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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 30, 2019	2018_749722_0013	009108-18, 009120-18	Complaint

Licensee/Titulaire de permis

Trilogy LTC Inc.
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

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

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

COREY GREEN (722)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 17, 18, 19, 20, and 21, 2018

During this inspection, the following intakes were inspected:

Log #009120-18, a complaint involving provision of care, falls prevention, and an allegation of abuse
Log #09108-18, a critical incident related to an allegation of abuse

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), the Behavioural Support Ontario (BSO) nurse, a Physiotherapy Assistant (PTA), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the resident, and the resident's substitute decision maker (SDM).

During this inspection, the inspector also reviewed relevant clinical and administrative records, and made observations of the resident and resident home areas.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. (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).

Findings/Faits saillants :

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

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) from resident #003's substitute decision maker (SDM) on a specified date, related to a specified injury sustained by resident #003. The SDM was concerned that the injury may have resulted from a fall or possible abuse. Inspector #722 reviewed the resident's plan of care, which indicated that the resident was a specified risk for falls, and required a specified level of assistance while ambulating in the home. However, during the inspection, Inspector #722 observed resident #003 without the specified level of assistance while ambulating in the home.

Inspector #722 reviewed resident #003's current written care plan on a specified date, including the history of revisions, related to falls, which indicated the following:
- Resident was at a specified risk for falls for a specified reason, created in the care plan on admission
- Resident required a specified level of assistance for ambulating, created in the care plan on admission

Inspector #722 observed resident #003 on a specified date and time, in a specified resident home area (RHA), when attempting to interview the resident related to another issue. During the interview, Inspector #722 observed the resident ambulating without the level of assistance specified in the plan of care. Inspector #722 made similar observations of the resident ambulating in the home, without assistance as specified in the plan of care, on other specified dates and times.

Inspector #722 reviewed the progress notes for resident #722 related to falls, during a specified period since admission, which indicated that the resident had not had any documented falls during this period.

Assessments related to falls and falls risk were reviewed by Inspector #722 for resident #003 for a specified period of time since admission, which indicated the following:
- A specified falls risk assessment completed on a specified date, indicated that the resident had a history of falls, was identified as at risk for falls, and ambulated with specified assistive devices.
- A physiotherapy assessment on a specified date, indicated that resident #003

ambulated independently without need for assistive devices

Inspector #722 reviewed the RAI-MDS assessments for resident #003 since admission related to falls and mobility. A number of assessments on specified dates indicated that the resident had not sustained a fall over the specified period, and confirmed that the resident had not sustained a fall since admission to the home. A specified number of RAI-MDS assessments on identified dates indicated that resident #003 required a specified level of assistance while ambulating; the remaining RAI-MDS assessments on specified dates indicated that the resident required a different specified level of assistance while ambulating.

During an interview with Inspector #722 on a specified date, PSW #106 indicated that resident #003 did not have a specified risk for falls, and confirmed that they were not providing the level of assistance to resident #003 when ambulating as indicated in the written plan of care. The PSW indicated that they were not aware that resident #003's written plan of care indicated the other specified level of assistance.

Inspector #722 interviewed RPN #109 on a specified date, related to resident #003's risk of falls. During the interview, RPN #109 indicated that they did not believe that the resident was at a specified risk for falls, and that they did not believe that the resident required the level of assistance with ambulating as specified in the current written plan of care. The RPN also confirmed that staff were not providing resident #003 with the level of assistance as specified in the resident's written plan of care, and acknowledged that the written plan of care needed to be updated to accurately reflect the assistance required by resident #003 when ambulating.

On a specified date, Inspector #722 interviewed the Director of Care (DOC) related to resident #003's risk of falls and written plan of care. The DOC indicated that resident #003 did not require the level of assistance specified in the plan of care, that staff were not providing that level of assistance, and that resident #003 needed a different level of assistance when ambulating. The DOC confirmed that the written plan of care did not provide clear direction to staff related to resident #003's care needs with respect to ambulation, and indicated that the resident's written plan of care will need to be updated.

The licensee failed to ensure that there was a written plan of care for resident #003 that set out clear directions to staff and others who provide direct care to the resident, when resident' #003's written plan of care did not reflect the appropriate level of assistance required when ambulating. [s. 6. (1) (c)]

Issued on this 1st day of February, 2019

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

Original report signed by the inspector.