Ontario

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 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
Jul 19, 2019	2019_598570_0013	022436-17, 026483-17, 004622-18, 007011-18, 002700-19	Critical Incident System

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

SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 24, 25, 26, and 27, 2019; July 2, 3, 4, 5, and 8, 2019.

During this inspection, the following intakes were inspected:
- Log #022436-17, Critical Incident Report, related to a medication incident
- Log #026483-17, Critical Incident Report, related to improper transfer of a resident
- Log #004622-18, Critical Incident Report, related to an outbreak
- Log #007011-18, Critical Incident Report, related to an outbreak and
- Log #002700-19, related to follow-up to compliance order (CO) #001 from inspection #2018_749722_0012 / 019030-18 regarding s. 6. (7), compliance due date on May 30, 2019.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), wound care coordinator, and residents.

During the course of this inspection, the inspector, toured specific resident rooms and common residents' areas, observed residents to residents interactions and staff to residents interactions, reviewed clinical records, relevant policies to this inspection, the licensee's investigations documentation.

The following Inspection Protocols were used during this inspection:
Dining Observation
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Skin and Wound Care

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

- **3 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_749722_0012	570

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that an incident of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

A Critical Incident Report (CIR), was submitted to the Director on an identified date and time, related to improper and unsafe transfer of resident #001, occurred one day earlier. The CIR indicated the resident was transferred by one staff member using a lifting device and required two staff assistance. The resident was injured during the transfer.

Review of the CIR and progress notes for resident #001 indicated that the CIR was submitted to the Director one day after the incident had occurred. The CIR indicated the MOHLTC after hours pager was not contacted about this incident.

During an interview with Inspector #570, the Director of Care (DOC) indicated that they became aware of the incident on the same date it happened, and that the Assistant Director of Care (ADOC) #117 initiated the investigation on the same date. The DOC further indicated, the incident was not immediately reported as required and that it was an oversight.

The licensee had failed to ensure that an incident of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident that had occurred on identified date and time, was immediately reported to the Director. The Director was not informed of the incident until the following day. [s. 24. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that any actions taken with respect to a resident

under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Related to resident #003:

During a review of resident #003's progress notes, the following was revealed:
- On identified date, the resident had a skin impairment on specified area.
- On Identified date, skin impairment to an identified area healed.
- On identified date, skin impairment on identified area is resolved. Resident had altered skin integrity.

Review of Treatment Administration record (TAR) for an identified month, indicated: Weekly Skin Assessment: skin impairment to an identified area, specified intervention at specified date. The TAR was signed off on identified date and was not signed of on another identified date.

Review of clinical records for resident #003 indicated:
- RPN #105 completed an initial skin and wound assessment for resident #003 on point click care (PCC) on an identified date, and indicated skin impairment of an identified area.
- Assistant Director of Care (ADOC #106) completed skin and wound assessment for resident #003 on PCC on an identified date, and indicated skin impairment resolved.
The record review did not indicate any skin and wound assessments completed on PCC for resident #003 on two identified dates as directed in the TAR.

During an interview with Inspector #570, RPN #104 indicated upon review of resident #003's TAR of an identified month, that resident #003 had skin impairment on an identified area, but when it was checked on an identified date and it was all clear. The RPN indicated they did not complete a skin assessment form on PCC and they did not document in the progress notes as it was forgotten.

During an interview with Inspector #570, the wound care coordinator RPN #107 indicated upon review of resident #003's TAR that registered staff did not complete the skin assessment form under assessments on PCC for resident #003 on two identified dates.

During an interview with Inspector #570, the Assistant Director of Care (ADOC) #106 indicated there was no skin assessment forms completed for resident #003 on two identified dates. The ADOC indicated that they completed a skin assessment for resident

#003 on an identified date and that the resident had no skin impairment in that area. The ADOC confirmed that when assessing skin, registered staff should be using and documenting the assessment on PCC under assessments. Also, staff could document on the progress notes but there was no documentation on an identified date.

During an interview with Inspector #570, the Director of Care (DOC) indicated skin assessments should be completed for skin impairments and documented on the skin and wound assessment form on PCC and documented in the progress notes. In reviewing the TAR for an identified month, for resident #003, the DOC indicated that staff signed off they completed the skin assessment on an identified date, but they did not document that under assessments in PCC or in the progress notes.

The licensee had failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions were consistently documented as resident #003's skin assessments were not documented using the skin assessment form on PCC on two identified dates, and there was no documentation of the skin assessment on an identified date in the progress notes. [s. 30. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee had failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident Report (CIR) was submitted to the Director on an identified date, related to improper and unsafe transfer of resident #001. The CIR indicated the resident was transferred by one staff member using a a lifting device and required two staff assistance. The resident was injured during the transfer.

Review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) quarterly assessment of an identified date, for resident #001 indicated, the resident was total dependent for transfers by two staff with a lifting device.

Review of resident #001's written plan of care indicated that the resident was to be provided total assistance by two staff using a a specified lifting device with a specified sling for transfer.

Review of the home's investigation notes indicated PSW #101 completed a transfer of resident #001 without a second staff causing the resident to slip out of the sling to the floor.

During an interview with Inspector #570, PSW #101 indicated that they were covering for a co-worker when they completed a transfer alone using a lifting device for resident #001 who fell from the sling during the transfer. The PSW indicated that they were aware that two staff were required when using the lift and that it was a mistake not having a second staff to assist.

During an interview with Inspector #570, RPN #102 indicated when a lifting device is used to transfer a resident, two staff should be available to assist with the transfer. RPN #102 indicated that PSW #101 was covering for another PSW and that PSW #101 did not ask for another staff member to assist to transfer resident #001 using a lifting device.

During an interview with Inspector #570, the Director of Care (DOC) indicated that resident #001 was not transferred safely by staff #101. The DOC indicated staff are expected to have two staff available when using lifting devices to transfer residents.

The licensee had failed to ensure that staff used safe transferring and positioning devices or techniques when PSW #101 transferred resident #001 using a lifting device without the assistance of a second staff. [s. 36.]

Issued on this 26th day of July, 2019

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

Original report signed by the inspector.