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
Dec 2, 2015	2015_302600_0022	028404-15	Resident Quality Inspection

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), MATTHEW CHIU (565), SOFIA DASILVA (567), STELLA NG (507), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 20, 22, 23, 26, 27, 28, 29 and 30, 2015, and November 1, 2 and 3, 2015.

The following critical incidents were inspected concurrently: CSC #001919-15, CSC #003291-15, CSC #011061-15, CSC #015001-15, CSC #00508-14, CSC #006626-14, CSC #008680-14 and CSC #030341-15.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), personal support workers (PSWs), registered dietitian (RD), registered nurses (RNs), registered practical nurses (RPNs), Family Council president, Residents' Council president, Resident Assessment Instrument-Minimum Data Set (RAI-MDS) coordinator, physiotherapy assistant (PTA), business manager, director of social services, residents and Substitute Decision Makers (SDMs).

During the course of the inspection, the inspector(s) conducted a tour of the home, observed meal service, medication administration system, staff and resident interactions and the provision of care, and reviewed health records, complaint and critical incident record logs, staff training records, meeting minutes for Family and Residents' Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **6 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 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and

friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in

order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Interview with resident #011 revealed that an incident occurred recently that made him/her upset. The resident was told he/she was going to be showered by an identified PSW that resident does not prefer and when he/she complained to registered staff, he/she was told in an abrupt and "nasty" tone that "this had nothing to do with me".

Interview with registered staff #132 revealed he/she was the staff member resident #011 had spoken to regarding not wanting to have an identified PSW shower her. Registered staff #132 denied speaking with the resident in an inappropriate manner but admitted he/she could have taken more time to calm and reassure resident #011 that identified PSWs would not be showering him/her that day or in the future.

Interview with the DOC confirmed that since resident #011 had felt nervous and the staff failed to provide reassurance regarding the above mentioned issue, then the home did not fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects their dignity. [s. 3. (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 fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, 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).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

Review of resident #024's progress notes revealed he/she had some falls for the identified period of times. After the last fall on identified date, when the resident was unresponsive for some time, he/she was transferred to the hospital and admitted with a head injury.

Review of resident #024's written plan of care revealed resident was at high risk for falls and the goal for this resident's care was to maintain present interventions to sustain current status. Some of the interventions for falls prevention were:
- Due to frequent falls during the night staff are to complete frequent checks between midnight and 6:00 AM.
- Staff to remind resident to use washroom around early morning time.
- Staff will remind resident to use mobility device at all times and cue/remind resident of correct use of gait aid (walker).

Interview with PSW #140 revealed he/she was not able to describe what frequent checks mean and how often the resident should be checked.

Interview with RPN #107 revealed he/she was not able to describe what to sustain current status referred to.

Interview with the RAI Coordinator #113 confirmed the goal to sustain current status and the intervention of frequent checks did not give clear direction to the staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Interview with resident #011 on identified date, revealed that in a recent incident he/she became very upset because he/she thought a identified PSW was going to be giving him/her a shower. The resident stated he/she expressed his/her preference not to have the identified care giver at that time to registered staff. Review on identified date revealed that the most recent plan of care did not indicate resident #011 prefers not to have identified PSWs provide showers or personal care.

Review of resident #011's progress notes revealed the above mentioned incident occurred on identified date and was documented by registered staff #132. Interview with registered staff #132 revealed that resident #011 made his/her preference known on different dates but the registered staff had failed to indicate this on the written plan of

care for all staff to be aware of.

Interview with registered staff #132 confirmed that not wanting a male to provide personal care is an important preference that should have been added to the written plan of care as soon as it was assessed. [s. 6. (2)]

3. The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care.

Interview with resident #011 revealed he/she had not been receiving mouth care in the evening.

Record review of MDS assessment from identified date revealed resident #011 had own teeth, and needed assistance by one staff to set up the items for oral care. Review of resident #011's most recent written plan of care indicated staff were to load toothbrush with toothpaste and cue resident to brush his/her teeth.

Interview with staff #130 and #131 confirmed they were not aware of the contents of the resident #011's written plan of care to perform mouth care every shift.

Interview with DOC confirmed the staff have access to the plan of resident's care through the kardex and they are expected to review it and be aware of what care they need to provide to the resident during their shift. [s. 6. (8)]

4. The licensee has failed to ensure that the plan of care is revised when care set out in the plan is no longer necessary.

A review of resident #050's progress notes revealed the resident had injury on identified date. A review of the current plan of care revealed the resident required two-person extensive assistance for walking.

On October 20, 2015, the inspector observed the resident walking in the hallway, using a wheeled walker and the resident was unattended by staff.

Interviews with PSWs #100, #101, RPN #102 and #103 indicated the plan of care for two-person extensive assistance for walking was initiated when the resident sustained the injury on the identified date. The resident had progressed and he/she was able to walk independently, or sometimes with staff supervision, using a walker.

The staff members confirmed the plan of care for the resident's two-person extensive assistance for walking was not revised when it was no longer necessary. [s. 6. (10) (b)]

5. 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 the care set out in the plan is no longer necessary.

Review of the resident #050's clinical records revealed the resident was admitted on identified date. At the time that the resident was admitted, the resident was ambulatory and participated in his/her care. A review of the resident's most recent plan of care, revised on identified date revealed that the PSWs assist with care.

Interview with PSW #109 and RPN #111 revealed that the resident does not perform his/her own care. The PSW and RPN stated that the resident often misuse the equipment so the staff decide it would be easier and safer staff to use another equipment.

Interview with ADOC #139 confirmed that the plan of care had not been reviewed and revised to reflect the care that staff provide to the resident when performing care. [s. 6. (10) (b)]

6. The licensee has failed to ensure that when the plan of care is revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care.

A review of resident #050's most recent plan of care revealed the resident was at high risk and some interventions were in place since identified date for prevention. There were other prevention interventions included as well:
- Clip call bell to pillow/bed sheet,
- Leave bathroom light on at night,
- Remind resident to call for assistance and wait before getting up, and
- Monitor resident at all times when up walking.

A review of the progress notes from identified dates indicated the resident had removed the equipment and staff had to reinstall it. The plan of care was revised on identified date and indicated that because the resident was not compliant in using the equipment it was removed. Other prevention interventions had been continued.

Interviews with PSWs #100, #101, RPN #102 and #103 confirmed the equipment was removed because it had not been effective and the resident was at risk if he/she was unattended.

Interviews with RPN #102 and #103 confirmed when the bed alarm was removed, no different approach was considered in the revision of the plan of care. [s. 6. (11) (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:
-the plan of care set out clear directions to staff and others who provide direct care to the resident,
-the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident,
-the staff and others who provide direct care to a resident are kept aware of the contents of the plan of care,
-the plan of care is revised when care set out in the plan is no longer necessary,
-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 the care set out in the plan is no longer necessary,and
-when the plan of care is revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs remain in the original labelled package provided by the pharmacy service provider until administered to a resident.

Review of the electronic Medication Administration Record (eMAR) for resident #061 revealed that the resident was prescribed medication by mouth once daily, and hold the medication if the resident experience any side effect.

On identified date and time, the inspector observed a in a medication cup in resident #061's medication bin of the medication cart. Interview with the RPN #104 identified the medication. RPN #104 further revealed that the medication was not given to the resident earlier during the morning medication pass because he/she had not assessed the resident. Review of the eMAR for resident #061 and interview with RPN #104 confirmed the resident was assessed and the resident was given the capsule at approximately 11:30 AM.

Interview with the Director of Care (DOC), revealed that residents' medications were received in individual pouches, and the home's expectation is to keep the medication(s) in the original package or container until they are administrated to the resident. The DOC further confirmed that the medication should be kept in the original pouch when one of the medications was to be given at a later time. [s. 126.]

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 drugs remain in the original labelled package provided by the pharmacy service provider until administered to a resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to immediately forward any written complaint that has been received concerning the care of a resident to the Director.

Review of the home's 2012-2014 complaint binder revealed there was a complaint letter from a family member that had not been responded to. The letter had identified date and interview with the Director of Social Services revealed this was from resident #030's family after the resident passed away.

Review of the letter indicated the resident and family were unhappy with the care provided by the home.

Interview with the Director of Social Services confirmed that this written complaint was never forwarded to the Director. [s. 22. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

Interview with resident #011 revealed he/she had not been receiving mouth care on the evening.

Record review of the MDS assessment from identified date revealed resident # 011 needed extensive assistance by one staff to assist the resident with personal hygiene. The assessment indicated the resident needed daily assistance to maintain status and disease prevention. Most recent plan of care, revised on identified date indicated resident need assistance and cuing to perform care.

Interview with PSW #130 on identified date confirmed he/she did not provide morning care to the resident as he/she had been working with some other residents.

Interview with the PSW #131 confirmed resident #011 had not been receiving mouth care in the evening and staff only wipe resident's mouth after eating supper in bed.

Interview with the DOC confirmed the resident #011 should be assisted with care in the morning and in the evening. [s. 34. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written complaint made to the licensee concerning the care of a resident, the licensee has responded to the person who made the complaint.

Review of the home's 2012-2014 complaint binder revealed there was a complaint letter from a family member that had not been responded to. The letter was dated and interview with the Director of Social Services revealed this was from resident #030's family after the resident passed away.

Interview with the Director of Social Services and the Administrator confirmed that the home had not responded to this letter. [s. 101. (1) 3.]

2. The licensee has failed to ensure that a documented report is kept in the home that includes the nature of each verbal and written complaint, the date the complaint was received, the type of action taken to resolve the complaint, the final resolution, if any, every date on which any response was provided to the complainant and any response made by the complainant.

Interview with resident #005's SDMs revealed that the resident's personal belongings went missing quite a while ago and they were never found. Review of the home's 2012-2014 complaint binder revealed there was no missing item form for these missing items.

Review of resident #005's progress notes revealed these items went missing on identified date, a search had been conducted and a missing item form was initiated by registered staff #126.

Interview with registered staff #126 revealed he/she does not recall completing a missing form but stated that the home's policy is to fill out such a form and circulate it to all departments.

Interview with the Administrator revealed the home keeps track of all missing items in their complaint binder but confirmed that in the above mentioned case, it was not recorded in their complaint log workbook and the form was not kept in the complaints binder. [s. 101. (2)]

Issued on this 19th day of January, 2016

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

Original report signed by the inspector.