Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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
Nov 4, 2021	2021_902622_0006	011341-21, 014378-21, 015175-21	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): October 18, 19, 20, 21, 22, 25, 26, 27, 2021

The following inspections were completed:

Log # 014378-21/ CIS # 2790-000017-21- regarding a fall with injury and transfer to hospital.
Log # 011341-21/ CIS # 2790-000013-21- regarding an alleged incident of staff to resident physical abuse.
Log # 015175-21/ CIS # 2790-000021-21- regarding an alleged incident of resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Associate Director of Care (ADOC) Maintenance Manager, Nurse Practitioner (NP), Infection Control Lead, Behavioural Support Ontario (BSO), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered practical Nurse (RPNs), Personal Support Workers (PSWs), and the residents.

Also during the course of the inspection, the inspector reviewed Critical Incident System reports (CIS), the licensee's investigation documentation, resident health records, the licensee's policy and procedures specific to: Falls Prevention and Management Policy#: VII-G-30.10 revised February 2020, Prevention of Abuse and Neglect of a Resident Policy# VII-G-10.00 revised April 2021, Documentation - Plan of Care Policy# VII-C-10.90 revised April 2019, Medication Reconciliation Policy# VIII-E-10.30 revised May 2019, Return from Hospital Policy# VIII-B-10.70 revised May 2019, made observations of staff to resident, resident to resident interactions and resident care and services.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **4 WN(s)**
- **3 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. (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).

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 care set out in the falls prevention plan of care was provided to a resident as specified in the plan.

The resident's current plan of care stated that the resident was to have specific falls prevention equipment in place, on each side of the bed.

On October 20, 2021, inspector observed the resident lying in bed, the care planned specific fall prevention equipment was noted to be on one side of the bed only.

Failing to follow the falls prevention plan of care may result in risk of harm to the resident.

Sources: the plan of care, observation of resident care and services, interview of the RPN and other staff. [s. 6. (7)]

2. The licensee has failed to ensure that a resident's plan of care was revised when the care set out in the falls prevention plan was not effective.

The resident was assessed as a risk for falls and used a specific device as an intervention to prevent falls. The resident fell three times in a two-month period. During a fall in September 2021, the resident sustained substantial injuries with a significant change in their condition and was transferred to the hospital for assessment.

The post fall assessments completed for all three falls stated that the specific falls prevention device failed to function, two of which the resident removed the specific falls prevention device prior to the falls.

Review of the progress notes indicated that four days prior to the fall in September 2021, the resident kept removing the specific falls prevention device while in bed.

The plan of care, that was updated after the resident fell in September 2021, stated that the resident continued to use the specific falls prevention device for falls prevention, but they were able to remove it and required monitoring.

On October 21, 2021, the Registered Practical Nurse (RPN) said that when the resident fell on the date in September 2021, the resident had removed the specific falls prevention device causing it not to function. This was indicated to be a common behaviour for the resident. The same specific falls prevention device was used and no other type of fall prevention device was trialed for the resident.

On October 22, 2021, the DOC indicated that when a plan of care was not effective, the licensee had a process to ensure the plan was reviewed and updated. In this case the specific falls prevention device's failure to function, was not reviewed and revised.

When an intervention within a plan of care was not effective and has not been reviewed and revised, it places risk of injury on the resident.

Sources: Critical Incident System report (CIS), the resident’s health records including the plan of care, point of care, progress notes, interview of the RPN and other staff. [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 that will ensure that the care set out in the plan of care is provided to the resident as specified in the plan

and

that will 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 care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Resident Falls Policy included in the required Falls Prevention and Management Program was complied with for a resident.

O. Reg. 79/10 s. 48(1) requires the licensee to have a falls prevention and management program developed and implemented within the home to reduce the incidence of falls and the risk of injury and O. Reg. 79/10 s.30(1) requires that this program include relevant policies, procedures and protocols to reduce risk and monitor outcomes.

Specifically, the licensee's Falls Prevention and Management Policy was not complied with.

The Falls Prevention and Management Policy, specified that the initial post fall assessment note must include the VITAL SIGNS – (temperature, pulse, respiration, and blood pressure, (TPR and BP)).

On a date in September 2021, a resident fell and was found on the floor. The resident was noted to have injuries with significant change in their condition and was transferred to the hospital for assessment.

Review of the documentation related to the fall in September 2021, including; the Post Fall Assessment, Risk Management note, progress notes and the Weights and Vital signs tab on Point Click Care, indicated that vital signs including the TPR and BP were not documented as part of the resident's initial assessment after they fell.

On October 21, 2021, the Registered Practical Nurse (RPN) stated, that they had not taken vital signs as part of the resident's initial assessment because they were more concerned with getting the resident transferred to the hospital than taking vital signs.

Failure to follow the licensee's falls prevention and management policy and procedure, may result in risk of harm to the resident.

Sources: Critical Incident System report (CIS), health records (the Post Fall Assessment, the Risk Management note, the progress notes and the Weights and Vital signs tab on Point Click Care), interview of the RPN and other staff. [s. 8. (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 the fall prevention and management policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an allegation of staff to resident physical abuse that resulted in a risk of harm to the resident, was immediately reported to the Director.

According to O. Reg. 79/10, s. 2 (1)., the definition of "physical abuse" means,

(a) the use of physical force by anyone other than a resident that causes physical injury or pain,

(b) administering or withholding a drug for an inappropriate purpose, or

(c) the use of physical force by a resident that causes physical injury to another resident.

On a date in July 2021, a Personal Support Worker (PSW) reported to a Registered Practical Nurse (RPN), an allegation of PSW to resident physical abuse which they witnessed one day earlier.

On a date in July 2021, the Ministry of Long-Term Care after hours infoline was notified of the allegation of staff to resident physical abuse, one day after the incident occurred.

Sources: Ministry of Long-Term Care after hours Infoline, Critical Incident System report (CIS), licensee investigation documents, the Executive Director, and other staff. [s. 24. (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 that will ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's responses to interventions related to their responsive behaviours were documented on the Dementia Observational System (DOS) and the every 15 minute monitoring documents.

On a date in September 2021, staff reported an incident of resident to resident abuse between two residents. Following the incident, as part of the resident's responsive behaviour plan of care, staff were to complete Dementia Observational System (DOS) Data Collection Sheets and the every 15 minute monitoring documents.

Review of the DOS Data Collection Sheets for a resident during a 15 day period indicated omissions in documentation on seven of the dates.

Review of the every 15 minute monitoring documents for the same resident during a ten day period indicated omissions in documentation on nine of the dates.

Sources: Progress notes, DOS Data Collection Sheets, the every 15 minute monitoring documents and interview with the DOC and other staff. [s. 53. (4) (c)]

Issued on this 19th day of November, 2021

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

Original report signed by the inspector.