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

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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
May 12, 2015	2015_302600_0009	T-974-14	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

GORDANA KRSTEVSKA (600)

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): April 21-22, 2015.

During the course of the inspection, the inspector(s) spoke with the executive director (ED),the corporate consultant, the assistant director of care (ADOC), physiotherapist (PT), restorative care coordinator, registered practical nurses (RPN), personal support workers (PSW).

The following Inspection Protocols were used during this inspection:
Falls Prevention

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 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).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care that sets out the planned care for the resident.

Review of the record titled Ont-Post fall assessment revealed that resident # 1 has been on a scheduled toileting program prior to having two falls on July, 2014 and April, 2015. The written plan of care indicated staff are to provide extensive assistance to the resident for toileting however, there was no scheduled toileting program or plan for staff to follow.

Record review of POC, flow sheet and progress notes revealed that resident #1 had a fall in April 2015 at 4:40 p. m. in Activity Room, and he/she had not been toileted since 09:44 a.m.

Interview with identified registered staff confirmed that there is no scheduled toileting plan set out in the written plan of care to provide direction to the staff. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to

the resident as specified in the plan.

Record review revealed that resident #1 has history of falls and is at a high risk for falls; The plan of care directed the staff to ensure the resident is wearing hip protectors when he/she is awake. On April, 2015, the resident had a fall and sustained a fracture of the right hip. The resident#1 did not have the hip protector at the time of the fall.

Interview with identified staff confirmed that he/she did not apply the hip protector to the resident that morning when he/she dressed the resident#1 as specified in the plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Record review revealed and interview with Physiotherapist (PT) confirmed that resident #1 had a fall in April, 2015 and sustained fractures of the right hip and fifth digit on the right hand. Resident was assessed by PT upon return from the hospital and his/her plan of care was communicated to the nursing staff in April, 2015. The recommendation by the PT revealed that the staff were to transfer the resident on the tilt wheelchair using a Hoyer lift until weight bearing status is confirmed by the hospital.

On April 21, 2015, the written plan of care directed the staff to assist resident #1 with transfer, the resident can weight bear, and to provide extensive assistance by one staff during the transfer to ensure safety all the time. Resident #1 requires physical support due to his/her impaired and unsteady gait.
Interview with an identified registered staff confirmed that resident #1 had a fall, sustained right hip fracture and the written plan of care had not been reviewed and revised to reflect PT recommendation when resident's care needs changed. This resident plan of care did not reflect resident's current condition and this plan of care is no longer necessary [s. 6. (10) (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 there is a written plan of care that sets out the planned care for the resident., to be implemented voluntarily.

Issued on this 1st day of June, 2015

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

Original report signed by the inspector.