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
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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 |
|---|---|---|
| Jan 23, 24, 25, 27, 30, 31, Feb 6, 7, 8, 14, 15, 2012 | 2012_109153_0002 | Complaint |

**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**

LYNN PARSONS (153) Valerie Johnston (209)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**During the course of the inspection, the inspector(s) spoke with Administrator,Director of Care,Manager of Programs, Supervisor of Environmental Services, Registered Practical Nurses,Program and Support Services Aide, Maintenance Staff, Personal Support Workers and Residents.**

**During the course of the inspection, the inspector(s) Reviewed clinical health records,maintenance requisitions, Residents' Council minutes and manufacturers' specifications for restraints.**
**Reviewed the following home policies- Fall Prevention, Incident Reporting,Responsive Behaviors, Restraints, Physician Orders- Transcribing Written, Verbal, Telephone.**
**Completed observations of provision of care to residents in the dining room and throughout the unit.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Maintenance**

**Continence Care and Bowel Management**

**Falls Prevention**

**Minimizing of Restraining**

**Personal Support Services**

**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON-RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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. Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions related to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post- restraining care. O. Reg. 79/10, s. 110 (7)

The home's Restraint Policy section 6 - Procedure for Physical Restraint directs staff to document the restraint for the period it is in use.
The"Assessment of Restraint Use" form will be utilized and staff shall record the time of application and removal as well as the residents' response to the restraint.
The decision to continue the use of a restraint shall be re-evaluated prior to each application on an ongoing basis.
Hourly checks will be completed to monitor the resident's safety, comfort and the position of the restraint and the release of the restraint and repositioning every 2 hours when the resident is awake.
As confirmed by interviews the point of care documentation software only allows staff to currently complete the designated 2 questions.
The point of care software is designed to be completed 1 hour prior to the end of shift .
The home's restraint policy is not implemented or complied with.[r.8(1)]
2. The home's Fall Prevention Policy under Section C - Post Fall Management directs Registered Staff to monitor the resident for 72 hours after a fall and document accordingly.
Through interview it was verified by Director of Care that Registered Staff did not monitor the following 3 residents for 72 hours after they experienced a fall:
Resident A experienced an unwitnessed fall on October 27, 2011
Resident E experienced an unwitnessed fall on January 13, 2012
Resident D experienced an unwitnessed fall January 23, 2012.(r.8(1)

***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 the policies in the home for Falls Prevention and Restraints are implemented and complied with, to be implemented voluntarily.***

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**WN #2: 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).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to document the use of physical devices to restrain the following 3 residents:
Resident A - documentation does not identify time of application
Resident B- documentation does not identify time of application
Resident C- documentation does not identify time of application
A review of the Point of Care Documentation on Point Click Care reveals the opportunity to answer 2 questions which include the following;
Was restraint checked hourly?
Was resident turned and repositioned every 2 hours?
This documentation can only be completed once per shift within 1 hour of end of shift by Personal Support Worker.
Through interviews it was confirmed the point of care documentation does not allow for staff to document when device applied.[r.110(7)5]
2. The licensee has failed to document the use of physical devices to restrain the following 3 residents:
Resident A - documentation does not identify resident's response
Resident B- documentation does not identify resident's response
Resident C- documentation does not identify resident's response
Through interviews it was confirmed the point of care documentation does not allow for staff to document resident's response.[r.110(7)6]
3. The licensee has failed to document the use of physical devices to restrain the following 3 residents:
Resident A - documentation does not identify every release of the seat belt.
Resident B- documentation does not identify every release of the seat belt.
Resident C- documentation does not identify every release of the seat belt.
Through interviews it was confirmed that there is no documentation completed to identify every release of the physical devices.[r.110(7)7]
4. The licensee has failed to document the use of physical devices to restrain the following 3 residents:
Resident A - documentation does not identify the time of removal of the seat belt.
Resident B- documentation does not identify the time of removal of the seat belt.
Resident C- documentation does not identify the time of removal of the seat belt.
Through interviews it was confirmed the point of care documentation does not allow for staff to document the time the restraint was removed.[r.110(7)8]
5. The licensee has failed to ensure that Resident B's seat belt restraint is applied safely and according to manufacturer's specifications.
1.A physician order was obtained January 14, 2012 for a wheel chair lap belt restraint to prevent crawling/slipping onto the floor and to be used when resident in the chair.
2.On January 27, 2012 at 13:00 - Observed a personal support worker approach resident in the wheel chair and apply the seat belt.The seat belt was observed to be applied loosely and lying on the resident's upper thighs below abdomen.
3.Through interview and observation staff confirmed seat belt was applied loosely and indicated it could not be tightened.
4. Manufacturer's specifications were available and indicated "keep belt tightened during fitting and maintain this tightness during daily use to ensure correct placement".
5. Frequency of monitoring resident was increased to q 15 minutes and resident was situated near the nurses' station close to staff.
6. Vendor notified of concern, attended site and applied a new seat belt on January 27, 2012 at 16:00hrs.
7.On January 30, 2012 at 08:45hrs.observed seat belt to be applied as per specifications.[r.110(1)1]

*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 the home's method for documenting physical devices to restrain residents':***
***- includes the person who applied the device and time of application***
***- all assessment, reassessment and monitoring, including resident's response***
***- every release of the device and all repositioning***
***- the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement**
**For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:**
**1. Roller bars on wheelchairs and commodes or toilets.**
**2. Vest or jacket restraints.**
**3. Any device with locks that can only be released by a separate device, such as a key or magnet.**
**4. Four point extremity restraints.**
**5. Any device used to restrain a resident to a commode or toilet.**
**6. Any device that cannot be immediately released by staff.**
**7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.**

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**Findings/Faits saillants :**

1. Resident D was observed by 2 nursing staff to be tied to a wheel chair with a sheet on October 3, 2011. These individuals were interviewed during the inspection and confirmed the above observations.(r.112(7)

*Additional Required Actions:*

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure staff do not apply prohibitive devices that limit movement to residents for the purpose of restraining, to be implemented voluntarily.***

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**WN #4: 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).**

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**Findings/Faits saillants :**

1. On January 9, 2012 the home received a faxed physician order for Resident E which stated "increase Olazepine to 2.5 mg. po TID - it will take a few days to kick in".
This change in medication order was obtained to respond to the resident's aggressiveness to other residents resulting in injuries.
A review of the Medication Administration Record for January 2012 identified that the order for the increased dosage of Olazepine was not transcribed to the MAR and the resident did not receive.the new dosage.
The Registered Staff continued to sign for administering the lower dose of Olazepine 1.25 mg. po TID.
This medication incident was identified by the inspector during the inspection and confirmed by the Director of Care when interviewed.[r.131(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 Registered Staff follow the home's policy titled, " Physician's Orders - Transcribing Written, Verbal, Telephone" when receiving written faxed physician orders, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

**Specifically failed to comply with the following subsections:**

**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 following 2 residents who experienced a fall event were not assessed using a clinically appropriate assessment tool as identified during a review of clinical health records:
Resident E - with a risk for falls according to plan of care had an unwitnessed fall on January 13, 2012 at the Nurses' station. A post fall assessment was not located in the clinical health record which was confirmed by registered staff and Director of Care not to have been completed.
Resident D - with a risk for falls according to plan of care had an unwitnessed fall on January 23, 2012 in own room. A post fall assessment was not located in the clinical health record which was confirmed by registered staff and Director of Care not to have been completed.[r.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 a post- fall assessment is conducted when a resident has fallen using a clinically appropriate assessment instrument that is specifically designed for fall, to be implemented voluntarily.***

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**WN #6: 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.**

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**Findings/Faits saillants :**

1. It was identified during staff interviews that yellow wander strips were to be used on specific residents' doorways as a strategy to prevent Resident E from entering those residents' rooms.
Observed several times on January 23, and 24, 2012 yellow wander strip attached to 1 side of Resident A's door but not in place to prevent entry from wandering residents while resident was in the room.
On January 24, 2012 @ 15:45 hrs observed Resident E entering Resident A's room and grabbing and shaking Resident A while this resident was in bed resting. Nursing staff were notified at the time of the observed incident. A nursing manager was informed on January 24, 2012 @ 16:30hrs of shaking incident involving Resident E and Resident A.
On January 25, 2012 @ 13:15 hrs observed yellow wander strip attached to 1 side of Resident A's door but not in place to prevent entry from wandering residents while resident in room watching TV.
On January 25, 2012 @ 13:35hrs. observed staff leaving Resident A's room after transferring resident to bed and not attaching yellow wander strip to doorway to prevent wandering residents from entering.[r. 54 (b)]
Activation staff member was observed to attach yellow wander strip to doorway of Resident A's room on January 25, 2012 @ 13:40hrs.

***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 planned interventions for residents with responsive behaviors are in place to minimize the risk of altercations among residents, to be implemented voluntarily.***

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**WN #7: 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.**

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**Findings/Faits saillants :**

1. From October 24 to December 1, 2011 three tub rooms were placed out of service to allow for renovations to be completed which involved removal of tubs and replacement of floors on Ramara, Oro-Medonte and Orillia resident home areas.

Through interviews and record reviews it was identified that quality improvement to the three tub rooms was not communicated to Residents' Council. [ 228(3)}

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes**

**Specifically failed to comply with the following subsections:**

**s. 305. (3) A licensee may not commence any of the following work without first receiving the approval of the Director:**
**1. Alterations, additions or renovations to the home.**
**2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents. O. Reg. 79/10, s. 305 (3).**

**Findings/Faits saillants :**

1. From October 24 to December 1, 2011 three tub rooms were placed out of service to allow for renovations to be completed which involved removal of tubs and replacement of floors on Ramara, Oro-Medonte and Orillia resident home areas.
Residents who resided in the section where the tub room was taken out of service were required to receive their baths in a tub room located either on the other wing of the resident home area or outside the home area.
Residents' bathing schedules were impacted due to increase in the number of baths being completed with only half of the bathing facilities available for a period greater than 5 weeks.
The licensee confirmed the renovations were completed without requesting or receiving approval of the Director.[r.305(3) 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 work involving alterations, additions or renovations to the home does not commence prior to developing and submitting a plan to the Director for approval, to be implemented voluntarily.***

**Issued on this 22nd day of February, 2012**

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

Lynn Parsons