Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Ottawa Service Area Office

347 Preston St., 4th Floor
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Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité
Bureau régional de services de Ottawa

347, rue Preston, 4iém étage
Ottawa ON K1S 3J4
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November 1, 2010

Ms. Jennifer Powley
Administrator
Trillium Centre
800 Edgar Street
Kingston ON K7M 8S4

Dear Ms. Powley:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted on August 10 and 11, 2010 under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Ottawa Service Area Office, Performance Improvement and Compliance Branch.

Sincerely,

Kathleen Smid

for Darlene Murphy
LTC Home Inspector – Nursing

c President, Resident's Council
President, Family Council

Ontario

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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'insptection
August 10, 11, 2010	2010_103_2790_09Aug155214	Complaint Log # O-000792

Licensee/Titulaire

Specialty Care East Inc., 400 Applewood Crescent, Suite 110, Vaughan, ON L4K 0C3 Fax# 905-695-2940

Long-Term Care Home/Foyer de soins de longue durée

Trillium Centre, 800 Edgar Street, Kingston, Ontario K7M 8S4 Fax# 613-547-3734

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

Darlene Murphy (ID#103)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Complaint inspection related to resident behaviors.

During the course of the inspection, the inspector spoke with: Residents, family members, Registered Nurses, and Personal Support Workers, Assistant Director of Care and the Director of Resident Services

During the course of the inspection, the inspector also reviewed 2 resident health records.

The following Inspection Protocols were used during this inspection:

- Choice and Privacy Inspection Protocol
- Responsive Behaviors Inspection Protocol

Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O 2007, c.8 s6
(1)Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets

- **(a) the planned care for the resident;**
- **(b) the goals the care is intended to achieve; and**
- **(c) clear directions to staff and others who provide direct care to the resident.**

Findings:

1. **A resident's plan of care does not provide staff with clear directions related to the interventions for wandering behaviors.**
2. **A resident and a family member have reported to staff and to the Administration their concerns with a co-resident's wandering behavior. There are no clear directions to staff who provide direct care to this resident to assist in preventing the co-resident from entering the resident room.**

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 there **is a process whereby the wandering resident's plan of care provide staff with clear directions related to the wandering behavior and the co-resident's plan of care provides staff with clear directions to assist in preventing the wandering resident from entering the resident room .** This plan is to be implemented voluntarily.

Inspector ID #:	103

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O 2007, c.8 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.**
Findings: **1. A resident's plan of care indicates the need to be showered every Monday and Friday and all refusals are to be reported to the Registered Practical Nurse on the shift; the resident bathing records indicate the resident received a shower since admission (July 16, 2010) on July 23, August 2 and August 9, 2010; no refusals are documented.**

Inspector ID #:	103

WN #3: The Licensee has failed to comply with O. Reg. 79/10 s.53 **(4)The licensee shall ensure that, for each resident demonstrating responsive behaviours,** **(a) the behavioral triggers for the resident are identified, if possible** **(b) strategies are developed and implemented to respond to these behaviors, where possible; and** **(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions are documented**
Findings: **1. The plan of care does not reflect behavioral triggers for a wandering resident. Upon interviewing staff and residents, triggers such as sun-downing, lack of sleep the previous night, and noise were identified as triggers, but not included on the plan of care.** **2. Personal Support Worker (PSW) staff was able to identify redirection as the only strategy for the wandering behaviors of the identified resident. The PSW staff reported this strategy had been ineffective for months and without constant supervision the resident would enter co-resident rooms. Residents on the unit were able to support this information. There was no indication of reassessment of this responsive behavior.**

Inspector ID #:	103

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Oct 7/10 Darlene Murphy
Title: **Date:**	**Date of Report (if different from date(s) of inspection).**