Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection 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
Oct 25, 2018	2018_746692_0015	020912-17, 025787-17, 026902-17, 009072-18	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

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

SHANNON RUSSELL (692)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 15-18, 2018

The following intakes were inspected upon during this Critical Incident System inspection:
- Two Critical Incident (CI) reports submitted by the home to the Director related to alleged resident to resident abuse.
- One CI report submitted by the home to the Director related to a fall of a resident with significant change in status.
- One CI report submitted by the home to the Director related to alleged staff to resident abuse.

A Complaint inspection #2018_746692_000014 was conducted concurrently with this Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), Environmental Services Housekeeper, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes as well as reviewed licensee policies, procedure and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A Critical Incident Report (CIR), was submitted to the Director on an identified date; whereby, Housekeeper #110 observed residents #003 and #004 engaged in an identified physical interaction. Housekeeper #110 reported what they observed to RPN #106.

A review of resident #003’s health care record revealed that they did not exhibit a history of an identified responsive behaviour prior to and since admission to the home.

A review of resident #003’s progress notes revealed that an identified intervention was to be completed to monitor resident #003’s responsive behaviours each shift until the home was able to conduct appropriate assessments. During a review of resident #003’s clinical record, Inspector #692 was unable to locate the completion of any of the identified intervention for resident #003.

A review of the home’s policy titled “Responsive Behaviours”, #NPC E-20, effective November 2011, indicated the identified intervention was used as a screening tool that flags a problem or observation by staff to assist caregivers in understanding the cause of a residents responsive behaviour and to track patterns of those behaviours.

During an interview with PSW #107, they indicated that staff were to complete the

identified intervention for a specific time frame for resident #003 in order to monitor them for exhibiting the identified responsive behaviours.

In an interview with Inspector #692, RPN #106 indicated that staff were to complete the identified intervention for a specific time frame, unless otherwise directed by management or the physician. RPN #106 indicated that they were to initiate the identified intervention for resident #003 on an identified date to monitor if they were demonstrating the identified responsive behaviour. RPN #106 was unable to locate the completion of the identified intervention for resident #003.

During an interview with RN #103, they indicated that the plan of care revealed that the identified intervention was to be completed for resident #003 for a specific time frame and that there was no evidence that the identified intervention was completed. RN #103 confirmed that with the identified intervention not being completed that they could not identify if resident #003 was exhibiting the identified responsive behaviours.

In an interview with the Director of Care (DOC), they confirmed that it was the expectation that the identified intervention was to be completed for resident #003 for a specific time frame commencing on an identified date. Together, Inspector#692 and the DOC reviewed resident #003's health care record and identified there was not any evidence that the identified intervention was completed for resident #003. The DOC confirmed that without the completion of the identified intervention the home would not be able to identify if resident #003 was exhibiting the identified responsive behaviours, including the frequency they are exhibiting the behaviours. [s. 54. (b)]

2. A Critical Incident Report (CIR), was submitted to the Director on an identified date; whereby, PSW #105 observed resident #005 potentially displaying an identified responsive behaviour towards resident #006. PSW #105 reported what they observed to RN #103.

A review of resident #005's health care record revealed that they had a history of responsive behaviours but did not include the identified responsive behaviour that they were potentially displaying towards resident #006.

A review of resident #005's progress notes revealed that the identified intervention was to be completed to monitor resident #005's responsive behaviours to mitigate potential risk to co-residents. During a review of the identified intervention for resident #005, Inspector #692 determined the identified intervention was not complete for 10 of the

required shifts.

During an interview with PSW #105, they indicated that staff were to complete the identified intervention for a specific time frame for resident #005, in order to monitor them for identified responsive behaviours.

In an interview with Inspector #692, RPN #113 indicated that staff were to complete the identified intervention for a specific time frame for resident #005. RPN #113 was unable to locate the completion of the identified intervention for resident #005.

During an interview with RN #103, they indicated that resident #005's progress notes revealed that the identified intervention was to be completed for resident #005 and that there was no evidence that the identified intervention was completed. They confirmed that with the identified intervention not being completed they could not identify if resident #005 was exhibiting the identified responsive behaviours.

Together, Inspector #692 and the DOC reviewed resident #005's health care record and identified that there was not any evidence that the identified intervention had been initiated or completed for resident #005. The DOC confirmed that it was the expectation that the identified intervention was to be completed for resident #005 for a specific time frame and without the completion of the identified intervention the home would not be able to determine if resident #005 was exhibiting the identified responsive behaviours and the frequency of those behaviours. [s. 54. (b)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

Issued on this 25th day of October, 2018

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

Original report signed by the inspector.