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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 21, 2017	2017_641513_0012	022925-17	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26 Midhurst ON L0L 1X0

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

TRILLIUM MANOR HOME FOR THE AGED
12 GRACE AVENUE ORILLIA ON L3V 2K2

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

JUDITH HART (513), SARAH KENNEDY (605)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 4, 5, 6, 10, 11, 12, 13, 16, 17 and 18, 2017.

The following intakes were inspected concurrently with the Resident Quality Inspection:
Critical Incident Systems (CIS): CIS M585-000008-15; Log #007880-17, related to falls.

During the course of the inspection, the inspector(s) spoke with Residents, Substitute Decision Makers (SDM), family members, housekeeper, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Nurse Manager (NM), Director of Resident Care (DRC), Residents' Council President, Family Council President and Administrator.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_491647_0004	513
O.Reg 79/10 s. 53. (4)	CO #002	2017_491647_0004	513

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

During stage one of the Resident Quality Inspection (RQI), resident #009 triggered for a fall in the last 30 days for inspection.

On September 9, 2017, the written plan of care for resident #009 revealed he/she was at a high risk for falls, and could ambulate independently. Interventions included having a mobility device and keeping the bed at a specified height.

On a specified date in 2017, resident #009 fell in his/her room. At the time the resident was being treated for a medical condition.

A review of the resident's paper and electronic record did not reveal that a post falls assessment had been completed for the fall on a specified date.

An interview with RPN #114 revealed a post falls assessment had not been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

An interview with the Director of Resident Care (DRC) confirmed it was the home's expectation that a post falls assessment be completed when a resident falls. [s. 49. (2)]

2. A review of the Critical Incident Report (CIR) #M585-000008-17, revealed resident #021 sustained a fall on a specified date in 2017, which resulted in an injury.

A record review revealed the resident was admitted to the home on a specified date in 2015. A review of the resident's written plan of care from the time of the incident revealed the resident was at risk for falls and had a history of previous falls. Interventions were identified.

Inspector #605 was not able to interview resident #021 as the resident is no longer in the home.

An interview with PSW #106 revealed he/she witnessed resident #021's fall on a specified date in 2017. The PSW stated at the time of the fall the resident was ambulating in the hallway. An interview with RPN #101 revealed he/she also witnessed resident #021 fall on the identified date.

Two identified registered staff members (who were working at the time of the incident) no longer work at the home and were unable to be contacted.

A review of the resident's electronic records revealed a post-fall progress note was completed on a specified date in 2017. A record review revealed both the incident report in the risk management tab of the electronic record and the post fall assessment on this record was not completed after the incident.

An interview with the Administrator confirmed the home's expectation was to complete a post fall assessment using the clinically appropriate tool for falls. [s. 49. (2)]

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 when the resident has fallen, the resident has been assessed and that where the condition or circumstances of the resident require, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #2: 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:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to have his or her personal health information (PHI) 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.

On October 11, 2017, at 1200 hours (h) during the RQI mandatory medication administration observations on a specified care area, revealed several empty medication pouches were observed in the general trash bin on the medication cart. Three empty medication pouches were removed from this bin and shown to RPN #124. Each medication pouch contained a resident's name, room number and medication information. During the observation period it was also observed that a paper box for resident #014 containing a medicated powder was placed in the general trash bin on the medication cart. A black line was observed to be placed through the resident's name, however the name was still legible. RPN #124 made two attempts to mark out the resident's name with a black marker and returned the package to the trash bin. Inspector #513 retrieved the package from the bin and the resident's name was still visible. The RPN then removed the package from the cart and placed it in the medication room in a bin, which was to be sent to pharmacy for disposal.

An interview with RPN #124 revealed the process for disposing of mediation pouches was to put them in a white round container located for this purpose on the medication cart, add water so the letters dissolve and then dispose of them in the general trash bin. After the interview with the inspector, all untreated pouches were removed from the general trash bin and placed in the white container with water. RPN #124 acknowledged the process for disposal of the pouches had not been followed and the residents' PHI had not been protected.

An interview with RN #111 revealed the process for disposal of resident PHI for the medication pouches had not been followed and the residents' PHI had not been protected regarding disposal of the pouches and the cardboard medication box.

An interview with the DRC confirmed the process for disposal of resident PHI for the medication pouches and cardboard medication box had not been followed and the residents' PHI had not been protected. [s. 3. (1) 11. iv.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

During stage one of the RQI, resident #009 triggered for inspection related to a decline in bladder continence.

A review of the MDS on a specified date in 2017, revealed resident #009 was occasionally incontinent of bladder and frequently incontinent of bowel.

A review of the current written plan of care identified resident #009 was incontinent of bowel, was sometimes incontinent of bladder and required one staff to assist with toileting needs and providing hygiene.

An interview with the PSW #108 revealed the written plan of care for toileting did not reflect that the resident experienced urinary urgency and that he/she was assisted by two persons in order to void. An interview with RPN #114 confirmed the written plan of care for toileting did not reflect the resident's present urinary experiences and required the assistance of two persons for toileting.

An interview with the DRC confirmed the resident's written plan of care was not updated and therefore did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. During stage one of the RQI, resident #009 triggered for inspection related to a fall in the last 30 days.

On two specified dates in 2017, resident #009 fell in his/her room. After the initial fall he/she was treated for a medical condition.

The MDS on a specified date in 2017, revealed resident #009 required limited one-person physical assist with a mobility device and activities of daily living function had deteriorated.

A review of the current written plan of care identified resident #009 was at high risk for falls, ambulated independently with a mobility device and the bed was at a specified height.

Observations of resident #009 throughout the course of the inspection revealed he/she was receiving two-person assistance for toileting; utilized a specific device for mobility and the bed was positioned at a specific level, with a falls mat present at the bedside.

An interview with the PSW #108 revealed the resident required two-person assist with mobility and toileting; bed was at a specified height, with a floor mat beside the bed. An interview with RPN #114 revealed the resident was a high risk for falls, ambulated with a specific device, had a falls mat beside the bed and the bed was at a specified height. This information was not updated in the written plan of care.

An interview with the DRC confirmed the resident's written plan of care should be updated with the resident's current interventions and therefore the written plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

WN #4: 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:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that 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 is complied with.

On October 11, 2017, at 1200h, during the RQI mandatory medication administration observations on a specified resident care area, a medication device was observed in resident #012's medication bin with an illegible expiration date observed.

A review of the physician's prescription for the medication device for resident #012 was noted to be discontinued May 2, 2017.

The Medical Pharmacies "Pharmacy Policy and Procedure Manual for Long Term Care (LTC) Homes, 4-10 Discontinued Medications, dated February 2017," identified the procedure for discontinued medications was to remove the medication from the active medication cart/room and place drug in area for destruction (stericycle container or monitored surplus box).

Interviews with RN #111 and DRC confirmed that drugs that have been discontinued are to be removed from the medication cart and placed in a bin for return to pharmacy. [s. 8. (1) (b)]

Issued on this 23rd day of November, 2017

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

Original report signed by the inspector.