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
Sep 5, 2019	2019_630589_0019	003732-18, 019429-18, 032795-18, 000580-19, 014352-19, 016011-19	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

JOANNE ZAHUR (589), STELLA NG (507)

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): August 22, 23, 26, 27, 28, 29, & 30, 2019.

The following intakes were completed during this inspection:
-logs #014352-19, #016011-19 and #032795-18 related to withholding approval for admission,
-log #000580-19 related to neglect and emotional abuse,
-log #019429-18 related to injury of unknown cause, and
-log #003732-18 related to personal care, activities and drug administration.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Nurse Manager (A-NM), Assistant Director of Care (ADOC), Facility Charge Nurses (FCN), Registered Practical Nurses (RPNs), Personal Support Workers (PSW), Environmental Manager (EM), Central East Local Health Integrated Network Placement Coordinators (CELHIN-PC), Substitute Decision-Makers (SDM), and Residents.

During the course of the inspection, the inspector(s) observed staff to resident interactions, resident to resident interactions, resident and room observations, and the provision of care, reviewed health records, the Long Term Care Homes (LTCH) internal investigation notes, relevant annual program evaluations, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (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 has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A complaint was received by the Director regarding plan of care. During a conversation with the complainant, they voiced concerns that care was not provided to resident #001 as specified in the plan of care specific to toileting.

A review of resident #001's progress notes and the most recent Kardex indicated the resident was on an alternate mode of nutrition that would run continuously for 21 hours daily and which required specific directions when resident #001 was toileted.

During an interview, staff #109 stated that on an identified date in August 2019, at a specified time, resident #001 requested assistance with toileting. Staff #109 took the resident to the washroom with the alternate mode of nutrition in place. Staff #109 further stated that resident #001's alternate mode of nutrition was not discontinued prior to toileting as both the RPN and RN were busy with another resident.

During an interview, staff #108 stated that on an identified date in August 2019, at a specified time, they were busy caring for another resident. When they came to the nursing station, resident #001's family member was telling the RN that the PSW had taken resident #001 to the washroom without providing specific care to the alternate mode of nutrition. Staff #108 went to the washroom, and provided care while resident #001 remained in the washroom.

During an interview, staff #110 stated that due to frequent identified incidences with the alternate mode of nutrition, PSWs were to notify registered staff to provide the specified care before toileting. If the registered staff on the floor was not available at the time, PSWs were to call registered staff on other floors to provide this care to resident #001.

In interviews, staff #110 and staff #100 confirmed that care was not provided to resident #001 as specified in the plan of care. [s. 6. (7)]

2. A complaint was received by the Director regarding alleged abuse. During a conversation with the complainant, they voiced concerns that resident #005 sustained an injury of unknown cause.

A review of the Critical Incident System (CIS) report and resident #005's progress notes indicated that resident #005 had injuries to a specified body area of unknown cause. An x-ray report indicated an injury and an underlying health condition.

A review of resident #005's care plan at the time of the incident, indicated that they required extensive assistance with two staff support related to responsive behaviours.

The home conducted an internal investigation and notified the police due to the unknown cause of the above mentioned injury. During the investigation, staff #126 told staff #113 that during an identified shift, staff #126 had provided personal care without the assistance of another staff member despite the care plan at the time indicating that resident #005 required the assistance of two staff for personal hygiene related to responsive behaviours. Staff #126 further told staff #113 that during the provision of care, resident #005 had exhibited responsive behaviours while personal care was being provided..

Staff #126 was away from the Long Term Care Home (LTCH) at the time of this inspection, and therefore was not available for an interview.

During an interview, staff #100 confirmed that the personal care set out for resident #005 was not provided as specified in the plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to approve the applicants' admissions and failed to establish that the licensee lacked the physical facilities necessary to meet care requirements and that the staff lacked the nursing expertise necessary to meet applicant's #004, #008, and #009's care requirements.

Complaints were submitted to the Director from the Central East Local Health Integrated Network (CELHIN) related to written notices of withholding approval for admission to the LTCH for applicant's #004, #008 and #009.

1)The written notice of withholding approval for admission to the LTCH for applicant #008, indicated the staff lacked the nursing expertise necessary to meet their care requirements related to a specific medical condition. The written notice further indicated

the location of the LTCH might be a trigger or worsen their medical condition and that the LTCH could not monitor them and ensure their safety. As a result, the LTCH does not have the resources to safely meet the applicant's care and safety needs.

2)The written notice of withholding approval for admission to the LTCH for applicant #004, indicated the home could not provide the care they need because at the present time their care needs would be more that the LTCH would be able to effectively manage. The written notice further indicated that the basis for this decision was based on the LTCH having already reached their maximum amount of resources in the home and did not have the one to one care that applicant #004 required. The written notice did not include the specific care needs that the LTCH could not meet. The written notice also indicated the LTCH has a restraint policy which means residents are not allowed to be restrained in any way, including bed rails even though applicant #004's application indicated that bed rails were being used for bed mobility.

3)The written notice of withholding approval for admission to the LTCH for applicant #009, indicated the LTCH could not provide the care that applicant #009 needed, because their care needs would be more than the LTCH would be able to effectively manage. The written notice further indicated the LTCH would be unable to meet their needs based on the many responsive behaviours exhibited by the applicant, the risk that they may impose to themselves and others and the inability to predict when these responsive behaviours would be exhibited. A review of the most recent behavioural assessment sent to the LTCH from the CELHIN indicated that applicant #009 exhibited several responsive behaviours and this assessment also indicated interventions to manage these responsive behaviours.

During an interview, staff #100 stated the LTCH has access to external consultants for the management of responsive behaviours, one full-time (FT) RPN and one FT PSW involved in the home's internal responsive behaviour program. The LTCH also has registered staff trained in physical, intellectual, emotional, capabilities, environmental and social needs (P.I.E.C.E.S.) training, and both PSW and recreation staff trained in gentle persuasive approach (GPA) and Montessori. DOC #100 also stated a pass card is required to access the front entrance/exit doors and the elevators in the LTCH. Only residents that are deemed appropriate after a mini mental assessment is completed are given a pass card.

Staff #100 acknowledged that for applicant's #004, #008 and #009, citing that staff do not have the nursing expertise to manage responsive behaviours, and that the LTCH lacked

the physical facilities necessary to meet care requirements, were not sufficient grounds to withhold approval for admission to the LTCH. [s. 44. (7)]

2. When the licensee withheld approval for admission for resident #004, the licensee has failed to ensure that the written notice of withholding approval for admission provided a detailed explanation of the supporting facts, as they related to the both the LTCH and to the applicant's condition and their requirements for care.

A complaint was submitted to the Director from the CELHIN related to a written notice of withholding approval for admission to the LTCH for applicant #004.

A review of the most recent application from the CELHIN indicated that resident #004 had no responsive behaviours however required specific care needs related to an underlying medical condition causing altered skin integrity and required identified care every two hours when in bed. The application also indicated bed rails were used to aid with positioning.

The written notice of withholding approval for admission to the LTCH for applicant #004, indicated the home could not provide the care they needed because their care needs would be more that the LTCH would be able to effectively manage. The written notice further indicated that the basis for this decision was based on the LTCH having already reached their maximum amount of resources in the home and did not have the one to one care that applicant #004 required. The written notice did not provide a detailed explanation of resident #004's care needs and how the LTCH could not meet the requirements of care required.

During an interview, staff #100 stated that if they did not identify in the written notice that the withholding of an admission was based on responsive behaviours, it was then based on a resident's physical care needs. DOC #100 acknowledged that the written notice for resident #004 did not provide a detailed explanation of the supporting facts, the applicant's condition and their requirements for care, that they felt the LTCH could not provide. [s. 44. (9)]

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 shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care
requirements; or
(c) circumstances exist which are provided for in the regulations as being a ground for
withholding approval,
- the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval;
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care;
(c) an explanation of how the supporting facts justify the decision to withhold approval; and
(d) provide contact information for the Director, to be implemented voluntarily.

Issued on this 6th day of September, 2019

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

Original report signed by the inspector.