Ontario

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

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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559
ottawadistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 24, 2023

Inspection Number: 2022-1281-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP

Long Term Care Home and City: Trillium Retirement and Care Community, Kingston

Lead Inspector	**Inspector Digital Signature**
Heath Heffernan (622)	Heath Heffernan Digitally signed by Heath Heffernan Date: 2023.01.24 11:28:40 -05'00'

Additional Inspector(s)
Erica McFadyen (740804)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 27, 28, 31, 2022 and November 2 - 4, 10 and 14 - 18, 2022.

The following intake(s) were inspected:

- Complaint Intake: #00001270- related to resident care, services and infection prevention and control.
- Complaint Intakes: #00001666, #00007115 related to resident care, services, and sufficient staffing.
- Critical Incident Intakes: #00001777/CI: 2790-000024-22, #00002849/CI: 2790-000023-22, and #00006538/CI: 2790-000028-22 related to related to a fall of a resident with injury, for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition.
- Critical Incident Intake: #00002388/CI: 2790-000022-22 related to alleged staff to resident abuse.

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

Falls Prevention and Management
Prevention of Abuse and Neglect
Infection Prevention and Control
Resident Care and Support Services
Food, Nutrition and Hydration
Safe and Secure Home
Medication Management
Staffing, Training and Care Standards

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 12 (1) 3.

On October 27, 2022, inspector #622 observed the laundry chute room door on Orchard Resident Home Area (RHA) was able to be opened without entering the code for the electronic locking system. No staff were in the area monitoring the door which was in a resident hallway. Inspector #622 observed that the laundry chute inside the room had a door covering it and this door was locked. Inspector #622 informed the Associate Director of Care (ADOC) #107 that the laundry chute room door on Orchard RHA was not locking. ADOC #107 assessed the door and noted that the electronic lock was not functioning every time. ADOC #107 stated that they would have maintenance look at it.

On November 2, 2022, inspector #622 observed that the electronic lock on the Orchard RHA laundry chute room door was not functioning at all times. Inspector #622 informed ADOC #106 who stated that they would have maintenance look at the door immediately.

Inspector #622 made multiple observations of the laundry chute room door on Orchard House RHA between November 3 and 10, 2022, and the electronic locking system functioned correctly each time.

Remedy Implemented: November 3, 2022.
[622]

WRITTEN NOTIFICATION: Binding on licensees

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The Licensee has failed to ensure that where the Act required the Licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, that the Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes and the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, the Licensee was required to ensure that Infection Prevention and Control (IPAC) audits were completed at least weekly when the home is in outbreak and at least every other week when the home is not in outbreak.

Rationale and Summary:
Record review of the licensee's IPAC self-audits showed that audits were not completed as required by the Minister's Directive. During an interview with the IPAC Lead and the Director of Care (DOC) it was confirmed that no weekly self-assessments were completed while the home was in outbreak during the weeks of September 4th, September 11th, October 2nd or October 23rd.

During an interview with the IPAC Lead it was confirmed that no self-assessments were done while the home was not in outbreak, during the weeks of September 18th and September 25th.

The impact of not completing IPAC Self Assessments is that areas for improvement of the IPAC program may not be promptly identified.

Sources: Interviews with the DOC and the IPAC Lead, review of the IPAC Self Assessments.
[740804]

WRITTEN NOTIFICATION: Reports of Investigation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 27 (2)

The licensee has failed to ensure that the results of the investigation of an alleged incident of staff to resident neglect was reported to the Director.

Rationale and Summary
Review of the Critical Incident System report (CIS) submitted on a date in May 2022, for allegations of neglect to a resident indicated that the report was not amended to include the results of the investigation.

During an interview the Executive Director (ED) indicated that the CIS report had not been amended to include the results of the investigation.

Sources: Review of the CIS report and interview of the ED.
[622]

WRITTEN NOTIFICATION: Plan of Care - Clear direction

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions for a treatment application.

Rationale and Summary
Interview with multiple personal support workers and registered staff indicated that the resident was to have a treatment applied to a specific area of the body. Staff stated that direction for the treatment would be found on the care plan, kardex and the treatment administration record (TAR).

A review of the plan of care which included the care plan, kardex and TAR indicated that there was no direction for the application of the treatment to the resident's specified area of the body.

During separate interviews, a Registered Practical Nurse (RPN) and a Registered Nurse (RN) stated that there was no clear direction for the application of the treatment to the resident's specified area of the body on the plan of care.

Failure to have clear directions for treatment on the plan of care places the resident at risk for not being provided the care required.

Sources: Review of the resident's plan of care, interview of an RPN and other staff.
[622]

WRITTEN NOTIFICATION: Reassessment, revision of plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)

The licensee has failed to ensure that when a resident's falls plan of care was not effective, different approaches were considered in the revision of the plan of care.

Rationale and Summary
On a date in July 2022, a resident fell and sustained an injury with significant change in health status.

Review of the post fall assessments indicated that the resident was assessed at risk for falls and had fallen multiple times prior to the fall in July 2022.

There was no documentation to support that the plan of care had been updated with new approaches following the resident's falls prior to their fall in July 2022.

During an interview, the Executive Director (ED) reviewed the resident's health records and stated that they had not identified any additional approaches implemented to prevent the resident from falling following the resident's falls prior to July 2022.

Failure to update the resident's falls prevention plan of care with new approaches after they fell multiple times, put the resident at risk to have additional falls.

Sources: Review of the resident's health records and interview of the Executive Director and other staff.
[622]

WRITTEN NOTIFICATION: Duty of Licensee to comply with the plan

NC #006 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 the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
A review of the Treatment Administration Record (TAR) indicated that registered staff were signing for the application of a treatment to a specified area of a resident's body twice daily.

During separate interviews with multiple Personal Support Workers (PSWs), a Registered Practical Nurse (RPN) and a Registered Nurse (RN), they stated that they had been applying and signing for the treatment to an area of the resident's body other than specified on the TAR.

Therefore, application of the treatment to the resident's specified area of the body was not always being applied as set out in the plan.

Failure to follow the resident's plan of care placed the resident at risk for not being provided the care required.

Sources: Review of the TAR and interview with a PSW and other staff.
[622]

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

Rationale and Summary
A review of the Team Member Accident/Incident Report for two Personal Support Workers indicated that an incident occurred while transferring a resident using an assistive device.

A review of the plan of care stated that the resident required the use of a different assistive device for transfers than had been used at the time of the incident.

During an interview, the Executive Director (ED) indicated that the resident required the use of a specific assistive device for transfers.

Failure to follow the resident's transfer plan of care placed the resident at risk for injuries.

Sources: Review of progress notes, care plan, Team Member Accident/Incident Report, and interview with the ED and other staff.
[622]

WRITTEN NOTIFICATION: Compliance with Manufacturer's instructions

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 26

The licensee has failed to ensure that Personal Support Workers (PSWs) used an assistive device in accordance with manufacturers' instructions.

Rationale and Summary
On a date in August 2022, an incident occurred while using an assistive device to transfer a resident to their chair.

A review of the assistive device operating manual indicated that the base should be opened as much as possible for optimum safety.

During an interview, a PSW stated that when the incident occurred on the date in August 2022, they had not opened the base on the assistive device during the transfer with the resident.

Failure to follow the manufacturer's instructions for the assistive device placed the resident and staff at risk for injury.

Sources: Review of the Team Member Accident/Incident Report, the assistive device Operating Manual and interview of the PSW and other staff.
[622]

WRITTEN NOTIFICATION: Report re: critical incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that an incident that caused an injury to a resident, for which the

resident was taken to the hospital and that resulted in a significant change in the resident's health condition, was reported to the Director no later than one business day after the occurrence of the incident.

Rationale and Summary
Review of the progress notes indicated that a resident fell on a date in July 2022. The resident was transferred to the hospital for assessment the following day. A Registered Practical Nurse (RPN) received confirmation that date from the hospital that the resident had suffered injury because of the fall and was admitted for surgery.

Review of the Critical Incident System report (CIS) indicated that the date of submission was four days after the resident was admitted to the hospital.

During an interview, the Executive Director (ED) indicated that they should have reported the incident to the Director no later than one day after the RPN received confirmation of the resident's change in health status from the hospital.

Sources: Review of the Critical Incident System report, progress notes, and interview with the Executive Director.
[622]

WRITTEN NOTIFICATION: Infection and Prevention Control Program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with the Routine and Additional Precautions section 9.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022), the Licensee shall ensure that hand hygiene is conducted after body fluid exposure risk.

Rationale and Summary:
On a date in October 2022, the screener was observed to complete a rapid test and to not perform hand hygiene following the procedure. During an interview with the screener, they stated that they did not perform hand hygiene after completing the rapid test. During interviews with the IPAC Lead and the Director of Care (DOC), it was confirmed that staff should perform hand hygiene after completing rapid

tests.

During a dining room observation, a Personal Support Worker (PSW) and a PSW student were sitting at different tables and were observed to be assisting multiple residents with feeding. While moving between feeding different residents neither the PSW nor the PSW student performed hand hygiene. During an interview with the PSW and the PSW student it was confirmed that hand hygiene was not performed between feeding residents. During an interview the DOC stated that staff should perform hand hygiene between feeding residents in the dining room.

Hand Hygiene Policy IX-G-10.10 states that team members should wash their hands after body fluid exposure risk.

The risk of not performing hand hygiene as required under the Additional Requirements in the IPAC Standard for Long Term Care Homes April 2022 is that infectious organisms may be spread between residents, which can impact the health of residents.

Sources: Interviews with DOC, IPAC Lead, PSW, PSW student and the screener, observations, Hand Hygiene Policy IX-G-10.10, The IPAC Standard for Long Term Cares Homes April 2022.
[740804]

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with the Routine and Additional Precautions section 9.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the Licensee shall ensure that point-of-care signage is in place to indicate when enhanced IPAC control measures are required.

Rationale and Summary
On a date in November 2022, it was observed that there was no signage present outside the room of a resident who was COVID-19 positive to indicate that precautions were necessary in order to enter. The identified room was on a resident home area experiencing an outbreak of COVID-19.

A Registered Nurse (RN) and the IPAC Lead confirmed that there was no signage present on the door of the room of the COVID-19 positive resident. The IPAC Lead stated that there should be signage outside the doorway of the COVID-19 positive resident providing point-of-care information indicating enhanced point-of-care IPAC measures.

The risk of not ensuring accurate point-of-care signage on the room of a resident with a COVID-19 infection is that it increases the risk of spread of microorganisms throughout the unit or home.

Sources: Interviews with the RN, the IPAC Lead, and observations.
[740804]

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with the Hand Hygiene program section 10.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the Licensee shall ensure that the hand hygiene program includes access to hand hygiene agents.

Rationale and Summary
On October 31st, 2022, it was observed that the tabletop pump hand sanitizer outside of a specified unit, which was in COVID-19 outbreak, had expired in April 2022. On November 2nd, 2022, it was observed that there was a tabletop hand sanitizer pump on a resident supply cart in the hallway of the Ridge building that had expired in April 2022. On November 2nd, 2022, it was observed that hand hygiene for residents eating on a specified unit was provided using hand sanitizer wipes that expired in March 2022.

During an interview the IPAC Lead stated that they had been aware of the expired hand sanitizer following an email sent by the Sienna Living Procurement Team on August 8th, 2022. The IPAC Lead stated that action was not taken on removing and replacing stock until the expired hand sanitizer was observed by the inspector on October 31st, 2022.

Record review of the email sent to the home by the Procurement Team showed that the Procurement Team had identified that hand sanitizer purchased at the beginning of the pandemic was expiring. This email was sent to the Executive Director of the home and forwarded to the IPAC Lead on August 8th, 2022.

During an interview the IPAC Lead stated that the local public health unit was contacted on November 7th, 2022, and that the direction received from public health was to replace the expired hand sanitizer as quickly as possible.

Record review of the homes IPAC Self Assessments completed November 4th and 7th, 2022, both noted that there was expired hand sanitizer identified and that corrections had been made to remove and

replace the expired hand sanitizer.

On a date in November 2022, on a specified unit, which was in COVID-19 outbreak, it was observed that the hand sanitizer pump on the medication cart had expired July 2022, and that the tabletop hand sanitizer pump outside of the room of a COVID-19 positive resident had expired in April 2022. During interviews with the IPAC Lead and a Registered Nurse (RN), it was confirmed that expired hand sanitizer was present outside of the room of a resident with COVID-19 on an outbreak unit.

The risk of using expired hand sanitizer is that microorganisms may not be effectively removed from the hands during hand hygiene, which can contribute to the spread of infectious disease between residents and the spread of outbreaks within the home.

Sources: Interviews with the IPAC Lead and a RN, document review of email sent by the Sienna Living Procurement Team, document review of IPAC Self Assessments.
[740804]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (15) 2.

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Lead designated under this section works regularly in that position on site in a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

Rationale and Summary
The schedule for the IPAC Lead indicated that they were reassigned from their IPAC duties on six occasions during the weeks of October 16th and October 23rd. As a result, the IPAC Lead did not meet the legislative requirement of hours per week dedicated to IPAC.

During interviews the Executive Director and the Director of Care (DOC) stated that the IPAC Lead did not fulfil the required 26.25 hours of IPAC duties during the weeks of October 16th and October 23rd.

During an interview, the IPAC Lead stated that the home was in a COVID-19 outbreak during the time that they were reassigned from their IPAC duties.

The impact of this non-compliance was that the IPAC Lead was not conducting their IPAC duties while the home was experiencing a COVID-19 outbreak, which does not allow the IPAC lead to carry out their IPAC responsibilities.

Sources: IPAC Lead schedule, interview with the IPAC lead, interview with the DOC.
[740804]

WRITTEN NOTIFICATION: Reports re: Critical Incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (4) (a)

The licensee has failed to ensure that where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, that they contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition.

Rationale and Summary
On a date in August 2022, a resident sustained a fall for which they were sent to the hospital for assessment.

During an interview the Associate Director of Care (ADOC) stated that the licensee did not contact the hospital for an update on the health condition of the resident until six days later when they received confirmation that the resident had sustained injury and had undergone surgical repair.

The licensee failed to contact the hospital within three calendar days after the occurrence of the injury to determine whether the injury resulted in a significant change in the resident's health condition. The risk of this noncompliance is that the Director was not informed of the resident's change in condition until six calendar days following the incident.

Sources: Clinical record review of the resident, interview with ADOC, Critical Incident System (CIS) Report.
[740804]

WRITTEN NOTIFICATION: Bathing

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 37 (1)

The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Rationale and Summary
On a date in August 2022, two residents were scheduled to receive baths. Interviews with Personal Support Workers (PSWs) confirmed that the residents did not receive their scheduled baths on that date. Point of Care (POC) bathing documentation for the date in August 2022, showed that the PSW staff documented "activity did not occur" for the resident's scheduled baths.

On a date in August 2022, a resident was scheduled to receive a bath. A PSW stated that the resident did not receive their scheduled bath that date. POC bathing documentation for the date in August 2022, showed that the PSW staff documented "activity did not occur" for the resident's scheduled baths.

On three dates in September 2022, a resident was scheduled to receive a shower. POC bathing documentation for the three dates showed that the PSW staff documented "activity did not occur" for the resident's scheduled shower. In an interview the resident stated that they did not receive any scheduled showers during the COVID-19 outbreak, and that their hygiene needs were not always maintained.

During interviews a Registered Practical Nurse (RPN) and the Executive Director (ED) confirmed that baths were not always completed during the COVID-19 outbreak in the specific Building.

The impact of this noncompliance is that residents on a specific unit did not consistently receive their scheduled baths during the COVID-19 outbreak, and that when they did receive a bath it was not in their method of choice. The risk of not receiving baths as scheduled is poor hygiene and skin breakdown.

Sources: Clinical documentation review of the residents, interviews with PSWs, a RPN, the Executive Director, document review of staffing schedules.
[740804]

WRITTEN NOTIFICATION: Documentation

NC #013 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 a resident's falls prevention plan of care has been documented.

Rationale and Summary
Review of a resident's fall prevention plan of care indicated that staff were to perform hourly fall checklists.

Review of the hourly fall checklists for thirteen days, located on the resident's hard copy health records indicated that documentation was incomplete on three dates.

During separate interviews a Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) stated that staff would have completed the hourly fall observations however missed documenting the provision of care on the hourly fall checklist.

Failure to document the care set out in the falls plan of care may increase the resident's risk for future falls.

Sources: Review of the resident's plan of care, hourly fall checklists, interview with the PSW and other staff.
[622]

The licensee has failed to ensure that the provision of the care set out in a resident's falls prevention plan of care has been documented.

Rationale and Summary
Review of a resident's falls prevention plan of care indicated that staff were to perform hourly fall checklists.

Review of the hourly fall checklists for sixteen days, located on the resident's hard copy health records

indicated that documentation was incomplete on three dates and the hourly falls checklist was missing for four days.

During separate interviews two Personal Support Workers (PSWs) and a Registered Practical Nurse (RPN) stated that staff would have completed the hourly fall observations however, documentation had not been completed on three dates and the missing four day hourly fall checklists had been misplaced.

Failure to document the care set out in the falls plan of care may increase the resident's risk for future falls.

Sources: Review of the resident's plan of care, hourly fall checklists and interview with the PSW and other staff.
[622]

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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559
ottawadistrict.mltc@ontario.ca