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**

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 25, 2017 | 2017_505103_0022 | 008671-17 | Complaint |

### Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Trillium Retirement and Care Community
800 EDGAR STREET KINGSTON ON K7M 8S4

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

DARLENE MURPHY (103)

### 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): May 17-19, 2017**

**Log #008671-17 (complaint related to resident care).**

**During the course of the inspection, the inspector(s) spoke with Personal support workers (PSW), Registered Practical Nurses (RPN), Restorative Care lead, the Physiotherapist (PT), and the Assistant Director of Care (ADOC).**

**During the course of the inspection, the inspector reviewed the resident health care record including plan of care, progress notes, medication administration records and documented assessments related to continence care and mobility/transfers.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Medication**
**Personal Support Services**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 has 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 are documented.

In accordance with the LTCHA, 2007, s. 9 (1), Restorative care, including physiotherapy, are considered to be an organized program and as such are required to document all resident assessments, reassessment and resident responses to interventions.

Resident #001 was admitted to the home on an identified date. A physiotherapy referral was made on the day of admission and indicated the reason for the referral was a decline in transfer ability, ambulation concerns, decline in ROM, and pain management. The referral provided additional information that the resident ambulated with a walker with the assistance of two staff, but as a result of a recent injury, was experiencing a decline in the ability to ambulate. The referral indicated the goal was to improve the resident's ambulation with the use of a walker. The referral form indicated the resident was assessed by the physiotherapist five days following the date of the referral and qualified for physiotherapy. Documentation related to this assessment was not found.

On another identified date, a second physiotherapy referral was submitted from the nursing department to reassess the resident transfer due to a decline in transfer ability and range of motion. The referral indicated the resident was no longer safe to use a Sara lift. The referral form indicated the physiotherapist had assessed and the resident qualified for physiotherapy, but there was no documented assessment found associated with this referral.

On another identified date, a third referral to physiotherapy was made requesting a reassessment of the resident's ability to safely use a transfer sling. The referral form indicated the physiotherapist had completed an assessment and indicated the resident did not qualify for physiotherapy.

On another identified date, a referral to physiotherapy was once again made from the nursing department indicating the family and the physician were requesting an assessment of the resident's ability to stand. The physiotherapist indicated the resident did not qualify for physiotherapy and there was no documented assessment or recommendations found.

The Physiotherapist (PT) was interviewed and indicated he had gone to see the resident in their room following the first request for a physiotherapy assessment. The PT advised this inspector that he made some identified observations and that during the assessment,

the resident became combative and he was unable to complete the assessment. The PT indicated he consulted with the Nurse Practitioner and the decision was made that the resident would not benefit from physiotherapy. The PT's assessment related to this initial assessment was not documented. The PT further indicated that despite additional requests for physiotherapy to reassess the resident, he did not attempt any additional assessments or make any recommendations due to the resident's combative nature.

Physiotherapy assessments and reassessments for resident #001 were not documented including the resident's responses to the interventions. [s. 30. (2)]

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**WN #2: 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,**
**(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that each resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder incontinence based on the assessment and that the plan is implemented.

Resident #001 was admitted to the home on an identified date and had identified diagnoses. The Minimum data set (MDS) completed by the Community Care Access Centre (CCAC) on an identified date was reviewed and indicated resident #001 was continent of both bladder and bowel and did not require the use of pads/briefs.

Staff were interviewed and indicated all residents admitted to the home have a three day journal completed to determine the resident's voiding/bowel patterns and to assess for any incidents of incontinence. Staff indicated this is done to assist in the development of the resident's plan of care such that continence can be maximized. The journal was reviewed and indicated the following:

December 17/16 (0700-1500 hour): the resident was toiletted 3 times and had no incidents of incontinence,
December 17/16 (1500-2300 hour): the resident was toiletted three times and had no incidents of incontinence,
December 18/16 (0700-1500 hour): there was no documentation,
December 18/16 (1500-2300 hour): the resident was toileted three times and had 2 incidents of a wet brief.
December 19/16 (0700-2300 hour): there was no documentation.
The journal did not include an area to reflect toiletting patterns during the overnight hours.

The ADOC was interviewed in regards to the three day journal and stated it is important in establishing a resident's toiletting pattern and agreed the information was used to assist staff in developing the resident plan of care and in providing care that will maximize the resident's ability to be continent. The ADOC agreed that the three day journal was not completed for the full three days for resident #001 and that the current documentation did not include any toiletting requirements during the hours of 2300 to 0700 hours.

The resident's progress notes were reviewed and indicated the following:
-December 16/16 at 0100 hour, resident #001 was toiletted and then settled to sleep,
-December 17/16 during the night shift, the resident was toiletted and
-December 17/16 at approximately 2100 hour, the resident requested to be toiletted and was transferred by means of a sara lift.

The resident progress notes were reviewed and indicated the following:
December 20, 2016 a multi-disciplinary conference was held and indicated resident #001 was occasionally incontinent with the use of a brief for containment, the resident did not follow instructions or routines and was not a candidate for a toiletting routine.
December 21, 2016, restorative care indicated a commode was now available at the resident's bedside and that a Hoyer lift and medium toiletting sling would be used to assist in toiletting.
December 22, 2016, the documentation indicated the resident was given a bedpan on two instances overnight and the resident voided a large amount and had a bowel movement,
December 28, 2016, restorative care reassessed the resident and indicated resident should be toiletted in bed and utilize a bedpan until further assessment completed.
December 30, 2016, staff documented restorative care had reassessed and staff should

continue to use the Hoyer lift and a yellow, medium toiletting sling.

PSW's #104 and #103 were interviewed. Both indicated they were familiar with the resident and indicated they recalled the resident used a bedpan at all times for toiletting. Both indicated the resident was occasionally incontinent of both urine and stool and required the use of briefs for containment.

Resident #001's plan of care was reviewed and indicated the following:
Under "bowel function": continent.
There were no entries to reflect the resident's bladder continence, use of briefs and any toiletting routines required to maximize the resident's ability to maintain continence.

The licensee failed to ensure an individualized plan of care was in place to promote and manage resident #001's bladder and bowel continence. [s. 51. (2) (b)]

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**Issued on this 25th day of May, 2017**

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

**Original report signed by the inspector.**