Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
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Original Public Report

Report Issue Date: September 8, 2023	
Inspection Number: 2023-1481-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Trillium Health Partners	
Long Term Care Home and City: McCall Centre Long Term Care Interim Unit, Etobicoke	
Lead Inspector Noreen Frederick (704758)	**Inspector Digital Signature**
Additional Inspector(s) Ryan Randhawa (741073)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 18, 21, 22, 23, 24, 25, 28, 2023

The following intake(s) were inspected:

- Intake: #00094689 - Proactive Compliance Inspection - McCall Centre LTC Interim Unit

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Residents' and Family Councils
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in resident #009 and #007's plan of care was provided to the residents as specified in the plan.

Rationale and Summary
a. Resident #009's care plan directed staff to provide nutritional supplement three times a day with their meals.

The inspector observed that staff did not offer the scheduled supplement with the resident's lunch.

Personal Support Worker (PSW) and Registered Practical Nurse (RPN) acknowledged that the resident did not receive the supplement at lunch but should have as it was required as per the resident's plan of care.

The Director of Care (DOC) indicated that the failure to follow the resident's plan of care put them at risk of not receiving proper nutrition and possible weight loss.

Sources: observation, resident's care plan, interviews with PSW, RPN, DOC and other staff.

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b. Resident #007's care plan directed staff to ensure an assistive aid was in use when they were in their assistive device.

The inspector observed that the resident did not have this assistive aid.

PSW acknowledged that that the resident did not have this assistive aid. The DOC acknowledged that the plan of care was not followed for the resident.

The DOC indicated that staff not following the plan of care placed the resident at risk for altered skin

integrity.

Sources: resident's care plan, observation, interviews with PSW, DOC and other staff.

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WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in the plan of care for resident's #007, #005, and #008 was documented correctly.

Rationale and Summary
a. Resident #007's care plan indicated that they required total assistance for Activities of Daily Living (ADLs) and their daily care flow sheet indicated incorrect level of assistance was provided.

PSW and the DOC indicated that the resident required total assistance for ADLs, and the DOC acknowledged that staff documented incorrectly.

Failure to ensure that the provision of the care set out in the plan of care for the resident was documented correctly provided minimal risk to the resident.

Sources: resident's care plan, resident's daily care flow sheet, interviews with PSW, and DOC.

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b. Resident #005's care plan indicated that they required total assistance for ADLs and their daily care flow sheet indicated incorrect level of assistance was provided.

PSW and the DOC indicated that the resident required total assistance for ADLs, and the DOC acknowledged that staff documented incorrectly.

Failure to ensure that the provision of the care set out in the plan of care for the resident was documented correctly provided minimal risk to the resident.

Sources: resident's care plan, resident's daily care flow sheet, interviews with PSW, and DOC.

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c. Resident #008’s care plan indicated that they required total assistance for ADLs and their t daily care flow sheet indicated incorrect level of assistance was provided.

PSW and the DOC indicated that the resident required total assistance for ADLs, and the DOC acknowledged that staff documented incorrectly.

Failure to ensure that the provision of the care set out in the plan of care for the resident was documented correctly provided minimal risk to the resident.

Sources: resident #’s care plan, resident's daily care flow sheet, interviews with PSW, and DOC.

[741073]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)

The licensee has failed to ensure to seek the advice of the Residents’ Council, in carrying out the Resident and Family/Caregiver Experience Survey and in acting on its results.

Rational and Summary
The home implemented a Resident and Family/Caregiver Experience Survey in 2022. The Administrator confirmed they did not seek the advice of Residents' Council in carrying out the Resident and Family/Caregiver Experience Survey or in acting on its results.

Not seeking the advice of Residents’ Council in carrying out the survey and in acting on its results, may risk potential feedback not being included to assist the home in improving the care, services, programs and goods provided.

Sources: review of Residents' Council Meeting Minutes and interview with the Administrator.

[704758]

WRITTEN NOTIFICATION: Licensee obligations if no Family Council

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7) (b)

The licensee has failed to ensure that semi-annual meetings to advise residents' families and persons of importance to residents of the right to establish a Family Council are convened.

Rational and Summary
The home did not have a Family Council. The Administrator acknowledged that semi-annual meetings to advise residents' families and persons of importance to residents of the right to establish a Family Council were not conveyed.

Failure to convene semi-annual meetings to advise residents' families and persons of importance to residents of the right to establish a Family Council, may risk loss of opportunities to improve the experience or residents and families.

Sources: Interview with the Administrator.

[704758]

WRITTEN NOTIFICATION: Doors in a home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.

The licensee has failed to ensure that doors that residents do not have access to were kept closed and locked.

Rationale and Summary
A laundry chute door was left open. The observations were brought to the attention of the RPN and they stated that the lock has been broken for several weeks. Maintenance Aide stated that they were aware that the lock has been broken for one month. The DOC acknowledged that the lock should have been repaired immediately.

When the laundry chute door was not closed and locked, there was a risk of residents' entering the

chute and getting injured.

Sources: inspector's observation, interviews with RPN, Maintenance Aide, and DOC.

[704758]

WRITTEN NOTIFICATION: Communication and response system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that can be easily seen, accessed and used by a resident at all times.

Rationale and Summary
A resident was sitting in their room with call bell not accessible to the resident.

Resident's care plan indicated that the call bell was to be left with them.

The policy titled "Nurse Call System," stated to ensure the call bell is easily accessible to the residents at all times while the resident is in their room.

PSW verified that the call bell was not left with the resident as per the resident's plan of care. PSW and RPN acknowledged that the call bell should have been accessible to the resident.

There was risk to the resident when the call bell was not accessible to them in the event they needed to call for assistance or in case of an emergency.

Sources: observation, resident's care plan, the policy titled "Nurse Call System," RC-08-01-01, last reviewed January 2022, interviews with PSW, RPN, DOC and other staff.

[741073]

WRITTEN NOTIFICATION: Air temperature

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 1.
The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in at least two resident bedrooms in different parts of the home.

Rationale and Summary
Review of the home's temperature logs indicated that air temperatures in at least two resident bedrooms were missed on several days during the period of May 15, 2023 to August 23, 2023.

The home's failing to measure air temperatures, created a potential risk for residents developing heat related illnesses.

Sources: home's temperature logs, and interview with ESM.

[704758]

WRITTEN NOTIFICATION: Air temperature

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 2.

The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in one resident common area.

Rationale and Summary
Review of the home's temperature logs indicated that air temperatures in one resident common area was missed on several days during the period of May 15, 2023 to August 23, 2023.

The home's failing to measure air temperatures, created a potential risk for residents developing heat related illnesses.

Sources: home's temperature logs, and interview with ESM.

[704758]

WRITTEN NOTIFICATION: Air temperature

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 3.

The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in every designated cooling area, if there are any in the home.

Rationale and Summary
Review of the home's temperature logs indicated that air temperatures in the dining room which was designated as a cooling area were missed on several days during the period of May 15, 2023 to August 23, 2023.

The home's failing to measure air temperatures, created a potential risk for residents developing heat related illnesses.

Sources: home's temperature logs, and interview with ESM

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WRITTEN NOTIFICATION: Air temperature

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)

The licensee has failed to ensure that the temperature required to be measured under subsection (2) was measured and documented at least once every evening or night.

Rationale and Summary
Review of the home's temperature logs indicated that air temperatures for every evening or night during the period of May 15, 2023 to August 23, 2023 were missed.

The home's failing to measure air temperatures, created a potential risk for residents developing heat related illnesses.

Sources: home's temperature logs, and interview with ESM.

[704758]

WRITTEN NOTIFICATION: Menu planning

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (1) (f)

The licensee failed to ensure that the home's menu cycle included a choice of snacks in the afternoon and evening.

Rationale and Summary
Review of the home's menu cycle showed that the menu did not offer a choice of snacks in the afternoon or evening. There was only one snack listed on the menu for the afternoon and evening snack service each day.

On August 25, 2023, a PSW was observed offering only one type of snack to residents during afternoon snack service. No choice of snack was available.

PSW indicated that the home did not offer choices for snacks for the afternoon and evening snack service as per the menu cycle for August 25, 2023.

The Dietician and DOC acknowledged that the home's menu cycle did not offer choices for snacks in the afternoon and evening snack service however a choice should have been provided.

Not receiving a choice of snacks in the afternoon and evening compromised the residents' right to choose and put the residents at risk for calory deficit.

Sources: the home's menu cycle; observation, interviews with PSW, Dietician, DOC and other staff.

[741073]

WRITTEN NOTIFICATION: Menu planning

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (a)

The licensee has failed to ensure that prior to being in effect, each menu cycle is reviewed by the Residents' Council for the home.

Rational and Summary
The home implemented Spring/Summer menu on June 19, 2023. Review of Residents' Council Meeting minutes from January to June of 2023, and Food Committee minutes from January to June 2023, indicated no discussion of this menu. The Dietary Manager stated that the Spring/Summer menu was not reviewed with the Residents' Council prior to it being in effect.

Failure to review each menu with the Residents' Council prior to it being in effect, may risk loss of opportunities for residents' preferences, and enhancement to nutritional care and dietary services.

Sources: review of Residents' Council and Food Committee meeting Minutes and interview with the Dietary Manager.

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WRITTEN NOTIFICATION: Dining and snack service

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

The licensee has failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

Rationale and Summary
On August 18, 2023, multiple residents were observed eating a cold food entrée for lunch in the dining room.

The home's policy, Holding and Distribution of Food, detailed that cold foods were to be held at a temperature below 4 degrees Celsius from the time the food is removed from the refrigerator until the end of meal service.

Review of the home's Food Temperature Logs from lunch service on August 18, 2023 showed that the entrée, which was a cold food, was measured at 5 degrees Celsius.

The Dietician and the DOC acknowledged that the entrée was in the danger zone and unsafe for residents and acknowledged that the entree should have been served at 4 degrees Celsius or less. There was no documentation that a corrective action to address this issue had occurred.

Failure to ensure that the cold food entrée was served at a temperature that was both safe and palatable to the residents put the residents at risk for negative health outcomes related to food safety

and quality.

Sources: observation, policy titled “Holding and Distribution of Food” NC-07-01-02, last reviewed January 2022, interviews with Dietician, DOC and other staff.

[741073]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.

The licensee has failed to ensure that the infection prevention and control (IPAC) lead worked the required amount of time per week.

Rationale and Summary

The home had a bed capacity of 21 beds. The DOC who also worked as the home's IPAC lead, advised that they worked 10 hours a week on IPAC. The Administrator confirmed that the DOC worked 10 hours a week as the IPAC Lead for the home. The DOC acknowledged falling short of the required 17.5 hours per week based on the legislative requirements for the bed capacity of the home.

Failure of the home to ensure that the IPAC lead worked the required legislative hours increased the risk of not monitoring and addressing IPAC concerns effectively.

Sources: interviews with DOC/IPAC Lead, and Administrator.

[741073]

WRITTEN NOTIFICATION: Quarterly evaluation

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)

The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary:
The home's quarterly Outcome Evaluation Medication meetings in January, April and July 2023, included Administrator, DOC, ADOC, Dietary Manager and a nursing representative, however the Medical Director, and the pharmacy service provider were not present. DOC acknowledged that the Medical Director, and the pharmacy service provider should be present.

Failure to include all required members of the interdisciplinary team to complete a quarterly evaluation of the effectiveness of the medication management system and to recommend any changes necessary to improve the system may risk lost opportunities for enhancement of the system or implementation of corrective actions to decrease medication incidents.

Sources: quarterly outcome evaluation medication meeting minutes and Interview with DOC.

[704758]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2)

The licensee failed to ensure their continuous quality improvement (CQI) committee was composed of at least the following persons:
1. The home's Administrator.
2. The home's Director of Nursing and Personal Care.
3. The home's Medical Director.
4. Every designated lead of the home.
5. The home's registered dietitian.
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.
9. One member of the home's Residents' Council.
10. One member of the home's Family Council, if any

Rationale and Summary:
The home's Continuous Quality improvement team did not include the following required roles: Medical Director, registered dietitian, pharmacy service provider, at least one employee who was a member of

the regular nursing staff, at least one employee who was hired as a personal support worker, and one member of Residents' Council.

The Administrator acknowledged that their CQI team did not include all the required members.

Not including all required roles in the CQI committee may risk relevant interdisciplinary feedback not being captured to assist the home in their CQI initiatives or outcomes.

Sources: CQI committees meeting minutes and agenda, and interview with the Administrator.

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