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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 27, 2014	2014_252513_0012	T-997-14	Critical Incident System

Licensee/Titulaire de permis

TRILOGY LTC INC.
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

TRILOGY LONG TERM CARE
340 McCowan Road SCARBOROUGH ON M1J 3P4

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

JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 17. 19, 22, 23, and 24, 2014.

During the course of the inspection, the inspector(s) spoke with personal support workers (PSW), registered staff, registered social services worker (RSSW), behavioural support of Ontario (BSO) worker and PSW, acting director of care (ADOC), resident assessment instrument (RAI) coordinator, and administrator.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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 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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every residen's right to be protected from abuse is fully respected and promoted.

On a specified date, in the resident activity room, without provocation, resident #001 struck resident #002 causing two small cuts, which required the application of two steri-strips.

Record review showed that residents #001 and #002 were living with the same medical diagnosis. Resident #002 had severe vision impairment, resistive behaviours specific to physical care, no aggressive behaviours with other residents, was wheelchair bound and independently propeled the wheelchair about the unit. The minimum data set (MDS) assessment of June 12, 2014, indicated that resident #001 had verbal and physical abusive behaviour towards staff and residents, socially inappropriate behaviour, and wandering. The resident assessment protocol (RAP) of June 12, 2014, stated resident #001 to have shown a deterioration related to behaviours from the previous assessment. Resident #001's progress notes from May 23, 2014, to July 5, 2014, showed the resident to ambulate independently with a walker, have frequent occurrences of behaviours that include trying to hit residents and staff with his/her walker, spitting, screaming out "hello" and making sexually inappropriate requests to staff. On a specified date, staff reported that resident #001 struck the cheek of another resident with the palm of his/her hand. There was no visible injury.

Interviews with identified staff stated that resident 001's behaviours were unpredictable and included spitting, hitting, yelling, screaming and shoving other residents, staff, visitors with the wheeled walker.

The registered social services worker and lead for the responsive behaviour program, and the ADOC, confirmed that resident #002's right to be protected from abuse from resident #001 was not respected.

The inspector also observed that on a specified date, resident #002 was in his/her wheelchair in the den on the unit close to the nursing station with resident #003. Resident #003 was heard by the inspector to call out loudly, twice, "don't do that," and then heard a skin-on-skin slap. Resident #003 was observed to be standing with a wheeled walker, while leaning over resident #002. Resident #003 was removed from the room. The facility charge nurse attended resident #002. Resident #002 did not sustain any visible physical injury.

Staff confirmed that resident #002 was not protected from abuse from resident #003. [s. 3. (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 resident #002 is protected from abuse, to be implemented voluntarily.

WN #2: 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 sets out clear directions to staff and others who provide direct care to the resident.

On a specified date, without provocation in a resident activity area, resident #001 struck resident #002 causing two small cuts, which required the application of two steri-strips. On a specified date, the progress notes stated that resident #001 showed aggression to the left cheek of another resident.

Record review for resident #001 identified that she/he is living with a specific medical diagnosis and experienced almost daily unpredictable responsive behaviours that included spitting, hitting, yelling, screaming, shoving other residents, staff, visitors with the wheeled walker, and making sexually inappropriate requests. These behaviours were confirmed by staff interview. The care plan did show interventions for wandering, sexual explicit behaviours, memory impairment and activities of daily living including toileting and morning and evening care. The resident assessment protocol (RAPs) of June 12, 2014, state resident #001 to have shown deterioration related to behaviours from the previous assessment.

The care plan dated June 23, and June 25, 2014, identified resident #001's responsive behaviours were related to toileting and morning and evening care and stated that if aggressive behaviour escalates, to ensure that the resident is safe, leave the room and return in 10-15 minutes with another staff member. The progress notes and medication administration record (MAR) identified staff interventions such as removing the resident from the situation or occasionally administering lorazepam PRN. The plan of care did not identify specific interventions that staff could implement for the responsive behaviours identified as spitting, hitting, yelling, screaming, and shoving other residents, staff, visitors with the wheeled walker.

Interviews with staff, the RAI Coordinator, and ADOC confirmed that the care plan did not include clear directions for resident #001's responsive behaviours of spitting, hitting, yelling, screaming, and shoving other residents, staff, visitors with the wheeled walker. [s. 6. (1) (c)]

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 plan of care for resident #001 sets out clear directions to staff and others who provide direct care, identifying the responsive behaviours with corresponding focused interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 receive only drugs that are prescribed for the resident.

Resident #001 is living with a specific medical diagnosis and experienced frequent unpredictable behaviours. The progress notes stated that on a specified date, in a resident activity area, without provocation, resident #001 struck resident #002 causing two small cuts, which required the application of two steri-strips.

Record review indicated that on July 15, 2014, a nurse practitioner prescribed a specified drug 0.25 mg by mouth (PO) twice daily at 08:00 a.m. and 17:00 p.m and the same drug 0.25 mg when necessary (PRN) for agitation/aggression to a maximum of two doses in 24 hours.

Record review indicated that on August 8, 2014, the physician discontinued the specified drug. The medication administration record (MAR) indicated that on August 15, 2014, at 10:23 a.m., one 0.25 mg tablet of this specific drug was administered to resident #001 by a registered staff.

The facility charge nurse confirmed that the physician's order to discontinue this specifc drug applied to both the scheduled and PRN prescriptions and that resident #001 should not have received the PRN drug dosage of this drug on August 15, 2014. [s. 131. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's written record is kept up to date at all times.

On a specified date, without provocation, in a resident activity area, resident #001 struck resident #002 causing two small cuts, which required the application of two steri-strips.

Record review for resident #001 identified that she/he is living with a specific medical diagnosis and experienced almost daily unpredictable behaviours that included spitting, hitting, yelling, screaming, shoving other residents, staff, visitors with the wheeled walker, and making sexually inappropriate requests. These behaviours were confirmed by staff interview.

Progress notes on July 3, 2014, at 14:23 p.m. identifed that a behavioural services observation (BSO) form was initiated for resident #001. On the same date at 21:30 p.m. the progress notes stated this resident was on every 30 minute monitoring concerning behavior and monitoring was increased to every 15 minutes.

Record review revealed that there was no documented record of every 30 minute observations from July 3, 2014 at 14:23p.m. to July 5, 2014 at 21:30p.m. The Director of Social Services confirmed that no documentation could be found for every 30 minute observations for these dates. [s. 231. (b)]

Issued on this 30th day of November, 2014

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

Original report signed by the inspector.