, indicated that the home’s DOC was assigned to the role of Residents' Council assistant for January 2018, and the Administrator was assigned from February – May 2018. The minutes did not provide any supporting documentation related to the appointment of an assistant.

An interview held with the Administrator indicated that the home encountered difficulty in supporting the role of an assistant due to the previous assistant no longer being employed with the home. The Administrator indicated being present on January 9, 2018, during a meeting where the Residents' Council appointed them as the assistant and produced meeting notes dated January 9, 2018, signed by the current President supporting the appointment. A review of the attendees of the meeting held on January 9, 2018, did not reflect the Administrator being present.

Interviews held with the Residents' Council President and Vice President(s) indicated that they were unaware if the council had appointed an assistant and of the Administrator’s role as the assistant to the council. Further interview held with the Residents' Council President on May 30, 2018, revealed that they signed meeting notes when presented by the Administrator on May 30, 2018, however, was unaware of what they signed.

A record review and interviews held with the Administrator, Residents' Council President and Vice President(s) provided conflicting information regarding the appointment of an assistant who was acceptable to the council. The licensee had failed to ensure that an assistant who was acceptable to the Council, had been appointed to assist the Residents' Council. [s. 58. (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 the licensee of a long-term care home shall appoint a Residents' Council assistant who is acceptable to that Council to assist the Residents' Council, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that there was a system in place to measure and record, with respect to each resident, body mass index, and height upon admission and annually thereafter.

During stage one of the RQI, 31 out of the 40 residents within the sample size were identified by the inspectors with missing heights for an identified year, during the census record review.

A review of the following residents' clinical records by inspector #116 identified no annual heights had been documented for the identified year: residents #006, #037, #038, and #039.

A review of the following residents' clinical records by inspector #604 identified no annual heights had been documented for the identified year: residents #001, #003, #004, #005, #010, #011, #033, #034, #035, #036, #041, #042, and #043.

A review of the following residents' clinical records by inspector #653 identified no annual heights had been documented for the identified year: residents #002, #007, #009, #012, #013, #014, #015, #016, #017, #018, #019, #020, #021, and #022.

Interviews with the home's RD and Food and Nutrition Manager (FNM) indicated that the residents' heights were required to be taken upon admission and yearly thereafter, and that the heights were needed in order to calculate the residents' Body Mass Index (BMI).

An interview with the DOC stated that the home was supposed to have a process in place to take the residents' heights, and indicated that it had not been followed. The DOC further acknowledged that the requirement for annual height monitoring had not been met for the above mentioned residents. [s. 68. (2) (e) (ii)]

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 nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s.101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

Findings/Faits saillants :

1. The licensee had failed to comply with the following requirements of the Long-Term Care Homes Act (LTCHA): It is a condition of every license that the licensee shall comply with every order made under this Act.

On November 21, 2017, Compliance Order (CO) #001, made under O. Reg. 79/10 s. 131. (1), had been served:

The licensee must be compliant with O. Reg. 79/10 s. 131 (1), specifically:

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's policies and procedures related to medication administration.

The compliance date was December 01, 2017, and the home's education records provided to the inspector indicated that the home had 66 registered staff, which included Registered Nurses (RNs) and RPNs. A review of the home's education records for the "College of Nurses of Ontario Professional Practice Standards and Guidelines Acknowledgment Form", signed off the by the registered staff, indicated 25 registered staff did not receive the education. A review of the home's education records for "Medication Management", of the home's policies and procedures, indicated 43 registered staff did not receive the education.

During an interview with the inspector, the DOC reviewed the RN and RPN staff list on the "College of Nurses of Ontario Professional Practice Standards and Guidelines Acknowledgment Form" and "Medication Management" sign in sheets, and acknowledged that the licensee did not educate all registered staff as required. [s. 101. (3)]

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 licensee comply with this Act, the regulations, and every order made under this Act, to be implemented voluntarily.

WN #5: 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 had failed to ensure that drugs remained in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

During stage two of the RQI, one drug storage area had been observed for controlled substances, as part of the mandatory medication inspection protocol process.

On an identified date and time, inspectors #116 and #724 observed the end of day shift controlled substance count completed by RPNs #122 and #123.

During the count, five identified blister packs which contained controlled substances of five residents, were observed to have tape adhered to the back, and the foil backing was observed not intact.

An interview held with RPN #122 indicated that the controlled substances should be discarded and removed upon the blister package being opened. RPNs #122 and #123 indicated that they felt the home's policy instructed them not to tape the back of the package and to waste the medication. RPN #122 contacted the pharmacy service provider to obtain direction on how to manage the destruction of the opened packages.

A review of the home's memorandum and nursing meeting minutes from an identified date, directed staff to ensure packages were inspected prior to administration, for any signs of tampering, opened, ripped or altered packaging and to discard immediately with two registered staff present for witnessing purposes.

An interview held with the DOC stated that upon discovery of a discrepancy with the condition of a blister pack, the staff were instructed to waste the identified controlled substance with another registered staff member and document the reason. The DOC further indicated that drugs should remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. [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 labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee had failed to ensure that all areas where drugs are stored were kept locked at all times, when not in use.

On an identified date and time, inspectors #116 and #723 entered an identified home area and observed a medication cart stored in the nursing station was unlocked and unattended. The nursing station was unlocked and accessible to the inspectors and others within the area. RPN #119 assigned to the cart returned to the cart within approximately five minutes.

An interview held with RPN #119 indicated that they stepped away from the medication cart to administer medications to a resident on the unit. RPN #119 indicated being aware that the medication cart was to be locked when unattended.

An interview held with the DOC confirmed that RPN #119 did not ensure that all areas where drugs were stored were kept locked at all times, when not in use on the identified date. [s. 130. 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 steps are taken to ensure the security of the drug supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

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 had failed to ensure that staff participated in the implementation of the infection prevention and control program.

On an identified date and time, the inspector carried out a lunch meal service observation on an identified home area. During the diet list check, the inspector was at the servery and observed the following:

At an identified time, Dietary Aide (DA) #121 was noted wearing yellow gloves. The DA took the dirty dishes from a gray bin, and then they loaded the dishwasher with the dirty dishes and soup bowls. As the dishes were washing in the dishwasher, the DA went ahead and had gotten more dirty dishes. When the dishes had been washed, the DA was observed to open the dishwasher and unloaded the clean dishes while still wearing the yellow gloves they loaded the dirty dishes with. The DA was observed to place the clean dishes on a metal cart, brought the other dirty dishes, and placed them in the dishwasher and started the dishwasher. The DA then placed the clean dishes under the servery.

In an interview, DA #121 stated that the home's expectation was to take out the clean dishes from the dishwasher without wearing the gloves. The inspector reviewed their observations as indicated above with the DA who acknowledged the observations made by the inspector. The DA acknowledged that they did not follow infection control processes when handling the clean and dirty dishes.

An interview with the FNM indicated that the DAs in the home had been educated on how to handle dirty dishes with the yellow gloves, and then after the dishes had been washed, they would take the yellow gloves off, and unload the clean dishes. The FNM was informed of the inspector's observations as indicated above, and the FNM acknowledged that DA #121 did not follow proper infection control practices when they handled the dishes during the observation. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to have his or her personal health information (within the meaning of the Personal Health Information Protection Act, 2004) kept confidential in accordance with that Act.

On an identified date and time, inspectors #116 and #723 entered an identified home area and observed a medication cart stored in the nursing station was unlocked and unattended. The electronic Medication Administration Record (eMAR) screen was unlocked and opened to the face page, which provided access to residents' personal health information. Opened medication pouches containing residents' names and prescribed medications were stored on top of the cart and were visible and accessible to others.

An interview held with RPN #119 who was assigned to the medication cart indicated that they stepped away from the medication cart to administer medications to a resident on the unit. RPN #119 indicated being aware that the eMAR screen and medication pouches were to be secured and discarded in a manner that protected the Personal Health Information (PHI) of residents during and after administration.

An interview held with the DOC indicated that the staff were directed to ensure PHI was kept confidential, and confirmed that RPN #119 did not fully respect and promote the residents' right to have their PHI within the meaning of the Personal Health Information Protection Act, 2004, kept confidential. [s. 3. (1) 11. iv.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

During stage one of the RQI, resident #001 triggered related to unclean ambulation equipment.

Multiple observations were made by the inspector of resident #001's personal assistive device on six different dates, and noted particles on the device.

A review of resident #001's written plan of care indicated under the bath section that the resident's shower days were scheduled on two identified days of the week.

A review of the identified home area's "Night Shift-Fulltime PSW, Part-time PSW, Casual PSW Cleaning/Disinfecting Schedule" sheet, directed all night Personal Support Workers (PSWs) to wash, clean, and disinfect personal assistive devices and personal equipments, for residents who have a shower/ bath the following day.

Interviews with RPN #112 and PSW #114 who worked on the identified home area indicated awareness of resident #001's care requirements. The RPN and PSW indicated that the resident's personal assistive device had to be washed the night prior to the resident's shower day, and the night PSWs were responsible for cleaning and signing off the "Night Shift-Fullt-ime PSW, Part-time PSW, Casual PSW Cleaning/Disinfecting Schedule" sheet located at the nursing station. The RPN and PSW carried out an observation of resident #001's personal assistive device with the inspector and both staff members acknowledged that it was unclean. The RPN and PSW reviewed the "Night Shift-Full-time PSW, Part-time PSW, Casual PSW Cleaning/Disinfecting Schedule" sheet from an identified month with the inspector, and acknowledged that there were no signatures to indicate that resident #001's personal assistive device was cleaned the night prior to the resident's shower day.

An interview with the DOC stated that personal assistive devices were to be cleaned by the night PSWs the night prior to the resident's shower day. On an identified date, the DOC carried out an observation of resident #001's personal assistive device with the inspector and acknowledged that it was unclean. The DOC reviewed resident #001's written plan of care and acknowledged that their shower was scheduled on two identified days of the week. The DOC indicated the expectation was for the personal assistive

device to be cleaned by the night PSW the night before the resident's shower day. The DOC further reviewed the "Night Shift-Full-time PSW, Part-time PSW, Casual PSW Cleaning/Disinfecting Schedule", from the identified month and acknowledged the missing staff signatures on four different dates, and that resident #001's personal assistive device had not been washed. [s. 15. (2) (a)]

Issued on this 24th day of July, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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) :	ROMELA VILLASPIR (653), SARAN DANIEL-DODD (116), SHIHANA RUMZI (604)
Inspection No. / No de l'inspection :	2018_486653_0012
Log No. / No de registre :	005361-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 23, 2018
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

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 :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the Long-Term Care Homes Act (LTCHA).

Upon receipt of this order the licensee shall: prepare, submit, and implement a plan to ensure the following:

1. Resident #009 and #032's health records, including but not limited to the electronic Treatment Administration Record (eTAR) and written plan of care, consistently reflect the prescribed treatments for areas of altered skin integrity.
2. Prescribed treatments for resident #009 and #032's areas of altered skin integrity are provided to them as specified in their plan of care.
3. The above mentioned documentation shall be available to the inspector upon request.

The plan is to be submitted by e-mail to CentralEastSAO.MOH@ontario.ca referencing report #2018_486653_0012 to Romela Villaspir, LTC Homes Inspector, MOHLTC, by August 6, 2018, and implemented by September 6, 2018.

Grounds / Motifs :

1. The licensee had failed to ensure that the care set out in the plan of care had been provided to the resident as specified in the plan.

During stage one of the Resident Quality Inspection (RQI), resident #009 triggered related to altered skin integrity from both a staff interview and census record, as well as from the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) previous to most recent.

A review of resident #009's written plan of care on an identified date, indicated they had an identified area of altered skin integrity.

A review of resident #009's prescriber order form indicated that on an identified date, Registered Practical Nurse (RPN) #115 received a telephone order from the physician confirming an outside provider's health treatment recommendation.

An observation conducted by inspector #653 on an identified date and time, noted that RPN #101 removed the previous treatment from the resident's identified part of the body, which was different from the prescribed treatment. Afterwards, RPN #101 carried out the treatment procedure as ordered.

An interview with RPN #101 indicated that the previous registered staff had applied an identified treatment to resident #009's identified part of the body, instead of the treatment that was ordered. An interview with RPN #115, confirmed that they had applied the identified treatment instead of the one prescribed, on the resident's area of altered skin integrity on an identified date, and acknowledged that they had not provided care to resident #009 as specified in the plan.

An interview with the Director of Care (DOC) acknowledged the above mentioned information and indicated that the registered staff had not provided care to resident #009 as specified in the plan and as per the treatment recommendation. (653)

2. Due to an area of non-compliance found related to resident #009's skin and wound care, the sample size had been extended to two more residents.

A review of resident #032's written plan of care on an identified date, indicated they had two areas of altered skin integrity. A review of the outside provider's health treatment recommendation that was approved by the physician on an identified date, indicated the treatment for one area of altered skin integrity.

A review of resident #032's electronic Treatment Administration Record (eTAR) for an identified month, revealed the treatment started on an identified date, and the treatment was slightly different from the treatment that was ordered.

An interview with RPN #115 acknowledged that they had incorrectly transcribed the treatment order to the eTAR for the one area of altered skin integrity, and did not write the treatment exactly as it had been ordered.

Further review of resident #032's eTAR from an identified month, revealed that RPN #116 completed the identified treatment on seven identified dates. An interview with RPN #116 indicated that they had been applying the treatment to resident #032 as per the instructions on the eTAR. The inspector read out the outside provider's health treatment recommendation that was approved by the physician, and RPN #116 acknowledged they had not provided care to the resident as prescribed.

An interview with the DOC acknowledged the above mentioned information and indicated that the registered staff had not provided care to resident #032 as specified in the plan, in regards to the treatment on the identified area of altered skin integrity.

The severity of the issue was determined to be a level 2 as there was potential for actual harm.
The scope was a level 2/ pattern as the issue had affected two out of the three residents that had been inspected.
The home had a level 4 compliance history as they had on-going non-compliance with this section of the LTCHA that included:
Voluntary Plan of Correction issued March 15, 2016, (#2016_382596_0003);
Voluntary Plan of Correction issued November 3, 2016, (#2016_235507_0014).
(653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 06, 2018

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 23rd day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Romela Villaspir

Service Area Office / Bureau régional de services : Central East Service Area Office