Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 30, Jun 1, 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 2012	2012_035124_0018	Resident Quality Inspection

Licensee/Titulaire de permis

SPECIALTY CARE EAST INC.
400 Applewood Crescent, Suite110, VAUGHAN, ON, L4K-0C3

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

TRILLIUM CENTRE
800 EDGAR STREET, KINGSTON, ON, K7M-8S4

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

LYNDA HAMILTON (124), DARLENE MURPHY (103), JESSICA PATTISON (197), PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

During the course of the inspection, the inspector(s) spoke with the Residents, Interim Administrator, Director of Care, Associate Directors of Care, Medical Advisor, Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Food Services Supervisor, Operations Manager, Personal Support Workers (PSW), Dietary and Housekeeping Staff,Program Managers,Program Staff, Restorative Care staff, Physiotherapist, Resident Assessment Instrument Co-ordinator, General Manager-Retirement, Volunteer Co-ordinator, Director of Resident and Family Services, President of Residents' Council, President of Family Council and Family Members.

During the course of the inspection, the inspector(s) did a walk through tour of the home, observed meal service, staff-resident interactions, medication administration, reviewed resident health care records, Registered Dietitian hours, Food Service Supervisor hours, staffing schedules, home's policies and procedures related to abuse, restraint, immunization, infection control, medication, consent and weight loss.
In addition to the Resident Quality Inspection, log O-001074-12 was inspected.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s.8. (1) (b) in that they did not comply with the schedules and procedures in place for routine, preventive and remedial maintenance as required under O. Reg. 79/10 s. 90 (1)(b).

Policy XV11-D-5.00, "Preventative Maintenance Schedule" stated the the Director of Environmental Services/Maintenance Manager will carry out preventative maintenance on a daily, weekly, monthly, quarterly, semi-annual and annual basis as per task list and will inspect the operation of listed items and make necessary corrections.

-Walls throughout the home are scarred and gouged and some have holes
-Baseboard is detached from the wall in two identified rooms
-Toilet paper holders are missing in three identified rooms
-In one room the cable outlet plate is loose and the wires are accessible behind the plate
-One room has making tape covering the door latch mechanism.

The home did not carry out preventative maintenance or make corrections to these areas and as such, did not comply with their procedures for preventative maintenance.
2. As per O. Reg. 79/10 s.136. (1) (a) the licensee shall ensure as part of the medication management system, that a written policy is developed in the home that provides for ongoing identification, destruction and disposal of (a) all expired medications.

The licensee has failed to follow their medication Policy 5-1, "Expiry and Dating of Medications". This policy states "a system is in place to ensure that an adequate and unexpired supply of medication is maintained for each resident". The relevant procedure states "examine the expiry date of all medications on a regular basis and to remove any expired medications from stock and order replacement as necessary."

On June 6, 2012, the medication cart on one unit was observed. The following medications were found to be expired:

Resident # 5 had a bottle of eye drops in the medication slot which according to the box had expired October 2011.

Resident # 6 had a glucose testing kit that contained testing strips with an expired date of October 2011.

An unlabelled box of suppositories were expired on March 2012.

A Glucagon injection kit was present which had expired November 2010.

On June 6, 2010 the stock medication room was observed. The following medications were found to be expired:

Mucillium bottle had expired May 2012,

Dimenhydrinate 100 mg tabs had expired November 2011and several boxes are due to expire June 2012. (103)

2. On June 6, 2012, a review of the medication cart on another unit (in med prep room) indicated that

Resident # 16 medication ordered February 10, 2011 with an expired date of February 2012 had not been removed from the medication cart. This medication was discontinued February 16, 2012.

Resident # 17 mediation with order date May 26, 2011 with an expired date of May 2012 had not been removed from the medication cart.

Resident # 18 mediation ordered February 15, 2011 had an expired date of February 2012.

Resident # 18 received this discontinued medication on May 7, 2012.

A bottle of stock Mucillium 336 gram with an expired date of May 2012 was found in the medication cart.

An audit of the Emergency stock box located in the Cottage Medication prep room indicated that Diphenhydramine 50 mg/ml injectable issued January 28, 2008 had an expired date of April 2012.

Additional Required Actions:

CO # - 901 was 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. 15. Accommodation services

Specifically failed to comply with the following subsections:

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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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 has failed to comply with LTCHA, 2007 S.O., c.8 s. 15 (2) (c) in that the home, furnishings and equipment were not maintained in a safe condition and in a good state of repair.

The following observations were made throughout the course of the Resident Quality Inspection and constitute potential risk related to infection control and resident safety

Lake Unit:

Room 238-The outer edge of the door is cracked and broken with splintering wood.

The walls of the Lake dining room were scarred and gouged. (124)

2. Country Unit:

Room 232-Was observed to have bare metal strapping at the corner of bathroom/entrance hall. The plaster is rough and breaks away when touched.

Room 226-The toilet paper holder is pulled off of the wall and the toilet paper is located on the back of the toilet

Room 231-Was observed to have bare metal showing and the plaster is rough and falling when touched.

Room 222-The toilet paper holder is missing and the toilet paper is on the back of toilet.

Heritage Unit:

Room 203-There are numerous gouges in the wall behind the lazy boy and it is rough to touch. There is a large area of plaster missing at the left edge of the entrance hall. The baseboard has rough/sharp edges and is detached by approximately eight inches.

Room 205-The over bed lamp is missing from the wall and there is missing drywall above the resident's bed.

Room 208-The toilet paper holder is missing and the drywall is loose with sharp edges. The toilet paper and remainder of the holder is on the back of the toilet. There is missing drywall down to the metal and the baseboard is detached from the wall by approximately eight inches.

Room 212-There is a hole in the wall at the corner of the lazy boy with loose drywall falling from the hole.

Room 216-The entrance hall has metal showing with a large area of paint and plaster missing and is rough to touch.

Dining room floor has duct tape covering an area of the floor and the middle area of duct tape is depressed and spongy.

Garden Unit:

Room 105-The bathroom has loose peeling paint which appears to be a result of water damage and the ceiling above the toilet has yellow, discoloured ceiling tiles that are sagging. The cable outlet plate is loose and the wires are accessible behind the plate.

Room 108-There is a hole in the wall all the way through to the drywall below the window. The toilet paper holder is pulled out of the wall. (103)

Harbour Unit:

Room 231-Was observed to have two holes on the closet exterior exposing jagged metal strapping. The bathroom door and interior wall in this room was scarred, gouged and paint was peeled.

Cottage Unit:

Room 224-Was observed to have a hole in the wall on the door entrance to the bathroom and a second hole on the right hand wall. The bathroom door was also observed to have paint chipped as well as exposed splintered wood at the base of the door.

Room 228-Was observed to have masking tape covering the door latch mechanism.

Room 227-Was observed to have a large hole on the wall behind the bed, exposing dry wall and jagged edges.

Orchard Unit:

The Nursing Station office door was noted to have peeling and chipped paint.

Hallway chairs throughout the Ridge and Court building were noted to have legs and arms with chipped paint and finish missing.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. On June 14, 2012 on or about 1400 hours, resident #12 was noted to be sitting in a wheelchair. The resident's front closing seat belt was observed to be loose and twisted. The belt could be held outward from the resident's abdomen by approximately four inches and the right side of the belt was observed to be twisted four times. RPN #S122 was asked to observe the resident's belt and she reapplied it correctly.

On June 15, 2012 on or about 1000 hours, resident #12 was once again observed to be sitting in a wheelchair with a front closing seat belt in place. The belt was observed to be loose and could be held four-five inches outward from the resident's abdomen. In addition, the right side of the belt was observed to be twisted several times. RPN #S122 was once again asked to observe the resident's belt and she readjusted it correctly. She indicated the resident does manipulate the seat belt and that perhaps further staff education is required in the application of restraints.

The plan of care for resident #12 indicates the resident is at high risk for falls, is cognitively impaired and it indicates the resident requires a seat belt restraint for resident safety when in a wheelchair.

On June 14, 2012 on or about 1430 hours, resident #13 was observed sitting in a wheelchair on another unit. The resident's front closing seat belt was noted to be snug. In addition, the resident's restraint was noted to be twisted six times. PSW #S133 was sitting in a nearby location and was asked to look at the belt. She indicated the resident sometimes plays with the restraint. RPN #S128 was asked to observe the resident's restraint and she made appropriate adjustments to it.

On June 15, 2012 on or about 1030 hour, resident #13 was observed sitting in a wheelchair. The front closing seat belt was noted to be snug and the resident's right side of the seat belt was once again twisted three to four times. RPN #S114 was asked if there had been any communication brought forward from previous shifts to her in regard to a problem with the application of this resident's seatbelt and she indicated there had been none. The RPN reapplied the resident restraint correctly.

The plan of care for resident #13 indicates the resident is at high risk for falls and requires the application of a seat belt restraint when in a wheelchair to prevent injury.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following subsections:

s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 r. 114 (1) in that the licensee of a long-term care home does not have an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

During the Resident Quality Inspection, six areas of non-compliance related to the medication management system received written notifications:

WN # 10 O. Reg. 131 (1) residents not receiving medication as prescribed

-poor therapy outcomes for pain management because of missed doses of routinely scheduled narcotic analgesic

-additional dose of antibiotic was given that was not prescribed

-altering the therapeutic effectiveness of medications through crushing of medication that was contraindicated to be crushed

WN #9 O.Reg. 129 (1)(b) related to the safe storage of controlled substances

-failure to keep controlled substances double locked

WN # 1 and corresponding immediate Compliance Order O. Reg. 8. (1) (b) related to 136 (1)(a) the management of expired medications

-widespread presence of expired medication throughout the home including a Glucagon injection kit on one medication cart that had expired November 2010. In addition a resident received an expired dose of medication.

WN #8 O. Reg. 135. (2) (a) related to the documentation of medication incidents

-Failure to complete medication incidents for omissions of a regularly scheduled narcotic analgesic for a resident with severe, chronic pain

WN #11 O. Reg. 126 related to the storage of medications in the original labelled container

-Loose medications not in their original labelled package found in two of the four areas inspected. These medications could not be linked to a specific resident nor could the reason for them not being given be identified.

WN O.Reg 129 (1) (a) (i) related to storage area for medication that is exclusive for drugs and drug related supplies

-personal belongings or personal care supplies were found in four of the four storage areas inspected

These findings of non-compliance demonstrate that the medication management system does not provide safe medication management and does not optimize effective drug therapy outcomes for residents. (103) (124) (143)

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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 subsections:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. Files for visiting pets coming into the home were reviewed. One volunteer had provided a health certificate for her visiting dog dated November 19, 2010. There was no further health certificates to date of inspection.
The licensee has failed to comply with O.Reg.79/10 s.229.(12)in that the visiting pet had no proof of up to date immunizations.
2. The following residents were not screened for tuberculosis(TB)within fourteen days of admission:

- Resident #1 was admitted to the home on a specific date; TB step one screening was initiated fifteen days later and step two screening was initiated ten days after that.
-Resident #2 was admitted to the home, TB step one screening was initiated thirty-nine days later and step two screening was initiated thirteen days after that.
-Resident #4 was admitted to the home, TB step one screening was initiated twenty-five days later and there was no indication that step two screening was completed.
The licensee failed to comply with O.Reg. 79/10 s. 229.(10)1. in that residents admitted to the home were not screened for TB within fourteen days of admission.

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 residents admitted to the home are screened for tuberculosis within fourteen days of admission as per O.Reg. 79/10 s.229.(10)1, to be implemented voluntarily.

WN #6: 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 subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Resident #8 was interviewed in regards to having choice in the bathing schedule. The resident indicated sometime in March 2012, while visiting with a family member who lives out of town, a PSW approached the resident and indicated it was time for a bath. Resident #8 asked if it could be given at a later time that day after the family member left and the staff member advised the bath was to be now or never. The resident stated that he/she did take a bath at that time.

The Director of Care was interviewed and indicated a staff member has been previously reprimanded related to demonstrating an inflexible approach to bathing.
2. Resident #30 reported to the inspector that PSW #S119 yelled at the resident during the delivery of care.
The Director of Care (DOC) confirmed that Resident #30 reported feeling uncomfortable with PSW #S119 and the way the staff member had spoken to to the resident. The DOC took action to address the situation.
3. On June 13, 2012 resident #29 reported to the inspector that medical staff and nursing staff did not notify the resident of medication changes prior to administering medications.The resident reported that the consequences of giving or refusing consent to treatment was not addressed prior to changes.
On May 5, 2012 the attending physician made changes to a resident #20's medication. A review of the resident health care record indicated that consent had not been documented in the progress notes as per policy #VI-D10.10, "Authorization of Personal Assistance and Consent to Treatment". Resident #20 was interviewed on June 12, 2012 and reported that the resident was not consulted and did not provide consent to change the medication.

The licensee has failed to comply with LTCHA 2007, s.3.(1)1.and 11.ii in that residents were not treated with courtesy and respect and that residents did not give or refuse consent to any treatment.

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 residents' right to be treated with courtesy and respect and to give or refuse consent to any treatment is respected, to be implemented voluntarily.

WN #7: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 6(10)(c) in that the resident has not been reassessed when care set out in the plan has not been effective.
On January 19, 2012 a Restorative/Nursing Rehab Note was made by staff member #S154 in resident #15's chart indicating that nursing requested equipment to help the resident with sore feet. The note also stated that the resident would be put on the list to see Shopper's on Monday to check if the equipment was appropriate for the resident's legs. There were no further progress notes made related to the use of this equipment.
Resident #15 was observed with her feet unsupported and dangling over the equipment on June 5, 8 and 12, 2012.
On June 8, 2012, Inspector #197 asked RPN #S123 to come and look at resident #15's positioning. RPN #S123 stated that resident #15's feet should not be dangling off the equipment.
2. The licensee has failed to comply with LTCHA 2007, s. 6(1)(c) in that resident's plans of care did not provide clear direction to staff.
PSWs #S126 and #S127 were interviewed in regards to resident #7's continence care needs. PSW #S126 stated the resident has been incontinent of urine for some time now and wears a continence product both night and day. She reported staff assist the resident with brief changes and that on occasion the resident changes the product.
During an interview, PSW #S127 reported that the resident had been having episodes of incontinence on clothing and furniture. Staff discussed with the resident the use of a continence product which the resident refused to wear initially. She stated the resident is now agreeable to wearing a product at all times and that the resident self-toilets and changes the briefs. She went on to advise that staff offer to assist but the resident will often decline.

The resident's plan of care related to continence indicates the resident's bladder function as continent and there is no indication the resident is wearing a continence product or any instructions to staff related to the changing or monitoring of a product.
3. PSW's #S153 and #S125 were interviewed in regards to resident #10's oral hygiene needs. Both staff members advised the resident is set up to brush his/her own teeth and requires extensive cueing to perform the task. Both advised that despite the cueing, the resident requires staff to complete the task as the resident frequently refuses to do the care or is not able to do the care.

Resident #10's plan of care for oral hygiene states the resident needs no assistance with performing the task.
4. The licensee failed to comply with LTCHA 2007 s. 6(7) in that the care set out in the plan of care was not provided to the resident as specified in the plan.
The plan of care for resident #14 details the toileting program as follows:
Toileting Program - Bladder/Bowel -1x Staff to toilet resident according to assessed needs - during specified times and before going to bed.
Resident #14 was observed during a specific time frame on June 14, 2012 in the activity room. During this time the resident was not toileted. The resident was observed again during another time frame on June 14, 2012 in the hallway outside the nursing station and the resident was not toileted during this time.
5. PSW #S101 reported to the inspector that during the day shift on June 12, 2012 resident #36 was not using the appropriate continence product.
On June 14, 2012, during the day shift, the inspector noted that the resident was not wearing the appropriate continence product.
On June 14, 2012, resident #36 reported that she/he had not used the appropriate continence product all week.
Resident #36's electronic Medication Administration Record (eMAR) stated that the resident was to use one type of continence product during the day.

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 residents' plans of care are followed, provide clear direction to staff and are reviewed and revised when interventions have not been effective, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following subsections:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 135. (2) (a) in that all medication incidents were not documented.

The physician prescribed narcotic analgesic every eight hours for resident #30. The resident's electronic Medication Administration Record (eMAR) specified that she was to receive the medication at 0800 hours, 1600 hours and 2359 hours.
It was documented on resident #30's eMAR that the resident did not receive the 2359 hours dose of Hydromorph Contin 6 mg CR on April 2, 3, 6, 15 and 30, May 1, 4, 5, 6, 9, 10, 15, 16, 17, 28, 29, June 1, 2, 3, 2012.
The Director of Care reported to the inspector that she would expect registered staff to administer the 2359 hours dose of medication as it was a regularly scheduled analgesic and if not administered, it would constitute an omission. She also indicated that an omission constitutes a medication incident.
The Director of Care reported to the inspector that there were no medication incidents completed for Resident #30's missed doses of 2359 medications.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s. 129. (1)(a) in that drugs are not stored in an area or medication cart that is used exclusively for drugs and drug-related supplies.

On June 12, 2012 at 10:54 the following was observed:

-in resident #35's medication slot there was a holder which contained personal card and a ring in a plastic bag
-in resident #38's medication slot there were three rings
-in resident #39's medication slot contained her health card. (124
-stock storage area on level 2 in the Court building contains storage of medications as well as dressing supplies, personal care supplies (toothpaste etc) urine collection cups etc. (103)
-On June 12, 2012 Resident #26 observed to have approximately thirty-five dollars stored in the Orchard medication cart.(143)
2. The licensee failed to comply with O.Reg. 129 (1)(b) related to the storage of controlled substances in a separate double locked area.

On June 13, 2012 Lorezapm 4 mg/ml injectable was observed stored in the fridge in locked medication room on Orchard Unit. Clonazepam was observed in the strip packaging for resident #25. (143)

On June 12, 2012, resident #30's 2000 hours dose of Diazepam 5 mg was observed included in the regular strip packaging along with her other medications. These strip packages were not double locked. (124)

During an observation of the medication cart on the Garden unit, resident #41 was noted to have Clonazepam 0.5 mg tablets included in the regular strip packaging along with his other medications. These strip packages were not double locked. According to RPN #S112 only the as required dosages of benzodiazepines are double locked. (103)

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 r. 131 (1) in that medication was not administered in accordance with directions for use specified by the prescriber.

The physician prescribed a narcotic analgesic every eight hours for resident #30. The electronic Medication Administration Record (eMAR) specified that the resident was to receive the medication at 0800 hours, 1600 hours and 2359 hours.

It was documented on resident #30's eMAR that the resident did not receive her 2359 hours dose of medication on April 2, 3, 6, 15 and 30, May 1, 4, 5, 6, 9, 10, 15, 16, 17, 28, 29, June 1, 2, 3, 2012.

Resident #30 demonstrated poor drug therapy outcomes following these missed doses as indicated by the documentation in the progress notes dated April 1-May 2, 2012 reviewed by the inspector:

-April 3 morning resident required as needed narcotic analgesic for complaints of pain to lower leg, resident received only minimal effect from the as needed analgesic and in addition received as needed benzodiazepine for continued complaints
of lower leg pain (missed 2359 dose on April 2, 2012)

-April 4-resident required two as needed doses of narcotic analgesice with only moderate effect for complaints of pain to lower leg (missed 2359 dose on April 3, 2012)

-April 7-resident required as needed narcotic analgesic at 0730 hours with only minimal effect and as needed benzodiazepine at
1100 hours with only minimal effect (missed 2359 dose on April 6, 2012)

-April 16-resident noted to be upset and required as needed narcotic analgesic at 0900 hours with only minimal effect, in addition the resident required as needed benzodiazepine at 1030 hours when resident noted to be crying in the hall (missed 2359 dose April 15, 2012)

-May 2, 2012-the resident required two doses of as needed narcotic analgesic with no effectiveness noted (missed 2359 dose on May 1, 2012)

There is no clinical information to indicate that these missed doses were communicated to the physician.

The physician prescribed narcotic analgesic every eight hours for resident #30. The resident's electronic Medication Administration Record (eMAR) specified that the resident was to receive narcotic analgesic at 0800 hours, 1600 hours and 2359 hours.

It is documented on resident #30's Individual Controlled Substance Monitoring Sheet that the resident received narcotic analgesic at 1200 hours and at 1600 hours on May 23, 2012 and at 1200 hours and 1700 hours on June 3, 2012.

It was confirmed with RPN #S100 that resident #30 did receive the 0800 hours doses of narcotic analgesic at 1200 hours.(124)

During an observation of the medication cart on a unit, a bottle of antibiotic tablets containing five pills were found in the medication slot for resident #44. The bottle indicated twenty-eight tablets of antibiotic were dispensed on June 6, 2012 and were to be given four times each day for a total of seven days. The eMAR indicated two doses of antibiotic had been administered on June 5, 2012 and the medication should
have been completed as of June 12, 2012 after the 1200 hour dose was given. The eMAR indicated an additional dose of antibiotic had been given on June 12, 2012 at 1700 hour.
RPN #S123 was interviewed and indicated the antibiotic was originally taken from the emergency stock box and a total of six pills would have been administered by staff before the bottle supplied by pharmacy were started.

Associate Director of Care indicated the medication error occurred because the eMAR will prompt the nurse to indicate if

this is the last dose to be administered. The RPN working the evening of June 12, 2012 indicated that it was not the last dose because she observed the remaining medication left in the bottle of antibiotic. After the dose was administered, the RPN realized an additional dose had been given. (103)

On June 13th, 2012 at approximately 0915 Staff #S134 was observed administering medications to resident #27. It was observed that a medication capsule was opened and its contents administered to the resident along with other crushed medications. This medication in a capsule format is a time released medication and as such was not administered to the resident in accordance with the directions for use by the prescriber.(143)

On June 12, 2012, resident #34 was observed to receive her 0800 hours doses of two medications in crushed format. One of the medications is a time released medication and as such was not administered to the resident in accordance with the directions for use by the prescriber. The Associate Director of Care, S#107 confirmed that the other medication was a medication that was not to be crushed and as such was not administered in accordance with directions for use by the prescriber.(124)

WN #11: 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 has failed to comply with O. Reg. 126 in that drugs for destruction did not remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered or destroyed.

During an observation of the medication cart on the Garden Unit, it was noted the fourth drawer had a container that held numerous opened baggies containing resident medications not administered. In addition, there were seven loose medications that were found in the bottom of the container. RPN #S112 was interviewed and indicated these medications are placed in this area of the cart when they are not administered to the resident for whatever reason. She indicated when the container is full, they are taken for destruction. (103)

A two litre white plastic container labelled Surplus Drugs was observed in the Lake House medication cart. This container held approximately 18 loose pills that were not in their original labelled container or package provided by the pharmacy.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following subsections:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee does not have the following required information posted in a conspicuous and easily accessible location:
-most recent audit report
-Resident Rights in French in the Court building
-policy on zero tolerance of abuse and neglect
-policy on minimizing of restraints
-evacuation procedure
The licensee has failed to comply with O.Reg. 79/10 s.79.(1) in that required information was not posted.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following subsections:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. Resident #19 was observed on June 4th and June 8th, 2012 with fingernails that were noted to be long and chipped. Resident reports that their nails are longer than normal and that staff provide nail care. Staff #S136 reported that resident would normally get nails trimmed on bath days weekly or bi-weekly. A review of the Personal Support Flow sheets indicated that nail care was last documented as provided on May 10, 2012. A review of the plan of care indicated that nails are to be checked and clean twice a day as required.

The licensee has failed to comply with O Reg.79/10 s.35.(2)by not ensuring that each resident receives fingernail care, including the cutting of fingernails.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. A review of minutes from Resident Council 2011 and 2012 meetings indicated improvements made through the quality improvement and utilization review system had not been communicated to the Resident Council.
The licensee has failed to ensure that O. Reg.79/10 s.228.(3) is complied with.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 33(1) in that residents are not bathed, at a minimum, twice a week by the method of their choice.
During an interview with a family member of resident #14, a concern was brought forward that on two occasions resident #14's bath was not done.
The plan of care for resident #14 related to bathing states the resident is to have tub baths on scheduled bath days. It also states that the resident is only to be put in a tub bath, no showers.
In May 2012, resident #14 received a total of 6 baths. An eight was coded on all other days to indicate that the activity did not occur. Furthermore, on May 21, 2012, resident #14 received a shower, which the plan of care specifically states the staff are not to do.
In April 2012, resident #14 received seven baths. All other days were coded with an eight, indicating that the activity did not occur.
2. According to PSW #S145, resident #15 receives a shower on the resident's scheduled bath days.
As of June 12, 2012, resident #15 had received a total of two baths. All other days were coded with an eight indicating that the activity did not occur.
In May 2012, resident #15 received a total of seven baths on the following dates. All other days were coded with an eight indicating that the activity did not occur.
In April 2012, resident #15 received a total of seven baths. All other days were coded with an eight indicating that the activity did not occur.
3. The plan of care for resident #5 specified the resident's bath days. Supervision and set-up help are needed.
For the month of May 2012 resident #5 received six baths. The number eight was coded on all other days to indicate that the activity did not occur.

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 residents are bathed, at a minimum, twice a week by the method of their choice, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following subsections:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 74 (2) in that the Registered Dietitian for the home was not on -site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.
As of June 14, 2012 there are 183 residents residing at Trillium Centre, requiring 91.5 hours per month of RD time.
For the month of May 2012, the on-site RD hours were 86 hours
(93 - 7 hours worked at home).
For the month of April 2012, the on-site RD hours were 82 hours
(93 - 11 hours worked at home).

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following subsections:

s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 75(3) in that they have not ensured that a Nutrition Manager is on-site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4).
Using the formula outlined in subsection (4), the minimum number of Nutrition Manager hours are calculated as 59.5 hours per week.
The Interim Administrator reported to Inspector #124, that the current Nutrition Manager, #S144, works 37.5 hours per week and that they've hired another Nutrition Manager to start on June 26, 2012 to cover the rest of the required hours.
The Interim Administrator stated that she knew the home would be short Nutrition Manager hours for 3 weeks, from June 4-25, 2012.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. On June 12, 2012 Inspector met separately with the President of the Residents' Council as well as the Program Manager. A review of the minutes from 2012 and 2011 indicated that meal and snack times had not been reviewed by the Residents' Council.
The licensee has failed to comply with O Reg.79/10 s.73.(1)2. by not ensuring that the Residents' Council reviewed meal and snack times.

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following subsections:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 31(2)5 in that a restraint plan of care did not include the consent by a resident's Substitute Decision Maker (SDM).
The licensee's policy # VII-F-10.08 defined bed rails as a physical restraint if used to limit the movement of a resident within the bed or between the bed and another area.
Resident #15's plan of care related to risk of falls instructs staff to put two bed rails up at all times when the resident is in bed for safety.
Upon review of the resident's health care record, there was no indication of consent from the resident's SDM related to the use of the two bed rails.
On June 13, 2012, RPN #S123 confirmed that the home did not have consent from resident #15's SDM for the use of 2 bed rails while in bed.

Resident #14's plan of care related to risk of falls instructs staff to put 2 bed rails up at all times when the resident in bed for safety to help prevent falls.
Upon review of the resident's health care record, there was no indication of consent from the resident's SDM related to the use of the 2 bed rails.
During an interview with RPN #S123 on June 13, 2012 she stated that as of today she has received verbal consent from resident #14's SDM to continue with the use of the 2 full bed rails for safety and a progress note was made to this effect.
RPN #S123 confirmed that prior to June 13, 2012 the licensee had not received consent for the use of the 2 bed rails.
2. The licensee has failed to comply with LTCHA 2007, s. 31(2)4 in that the use of two full bed rails as a restraint for a resident did not include an order by the physician or a registered nurse in the extended class.
The licensee's policy # VII-F-10.08: Restraint Implementation Protocols defines bed rails as a physical restraint if they are used to limit the movement of a resident within the bed or between the bed and another area.
The current plan of care for resident #15 instructs staff to put two side rails up at all times when the resident is in bed for safety. The resident was observed on the following dates in bed with both full side rails up - June 4, 8, 11, 2012.
Upon review of resident #15's physician's orders, it was noted that there was no order for the two full bed rails to be used for this resident.
On June 5, 2012 at 1315 hours, resident #15 was observed in her room sitting in her wheelchair with a lap belt restraint in place. There is no physician order in place for a lap belt for this resident.

The plan of care for resident #14 related to risk of falls instructs staff to put 2 side rails up at all times when the resident is in bed for safety to help prevent falls.
Upon review of the Physician's Orders for resident #14, there is no order by the physician for the use of the 2 bed rails.

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following subsections:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. On April 5th, 2012 a Resident Council Meeting occurred. Concerns were discussed related to noise in the dining rooms. A written response was provided on June 6, 2012. On March 8, 2012 concerns were raised at the Resident Council meeting related to activity programs, a written response was provided April 2, 2012. On February 2, 2012 concerns related to noise in dining rooms was discussed at Resident Council meeting. A written response was provided February 27, 2012.
The licensee has failed to comply with the LTCHA 2007, in that the licensee did not respond in writing to Resident Council in within 10 days .

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following subsections:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. A review of minutes from the Residents Council meetings indicated that the Resident Council advice was not requested in respect of developing and carrying out the satisfaction survey. The President of the Council was interviewed on June 12, 2012 and confirmed that Resident Council advice had not been requested in developing the satisfaction survey.
On June 11, 2012, the President of Family Council was interviewed and reported that the home did not request input when developing the satisfaction survey.
The licensee failed to comply with the LTCHA 2007, s.85. (3) in that the licensee did not seek the advice of Residents' Council and Family Council in developing the survey.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 r. 8. (1)	CO #901	2012_035124_0018	124
O.Reg 79/10 r. 15.	CO #001	2012_049143_0022	143

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Issued on this 25th day of June, 2012

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

Lynda Hamilton RN

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA HAMILTON (124), DARLENE MURPHY (103), JESSICA PATTISON (197), PAUL MILLER (143)
Inspection No. / No de l'inspection :	2012_035124_0018
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Date of Inspection / Date de l'inspection :	May 30, Jun 1, 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 2012
Licensee / Titulaire de permis :	SPECIALTY CARE EAST INC. 400 Applewood Crescent, Suite110, VAUGHAN, ON, L4K-0C3
LTC Home / Foyer de SLD :	TRILLIUM CENTRE 800 EDGAR STREET, KINGSTON, ON, K7M-8S4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~JENNIFER POWLEY~~ DAWN BLACK

To SPECIALTY CARE EAST INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 901

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that all medications in medication storage carts, emergency stock boxes, medication storage areas including medication storage fridges are reviewed and have all expired medications removed.

Grounds / Motifs :

1. As per O. Reg. 79/10 s.136. (1) (a) the licensee shall ensure as part of the medication management system, that a written policy is developed in the home that provides for ongoing identification, destruction and disposal of (a) all expired medications.

The licensee has failed to follow their medication Policy 5-1, "Expiry and Dating of Medications". This policy states "a system is in place to ensure that an adequate and unexpired supply of medication is maintained for each resident". The relevant procedure states "examine the expiry date of all medications on a regular basis and to remove any expired medications from stock and order replacement as necessary."

On June 6, 2012, the medication cart on one unit was observed. The following medications were found to be expired:

Resident # 5 had a bottle of eye drops in the medication slot which according to the box had expired October 2011.

Resident # 6 had a glucose testing kit that contained testing strips with an expired date of October 2011.

An unlabelled box of suppositories were expired on March 2012.

A Glucagon injection kit was present which had expired November 2010.

On June 6, 2010 the stock medication room was observed. The following medications were found to be expired:

Mucillium bottle had expired May 2012,

Dimenhydrinate 100 mg tabs had expired November 2011and several boxes are due to expire June 2012. (103)

2. On June 6, 2012, a review of the medication cart on another unit (in med prep room) indicated that

Resident # 16 medication ordered February 10, 2011 with an expired date of February 2012 had not been removed from the medication cart. This medication was discontinued February 16, 2012.

Resident # 17 medication with order date May 26, 2011 with an expired date of May 2012 had not been removed from the medication cart.

Resident # 18 medication ordered February 15, 2011 had an expired date of February 2012.

Resident # 18 received this discontinued medication on May 7, 2012.

A bottle of stock Mucillium 336 gram with an expired date of May 2012 was found in the medication cart.

An audit of the Emergency stock box located in the Cottage Medication prep room indicated that Diphenhydramine 50 mg/ml injectable issued January 28, 2008 had an expired date of April 2012. (103) 2. (143)

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

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with the requirement that the home, furnishings and equipment as noted in the grounds and as identified through an extensive home audit is maintained in a safe condition and in a good state of repair. The home shall also develop and implement a system of monitoring to ensure ongoing compliance.

This plan is to be submitted in writing by June 29, 2012 to LTCHA Inspector, Lynda Hamilton at 347 Preston Street, 4th Floor, Ottawa, ON K1S 3J4 or by fax at 613-569-9670.

Grounds / Motifs :

1. (124)
2. The licensee has failed to comply with LTCHA, 2007 S.O., c.8 s. 15 (2) (c) in that the home, furnishings and equipment were not maintained in a safe condition and in a good state of repair.

The following observations were made throughout the course of the Resident Quality Inspection and constitute potential
risk related to infection control and resident safety

Lake Unit:

Room 238-The outer edge of the door is cracked and broken with splintering wood.

The walls of the Lake dining room were scarred and gouged. (124)

2. Country Unit:

Room 232-Was observed to have bare metal strapping at the corner of bathroom/entrance hall. The plaster is rough and breaks away when touched.

Room 226-The toilet paper holder is pulled off of the wall and the toilet paper is located on the back of the toilet

Room 231-Was observed to have bare metal showing and the plaster is rough and falling when touched.

Room 222-The toilet paper holder is missing and the toilet paper is on the back of toilet.

Heritage Unit:

Room 203-There are numerous gouges in the wall behind the lazy boy and it is rough to touch. There is a large area of plaster missing at the left edge of the entrance hall. The baseboard has rough/sharp edges and is

detached by approximately eight inches.

Room 205-The over bed lamp is missing from the wall and there is missing drywall above the resident's bed.

Room 208-The toilet paper holder is missing and the drywall is loose with sharp edges. The toilet paper and remainder of the holder is on the back of the toilet. There is missing drywall down to the metal and the baseboard is detached from the wall by approximately eight inches.

Room 212-There is a hole in the wall at the corner of the lazy boy with loose drywall falling from the hole.

Room 216-The entrance hall has metal showing with a large area of paint and plaster missing and is rough to touch.

Dining room floor has duct tape covering an area of the floor and the middle area of duct tape is depressed and spongy.

Garden Unit:

Room 105-The bathroom has loose peeling paint which appears to be a result of water damage and the ceiling above the toilet has yellow, discoloured ceiling tiles that are sagging. The cable outlet plate is loose and the wires are accessible behind the plate.

Room 108-There is a hole in the wall all the way through to the drywall below the window. The toilet paper holder is pulled out of the wall. (103)

Harbour Unit:

Room 231-Was observed to have two holes on the closet exterior exposing jagged metal strapping. The bathroom door and interior wall in this room was scarred, gouged and paint was peeled.

Cottage Unit:

Room 224-Was observed to have a hole in the wall on the door entrance to the bathroom and a second hole on the right hand wall. The bathroom door was also observed to have paint chipped as well as exposed splintered wood at the base of the door.

Room 228-Was observed to have masking tape covering the door latch mechanism.

Room 227-Was observed to have a large hole on the wall behind the bed, exposing dry wall and jagged edges.

Orchard Unit:

The Nursing Station office door was noted to have peeling and chipped paint.

Hallway chairs throughout the Ridge and Court building were noted to have legs and arms with chipped paint and finish missing. (103)
3. Harbour Unit:
Room 231 was observed to have two holes on the closet exterior exposing jagged metal strapping. The bathroom door and interior wall in this room was scarred, gouged and paint was peeled.

Cottage Unit:
Room 224 was observed to have a hole in the wall on the door entrance to the bathroom and a second hole on the right hand wall. The bathroom door was also observed to have paint chipped as well as exposed splintered wood at the base of the door.
Room 228 was observed to have masking tape covering the door latch mechanism.
Room 227 was observed to have a large hole on the wall behind the bed, exposing dry wall and jagged edges.

Orchard Unit:
The Nursing Station office door was noted to have peeling and chipped paint.

Hallway chairs throughout the Ridge and Court building were noted to have legs and arms with chipped paint and finish missing. (143)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2012

Order # /
Ordre no : 002

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee will ensure all direct care nursing staff, both registered and non-registered, apply physical devices with respect to the restraining of a resident in accordance with manufacturer's instructions by:
-completing an immediate audit of all residents in a restraining device to ensure application is in accordance with home policy and manufacturer's instructions and establish a monitoring system to be implemented to ensure that all restraints are correctly applied at all times
-providing education and re-education as necessary on the home policy and procedure identified under policy # VII-F-10.08, "Restraint Management".
-ensuring Manufacturer's instructions for the application of a physical device are understood and followed, and
-ensuring staff demonstrate their ability to competently and consistently follow the policies and procedures of the home and manufacturer's instructions.

Grounds / Motifs :

1. On June 14, 2012 on or about 1400 hours, resident #12 was noted to be sitting in a wheelchair. The resident's front closing seat belt was observed to be loose and twisted. The belt could be held outward from the resident's abdomen by approximately four inches and the right side of the belt was observed to be twisted four times. RPN #S122 was asked to observe the resident's belt and she reapplied it correctly.

On June 15, 2012 on or about 1000 hours, resident #12 was once again observed to be sitting in a wheelchair with a front closing seat belt in place. The belt was observed to be loose and could be held four-five inches outward from the resident's abdomen. In addition, the right side of the belt was observed to be twisted several times. RPN #S122 was once again asked to observe the resident's belt and she readjusted it correctly. She indicated the resident does manipulate the seat belt and that perhaps further staff education is required in the application of restraints.

The plan of care for resident #12 indicates the resident is at high risk for falls, is cognitively impaired and it indicates the resident requires a seat belt restraint for resident safety when in a wheelchair.

On June 14, 2012 on or about 1430 hours, resident #13 was observed sitting in a wheelchair on another unit. The resident's front closing seat belt was noted to be snug. In addition, the resident's restraint was noted to be twisted six times. PSW #S133 was sitting in a nearby location and was asked to look at the belt. She indicated the resident sometimes plays with the restraint. RPN #S128 was asked to observe the resident's restraint and she made appropriate adjustments to it.

On June 15, 2012 on or about 1030 hour, resident #13 was observed sitting in a wheelchair. The front closing seat belt was noted to be snug and the resident's right side of the seat belt was once again twisted three to four times.
RPN #S114 was asked if there had been any communication brought forward from previous shifts to her in regard to a problem with the application of this resident's seatbelt and she indicated there had been none. The RPN reapplied the resident restraint correctly.

The plan of care for resident #13 indicates the resident is at high risk for falls and requires the application of a seat belt restraint when in a wheelchair to prevent injury. (103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 23, 2012

Order # /
Ordre no : 003

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Order / Ordre :

The licensee shall prepare. submit and implement a plan for achieving compliance to ensure the home is providing an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents through compliance with:
-O. Reg. 131 (1) related to administration of medication as prescribed,
- O.Reg. 129 (1)(b) related to the safe storage of controlled substances,
- O. Reg. 8. (1) (b) related to 136 (1)(a) related to the management of expired medications,
- O. Reg. 135. (2) (a) related to the documentation of medication incidents
- O. Reg. 126 related to the storage of medications in the original labelled container,
- O.Reg 129 (1) (a) (i) related to storage area for medication that is exclusive for drugs and drug related supplies.
The plan shall include:
-education and re-education on the home policies related to non-compliance
-establish a monitoring system to ensure continued compliance whereby staff demonstrate their ability to competently and consistently follow the policies and procedures to meet the legislative requirements related to medication.

This plan shall be submitted to Lynda Hamilton, LTCH Inspector by mail at 347 Preston Street, 4th floor, Ottawa, ON K1S 3J4 or by fax at 613-569-9670 on or before June 29, 2012.

Grounds / Motifs :

1. The licensee failed to comply with O.Reg. 79/10 r. 114 (1) in that the licensee of a long-term care home does not have an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

During the Resident Quality Inspection, six areas of non-compliance related to the medication management system received written notifications:

WN # 10 O. Reg. 131 (1) residents not receiving medication as prescribed

-poor therapy outcomes for pain management because of missed doses of routinely scheduled narcotic analgesic

-additional dose of antibiotic was given that was not prescribed

-altering the therapeutic effectiveness of medications through crushing of medication that was contraindicated to be crushed

WN #9 O.Reg. 129 (1)(b) related to the safe storage of controlled substances

-failure to keep controlled substances double locked

WN # 1 and corresponding immediate Compliance Order O. Reg. 8. (1) (b) related to 136 (1)(a) the management of expired medications

-widespread presence of expired medication throughout the home including a Glucagon injection kit on one medication cart that had expired November 2010. In addition a resident received an expired dose of medication.

WN #8 O. Reg. 135. (2) (a) related to the documentation of medication incidents

-Failure to complete medication incidents for omissions of a regularly scheduled narcotic analgesic for a resident with severe, chronic pain

WN #11 O. Reg. 126 related to the storage of medications in the original labelled container

-Loose medications not in their original labelled package found in two of the four areas inspected. These medications could not be linked to a specific resident nor could the reason for them not being given be identified.

WN O.Reg 129 (1) (a) (i) related to storage area for medication that is exclusive for drugs and drug related supplies

-personal belongings or personal care supplies were found in four of the four storage areas inspected

These findings of non-compliance demonstrate that the medication management system does not provide safe medication management and does not optimize effective drug therapy outcomes for residents. (103) (124) (143) (103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2012

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

Ministère 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

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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 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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

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

Ministère 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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of June, 2012

Signature of Inspector / Signature de l'inspecteur : L. Hamilton

Name of Inspector / Nom de l'inspecteur : LYNDA HAMILTON

Service Area Office / Bureau régional de services : Ottawa Service Area Office

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603