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

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 # / Registre no	Type of Inspection / Genre d'inspection
Nov 3, 2016	2016_235507_0015	025339-16, 030427-16	Complaint

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

Chartwell Trilogy Long Term Care Residence
340 McCowan Road SCARBOROUGH ON M1J 3P4

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

STELLA NG (507)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 18, 19, 20, 21 and 24, 2016.

This Complaint Inspection included a Critical Incident Report #2899-000029-16 related to fall prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSW), Recreation Aide (RA) and Substitute Decision Maker(s) (SDM).

During the course of the inspection, the inspector conducted observations of staff and resident interactions, provision of care, reviewed clinical health records, staff training records, and relevant policy and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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. (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).

Findings/Faits saillants :

1. The licensee has failed to 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.

Review of resident #021's progress notes and interview with DOC #106 revealed the resident was transferred from one identified floor to another identified floor on an identified date, as requested by the family. Review of resident #021's care plan on an identified date, indicated the resident required extensive assistance with two staff for transfer. The resident was at high risk for falls, and one of the interventions was placing the resident at a specific location for observation. Review of resident #021's progress notes revealed that on an identified date, the resident was placed in another location other than the mentioned specific location. The resident's shoes were observed on the floor twice and the resident was restless by PSWs staff #101 and #122. At an identified time on the same day, staff #119 found the resident on the floor.

Interview with assigned PSW staff #101 and registered staff on the identified floor staff #103 revealed they were not aware of resident #021's care plan of placing the resident at the mentioned specific location for observation when the resident was showing signs of restlessness when the resident was assigned to them. Interview with DOC staff #116 confirmed staff should aware of the resident's care plan when the resident was transferred to their floor. [s. 6. (8)]

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 staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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 licensee has failed to ensure that when the 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.

Review resident #021's progress notes revealed the resident had a fall on an identified date. Review the resident's Morse Fall Risk Assessment on an identified date two months prior indicated the resident was at high risk of fall.

Review of the home's "Resident Falls" policy (policy #LTC-CA-WQ-200-07-08, revised May 2016) indicated registered staff are to use the number of falls in the month and quarter to determine if a Post Fall Analysis is to be completed as follow:
High risk resident, if the fall is the first fall in the quarter (Quarters are set quarters of January to March, April to June, July to September and October to December), risk management, progress note and Post Fall Analysis are to be completed.

Review of resident #021's health record failed to reveal a completed Post Fall Analysis related to the fall occurred on the above mentioned date.

Interview with DOC #116 revealed that the fall occurred on the above mentioned date was resident #021's first fall of the quarter. According to the home's policy, a Post Fall Analysis should be completed. DOC #116 further confirmed that a Post Fall Analysis was not completed as required for resident #021 after the fall occurred on the above mentioned date. [s. 49. (2)]

Issued on this 9th day of November, 2016

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

Original report signed by the inspector.