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 28, 2017	2017_536537_0044	025869-17	Resident Quality Inspection

Licensee/Titulaire de permis

S & R NURSING HOMES LTD.
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

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

TRILLIUM VILLA NURSING HOME
1221 MICHIGAN AVENUE SARNIA ON N7S 3Y3

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

NANCY SINCLAIR (537), DEBRA CHURCHER (670)

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): November 20, 21, 22 and 23, 2017

The following intakes were completed concurrently within the RQI:
Log #016563-16/IL-44709-LO, a complaint related to improper transferring techniques resulting in resident injury.
Log #018115-17/CIS 2217-000005-17, a critical incident related to an injury of unknown cause.
Log #005514-17/CIS 2217-000004-17, a critical incident related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager Resident Care, Office Coordinator, Resident Assessment Instrument (RAI) Coordinator/ Registered Nurse (RN), Registered Dietitian, Maintenance Supervisor (MS), Manager Food Services, one Dietary Aide, one Registered Nurse (RN), seven Registered Practical Nurses (RPN), eight Personal Support Workers (PSW), Residents' Council Representative, residents and families.

The inspector(s) also conducted a tour of all resident areas and common areas, observed residents and care provided to them, medication passes, medication storage areas, reviewed health care records and plan of care for identified residents, reviewed policies and procedures, minutes from meetings, and observed the general maintenance, cleanliness and condition of the home.

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
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

4 WN(s)
3 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

During the initial tour of the home, Inspector #670 noted that the door leading to the hallway where the laundry area, maintenance office and a staff room were located was not secured. The laundry room was open and unattended at this time and again observed to be opened and unattended later during the day. The laundry room contained washers, dryers, bottles of chemicals and a labelling machine.

The Administrator observed the door with the Inspector and acknowledged that the door led to a non-residential area of the home. Administrator stated that they were aware that this door was not secured and that it should be. The Administrator stated that the home had been in contact with an electrician related to getting the door secured.

The maintenance office door was observed to be open and unsecured with no staff present. Scissors were noted to be on the desk.

The Maintenance Supervisor stated that they had been in contact with a vendor to try and get the door secured with a swipe card for entry. Maintenance Supervisor acknowledged that the area was not constantly supervised and stated that the laundry room and maintenance office doors should always be closed and locked when staff were not present.

The severity level was determined to be minimal harm or potential for actual harm. The scope was isolated. There was no previous history of this legislation being issued in the home. [s. 9. (1) 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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was on at all times.

During a tour of the home, Inspector #670 noted a small sign on the wall that stated “push button for assistance.” There was no call bell or button in the lounge. During the

remainder of the tour, a doorbell style button was noted in five locations of an identified home area. All of the doorbell style buttons had a sign under them reading "push button for assistance."

Inspector #670 and Maintenance Supervisor (MS) toured the home. MS stated that the buttons were doorbells purchased locally and were put in place as part of the call bell system for call bell access in resident common areas of this particular area of the home. MS stated that when the button was pushed, there was a sensor that was plugged in that would ring. A sensor was noted plugged into a wall outlet near each doorbell. The Inspector and MS tested all of the doorbells. The identified doorbells were not functioning in four of the five identified areas.

Administrator acknowledged that they were aware that the doorbells in place did not meet the legislative requirements related to the system being on at all times. Administrator stated that the system was an older system and it was difficult to integrate new items into the system. [s. 17. (1) (b)]

2. The licensee has failed to ensure that the resident-staff communication and response system allowed calls be cancelled only at the point of activation.

Inspector #670 and Maintenance Supervisor (MS) toured the home. MS and Inspector #670 tested all of the doorbells in the identified area of the home. MS stated that when the doorbell button was pushed, there was a sensor that was plugged in that would ring. Only one doorbell in the identified home area rang, and stopped ringing automatically after ten seconds. MS acknowledged the doorbell system did not allow for calls to only be cancelled at the point of activation as the bells stopped automatically within ten seconds of being activated.

Personal Support Worker (PSW) stated that they were aware of the buttons but did not know where they rang to, or how they would know where the call was coming from. PSW stated that as far as they knew, the buttons had never been pushed.

Another PSW stated that they were aware that the buttons were on the walls; however they had never seen them activated, did not know where they would find out where the call was originating from, did not know where they would ring or how it would be cancelled.

Administrator acknowledged that they were aware that the doorbells in place did not

meet the legislative requirements related to the system not being able to be cancelled at point of activation. [s. 17. (1) (c)]

3. The licensee has failed to ensure that the resident-staff communication and response system clearly indicated when activated where the signal was coming from.

Inspector #670 and Maintenance Supervisor (MS) toured the home. MS stated that when the doorbell button was pushed, there was a sensor that was plugged in that would ring. A sensor was noted plugged into a wall outlet near each doorbell. The sensors were not labelled. MS acknowledged that when the door bell system was activated it did not clearly identify where the signal was coming from.

Administrator acknowledged that they were aware that the doorbells in place did not meet the legislative requirements related to the system clearly indicating the point of origin. The Administrator #100 stated that the system was an older system and it was difficult to integrate new items into the system. [s. 17. (1) (f)]

4. The licensee has failed to ensure that the resident-staff communication and response system that used sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

Inspector #670 and Maintenance Supervisor (MS) toured the home. MS stated that when the doorbell button was pushed, there was a sensor that was plugged in that would ring. One doorbell of five in the identified home area did function and it was observed that the tone was very difficult to hear. The inspector needed to be within four meters of the sensor and the environment needed to be quiet to hear the bell. MS acknowledged that the call system was not calibrated properly so that the level of sound was audible to staff.

Administrator acknowledged that they were aware that the doorbells in place did not meet the legislative requirements related to the system being properly calibrated. Stated that the system was an older system and it was difficult to integrate new items into the system.

The severity level was determined to be minimal harm or potential for actual harm. The scope was isolated. There was no previous history of this legislation being issued in the home. [s. 17. (1) (g)]

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 home is equipped with a resident-staff communication and response system that is on at all times, allows call to be cancelled only at the point of activation, clearly indicates when activated where the signal is coming from, and in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff, to be implemented voluntarily.

WN #3: 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:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Review of medication incidents for three identified residents did not include documentation to support that the substitute decision-makers (SDM's) were notified. The Inspector was also unable to locate any documentation in the resident's charts or in Point Click Care related to the notification of the SDM's of the medication incidents.

The home's policy titled "RCM 09-19 Medication Incidents" last revised on November 6, 2017, stated "The Registered Team Member (RTM) will notify the resident, Substitute Decision Maker (SM), the prescriber, attending Physician or Nurse Practitioner (NP), medical Director, Manager of Resident Care (MRC) and the pharmacy provider."

During an interview with Manager of Resident Care (MRC), they stated that the SDM's should have been notified but if there was no documentation regarding the notification of the SDM's that they were not notified.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, and the resident's SDM.

The severity level was determined to be minimum risk. The scope was widespread. There was no previous history of this legislation being issued in the home. [s. 135. (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 that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #4: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On two occasions, an identified resident was observed with a device in place.

During an interview, Personal Support Worker (PSW) stated that the resident was to have a device in place and that the resident was able to manage the device on their own.

During an interview with Resident Assessment Instrument (RAI) Coordinator they stated that when a resident was assessed as requiring a specific device, it would be included in the written plan of care for the resident, and found on the computer. RAI Coordinator reviewed the plan of care for the resident and it did not include documentation to support the use of the device which was observed being used.

During an interview with Registered Practical Nurse, they stated that the care for the resident had been recently reviewed and updated and it did not include the device.

During an interview with the Manager of Resident Care and the Administrator, they both stated that the care provided to the resident was not as specified in the plan

The severity level was determined to be minimal harm or potential for actual harm. The scope was isolated. There was no previous history of this legislation being issued in the home. [s. 6. (7)]

Issued on this   30th   day of November, 2017

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

Original report signed by the inspector.