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 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**

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 30, 2019 | 2019_702197_0008 | 004179-19, 004243-19, 005256-19 | Complaint |

### Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Trillium Retirement and Care Community
800 Edgar Street KINGSTON ON K7M 8S4

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

JESSICA PATTISON (197)

### 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): March 28, 29, April 1-3, 2019 (on-site), April 4, 8, 2019 (off-site)**

**The following logs were completed as part of this inspection:**
**Logs 004179-19 and 004243-19 - a critical incident (2790-000012-19) and a complaint related to the fall of a resident that resulted in significant change in the resident's health status**
**Log 005256-19 - a complaint related to the personal care of a resident**

**During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Assistant Directors of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents and family members.**

**The inspector also reviewed resident health care records related to personal care and falls prevention and observed resident care.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Personal Support Services**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

On a specified date, resident #001 had a change in functional ability, was reassessed and identified to be at moderate risk for falls. The same day, the resident's POA indicated that they were concerned that the resident may have a fall as the resident was trying to get up and could not remember that they now had difficulty walking. Resident #001 was noted to have specified interventions put into place.

The following day, resident #001's transfer status changed and another specified intervention was put into place. Later that day, resident #001 was noted to have a fall in their room and appeared to have been trying to get out of bed on their own. There was no injury noted at this time.

On a following morning, resident #001 was noted to attempt to get out of bed on their own but was observed by staff and assistance was provided.

A few days later, the resident was found by PSW staff beside their bed. Progress notes indicated that the resident had been checked just prior in bed and the PSW was on their way back to do their next check when they found the resident on the floor.

Later that same day, ADOC #100 noted in the progress notes that they had a discussion with resident #001's POA and specified changes were to be made to the resident's plan of care to help reduce their risk of falling and prevent self-transferring. One of the specified interventions was for night staff to get the resident up at a specified time to void and get ready for the day and this was to be noted on task tab for PSWs on nights.

RPN #101 noted in the progress notes of resident #001 that night staff are to have resident toileted ,washed and dressed at the specified time and that the resident may lay down in bed if they want to once the care is provided.

On a specified date, resident #001 had a fall from their bed. No injury was noted as a result of this fall.

On another specified date, resident #001 was found on the floor. The progress notes indicated that the resident was last seen by the PSW at a certain time and was asleep in bed. The post-fall assessment by RN #102 indicated an injury and orders were then received from the doctor on call to send to the hospital with their POA's approval. Resident #001 was transferred to hospital and there they were diagnosed with a specified injury and received treatment.

A review of resident #001's follow-up questions report was conducted by the inspector for the time of the fall when the injury occurred. Under the task "Please get me up at specified time, please give me my morning care, toilet me and then lay me down if I am tired", it was documented by PSW #103, the morning the resident fell and sustained an injury, that this task had been completed.

During an interview with PSW #103, they stated that they came in to cover part of the night shift and worked until later that day. They indicated that they went down the hallways and did checks. PSW #103 stated they last saw the resident at a specified time and then went to the nursing station to complete their charting. They stated that when they saw the resident at this time, they had specified interventions in place and the resident was sound asleep.

PSW #103 stated they do not typically work nights, but was working overtime on this shift. The PSW stated they were not very familiar with resident #001 or their plan of care related to falls. When asked if the PSW had woken resident #001 at the specified time to toilet them and provide morning care, they stated that they were not aware that the resident was to be woken and further stated they could not have done this without help due to the resident's transfer status. The PSW did state that there is typically a float they can call or the RN if necessary, but they did not do this. PSW #103 said there was no communication to them about resident #001 when arriving on the floor, which is why they did not realize the resident had to be woken, toileted and provided morning care at a certain time.

RN #102 was also interviewed and indicated to the inspector that they recalled speaking to PSW #103 regarding resident #001's fall. The RN stated that the PSW had told them that they did not wake the resident at the specified time that morning but had checked on the resident at specific time intervals.

When resident #001 returned from the hospital, the resident was assessed as being at high risk for falls and further fall prevention measures were noted to be put into place.

During observation of resident #001 by the inspector on a specified date, it was noted that the resident was in bed without one of the noted interventions. The inspector spoke with RPN #101 who indicated that they thought the intervention should be in place when resident #001 is in bed. They proceeded to seek out PSW #104 who was providing care to the resident and the PSW confirmed that the intervention should have been in place.

Therefore, the care set out in the plan of care for resident #001 was not provided to the resident as specified in the plan. On the date of the resident's fall and injury, the resident was not woken and provided care at the specified time, as directed under tasks for the night PSWs. During observation of the resident during the inspection period, the resident did not have a specified fall prevention intervention in place while they were in bed, as indicated in the current plan of care. [s. 6. (7)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**Issued on this 28th day of May, 2019**

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

**Original report signed by the inspector.**

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

# Order(s) of the Inspector

# Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | JESSICA PATTISON (197) |
| **Inspection No. / No de l'inspection :** | 2019_702197_0008 |
| **Log No. / No de registre :** | 004179-19, 004243-19, 005256-19 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Apr 30, 2019 |
| **Licensee / Titulaire de permis :** | The Royale Development GP Corporation as general partner of The Royale Development LP<br>302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | Trillium Retirement and Care Community<br>800 Edgar Street, KINGSTON, ON, K7M-8S4 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Ashley Miller |

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

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. 2007, c. 8, s. 6 (7).

**Order / Ordre :**

The licensee shall comply with LTCHA 2007, s. 6(7).

Specifically, the licensee shall ensure that the care set out in the plan of care related to fall mitigation strategies for resident #001, and all other residents identified at risk for falls, is provided as specified in the plan.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

On a specified date, resident #001 had a change in functional ability, was reassessed and identified to be at moderate risk for falls. The same day, the resident's POA indicated that they were concerned that the resident may have a fall as the resident was trying to get up and could not remember that they now had difficulty walking. Resident #001 was noted to have specified interventions put into place.

The following day, resident #001's transfer status changed and another specified intervention was put into place. Later that day, resident #001 was noted to have a fall in their room and appeared to have been trying to get out of bed on their own. There was no injury noted at this time.

On a following morning, resident #001 was noted to attempt to get out of bed on their own but was observed by staff and assistance was provided.

A few days later, the resident was found by PSW staff beside their bed. Progress notes indicated that the resident had been checked just prior in bed

and the PSW was on their way back to do their next check when they found the resident on the floor.

Later that same day, ADOC #100 noted in the progress notes that they had a discussion with resident #001's POA and specified changes were to be made to the resident's plan of care to help reduce their risk of falling and prevent self-transferring. One of the specified interventions was for night staff to get the resident up at a specified time to void and get ready for the day and this was to be noted on task tab for PSWs on nights.

RPN #101 noted in the progress notes of resident #001 that night staff are to have resident toileted ,washed and dressed at the specified time and that the resident may lay down in bed if they want to once the care is provided.

On a specified date, resident #001 had a fall from their bed. No injury was noted as a result of this fall.

On another specified date, resident #001 was found on the floor. The progress notes indicated that the resident was last seen by the PSW at a certain time and was asleep in bed. The post-fall assessment by RN #102 indicated an injury and orders were then received from the doctor on call to send to the hospital with their POA's approval. Resident #001 was transferred to hospital and there they were diagnosed with a specified injury and received treatment.

A review of resident #001's follow-up questions report was conducted by the inspector for the time of the fall when the injury occurred. Under the task "Please get me up at specified time, please give me my morning care, toilet me and then lay me down if I am tired", it was documented by PSW #103, the morning the resident fell and sustained an injury, that this task had been completed.

During an interview with PSW #103, they stated that they came in to cover part of the night shift and worked until later that day. They indicated that they went down the hallways and did checks. PSW #103 stated they last saw the resident at a specified time and then went to the nursing station to complete their charting. They stated that when they saw the resident at this time, they had specified interventions in place and the resident was sound asleep.

PSW #103 stated they do not typically work nights, but was working overtime on this shift. The PSW stated they were not very familiar with resident #001 or their plan of care related to falls. When asked if the PSW had woken resident #001 at the specified time to toilet them and provide morning care, they stated that they were not aware that the resident was to be woken and further stated they could not have done this without help due to the resident's transfer status. The PSW did state that there is typically a float they can call or the RN if necessary, but they did not do this. PSW #103 said there was no communication to them about resident #001 when arriving on the floor, which is why they did not realize the resident had to be woken, toileted and provided morning care at a certain time.

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When resident #001 returned from the hospital, the resident was assessed as being at high risk for falls and further fall prevention measures were noted to be put into place.

During observation of resident #001 by the inspector on a specified date, it was noted that the resident was in bed without one of the noted interventions. The inspector spoke with RPN #101 who indicated that they thought the intervention should be in place when resident #001 is in bed. They proceeded to seek out PSW #104 who was providing care to the resident and the PSW confirmed that the intervention should have been in place.

Therefore, the care set out in the plan of care for resident #001 was not provided to the resident as specified in the plan. On the date of the resident's fall and injury, the resident was not woken and provided care at the specified time, as directed under tasks for the night PSWs. During observation of the resident during the inspection period, the resident did not have a specified fall prevention intervention in place while they were in bed, as indicated in the current plan of care. [s. 6. (7)]

The decision to issue this non-compliance as an order is based on the following:

Scope - Level 1: this incident was isolated as it only affected one resident

Severity - Level 3: there was actual harm to the resident as they sustained a major injury on February 17, 2019

Compliance History - Level 4: on-going non compliance with a CO or VPC to the same section (LTCHA 2007, s. 6(7) was issued as a VPC under inspection 2017_505103_0049 on March 9, 2017 and under inspection 2017_505103_0049 on November 7, 2017) (197)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** May 21, 2019

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 30th day of April, 2019**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Jessica Pattison

**Service Area Office /**
**Bureau régional de services :** Ottawa Service Area Office