Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 5, 2019	2019_630589_0018	013121-19, 014466-19	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

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

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

JOANNE ZAHUR (589)

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): August 22, 23, 26, 27, 28, 29, & 30, 2019.

The following intakes were completed during this inspection:
-logs #014466-19 and #013121-19 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Nurse Manager (A-NM), Facility Nurse Managers (FCN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Residents.

During the course of the inspection, the inspector(s) observed staff to resident interactions, resident to resident interactions, room observations and the provision of care, reviewed health records, the home's internal investigation notes, and relevant policies 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)**
- **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	Légende 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 the staff involved in the different aspects of care of resident #007 collaborated with each other in the development and implementation of the plan of care.

A Critical Incident System (CIS) report was submitted to the Director which indicated that resident #007 had experienced an incident that required a transfer to hospital. The CIS report further indicated that resident #007 sustained an injury. The CIS also indicated in the analysis and follow-up section that the new identified interventions were to be implemented after the above-mentioned incident:

Observations conducted during this inspection with staff #116 and staff #115 indicated the above-mentioned identified interventions were not in place.

A further review of resident #007's progress notes written after the above observations

had been conducted indicated the identified interventions were implemented after the inspector had brought it to the long term care home's (LTCH) attention that these identified interventions were not in place.

During an interview, staff #115, stated they had not been aware of these identified interventions noted in the analysis and follow-up section of the CIS report. Staff #115 further stated there had been a gap in communication related to implementing these interventions.

During an interview, staff #100 stated they had completed the CIS report and had documented the above-mentioned identfied interventions in the analysis and follow-up section of the report. Staff #100 acknowledged there had been a gap in their communication and collaboration, resulting in these interventions being implemented 37 days later. [s. 6. (4) (b)]

2. The licensee has failed to ensure the provision of care set out in the plan of care were documented for resident's #003 and #007.

A CIS report was submitted to the Director which indicated an incident involving resident's #002 and #003 had occurred. The CIS report further indicated that resident #003 was transferred to hospital for further assessment and was then diagnosed with an injury.

A review of resident #003's health record prior to this incident indicated they ambulated independently with the aid of an identified mobility aid. A further review of the health record including the Kardex, indicated that specifically timed safety checks were initiated after the above mentioned incident as a new strategy.

During an interview, staff #115 stated that when a resident is on specifically timed safety checks, PSWs are required to document this task in the Point of Care (POC) screens where all care provided to a resident during their shift is documented.

A review of resident #003's documentation survey report from Point Click Care (PCC) for two identified months in 2019, indicated the specifically timed safety checks had not been documented as required on several identified days and shifts during these two months.

During interviews, staff #115 acknowledged that staff had not documented the provision of care for resident #003. [s. 6. (9)]

3. A CIS report was submitted to the Director which indicated an incident had occurred that resulted in a transfer to hospital for further assessment. The CIS report further indicated that resident #007 had sustained an injury.

A review of resident #007's health record prior to this incident indicated they ambulated independently with the aid of a mobility aid. A further review of the health record including the Kardex, indicated that after the above mentioned incident, specifically timed safety checks were initiated as a new strategy.

During an interview, staff #115 stated that when a resident is on specifically timed safety checks, PSWs are required to document this task in the Point of Care (POC) screens where all care provided to a resident during their shift is documented.

A review of resident #007's documentation survey report from Point Click Care (PCC) for two identified months in 2019, indicated the specifically timed safety checks had not been documented as required on several identified days and shifts during these two months.

During an interview, staff #115 acknowledged that staff had not documented the provision of care for resident #007. [s. 6. (9)]

4. The licensee has failed to ensure resident #007 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when their care needs changed or care set out in the plan was no longer necessary.

A CIS report was submitted to the Director which indicated resident #007 had experienced an incident that required a transfer to hospital on the same day. The CIS report further indicated that resident #007 had sustained an injury. The analysis and follow-up section of the CIS report indicated that new identified interventions were to be implemented after the above-mentioned incident.

A review of resident #007's progress notes indicated an entry written by the LTCHs Falls lead that resident #007 would also benefit from the use of a specifically identified intervention after the incident.

Observations conducted during this inspection by the inspector with staff #116 and staff #115 indicated the above-mentioned interventions were not in place.

A review of resident #007's care plan in effect after the indicent, indicated it had not been revised and updated to indicate the above-mentioned interventions.

During interviews, staff #100 and staff #115 acknowledged that resident #007's plan of care had not been revised and updated after the resident's care needs had changed. [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 the staff involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care and to ensure the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure the plan of care for resident #002 included risk of falls.

A CIS report was submitted to the Director for an incident that had occurred involving resident's #002 and #003. The incident had not been witnessed however resident #002 is is related to resident #003 and is known to watch over them while they are sleeping to ensure their safety.

A review the LTCH's policy titled: Resident Safety and Risk Management, policy number LTC-CA-WQ-200-07-08, last revised December 2017, indicated on page 2 that if a Falls RAP is triggered after completing the admission falls assessment, the registered staff are to determine the level of risk related to falls and are to complete a resident specific care plan related to fall risk.

A review of resident #002's admission notes from an identified date in March 2019, indicated they had no history of falls but did have an unsteady gait. A review of the admission falls risk assessment identified resident #002 to be at low risk for falls however a fall Resident Assessment Protocol (RAP) was triggered that indicated a risk for falls.

A further review of resident #002's health record indicated they had experienced a total of five falls since their admission five months ago, noting these falls had occurred over the past two months. A review of resident #002's care plan from admission to the time of this inspection indicated that a fall focus had not been initiated.

During an interview, staff #115 acknowledged that since a fall RAP had been triggered from the admission assessments, staff should have initiated a fall focus for resident #002 in their care plan on admission. [s. 26. (3) 10.]

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 the plan of care for the resident included risk of fall, to be implemented voluntarily.

Issued on this 6th day of September, 2019

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

Original report signed by the inspector.