

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

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

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

**Division des opérations relatives aux
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

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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
May 14, 2021	2021_717622_0010	003901-21, 004692-21	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

HEATH HEFFERNAN (622)

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): April 27, 28, May 3, 4, 5, 6, 7, 10, 11, 2021

The following intake was completed during this complaint inspection:

Log #004692-21, related to Accommodation Services: Maintenance - cold air temperatures.

Log #003901-21, related to resident care and services.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Maintenance Manager, Director of Programs, Registered Nurses (RNs), Personal Support Workers (PSWs), maintenance and programming staff and the residents.

Also during the course of the inspection, the inspector reviewed the licensee's investigation and complaint documents, resident health records, staff schedules, licensee policies specific to: Complaints Management – Policy # XXIII-E-10.00 - revised June 2019 and Systems Temperature Control – Policy #V-C-10.40 – revised January 2015 and made observations of resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Safe and Secure Home

Snack Observation

During the course of this inspection, Non-Compliances were issued.

3 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that two written complaints concerning the care of residents were immediately forwarded it to the Director.

On a date in January 2021, the licensee received a written complaint related to resident care.

The Written or Verbal Complaints document, which was supplied by the long-term care home, stated that the written complaint received on a date in January 2021 was not forwarded to the Ministry of Long-Term care. [s. 22. (1)]

2. On a date in March 2021, a written complaint was received by the licensee related to a resident's care. The complaint record stated the complaint was reported to the Ministry of Long-Term Care, one day late.

An email from the Executive Director to the Ministry of Long-Term Care, indicated that the written complaint related to the resident's care was not forwarded until one day later.

Sources: review of the Ministry of Long-Term Care - Info-Line, Complaint and Concern documents, interview of the Executive Director and other staff. [s. 22. (1)]

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 every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Residents' Council advised the licensee of concerns related to air temperatures, they responded in writing within ten days of receiving the concern.

The Resident Council Concern and Recommendation form, which was documented for the March 5, 2021 meeting, indicated that there was a concern related to air temperature. The licensee responded to the resident council 26 days later, when the form was signed by the resident council president on April 1, 2021.

Sources: review of the Resident Council Concern and Recommendation Forms and interview of the Executive Director (ED) and other staff. [s. 57. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,

(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).

(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).

(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).

(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).

(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept of a verbal complaint related to the operation of the home.

A resident stated that on a date in March 2021, they reported a complaint to the Director of Programming related to the operation of the home.

There were no progress notes or complaint forms documented for the complaint which was reported to the Director of Programming on the date in March 2021.

The Director of Programs stated that they had not kept a documented record of the complaint.

Sources: review of complaint documents, progress notes and interview of resident, the Director of Programming and other staff. [s. 101. (2)]

Issued on this 19th day of May, 2021

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

Original report signed by the inspector.