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

Original Public Report

Report Issue Date: March 30, 2023	
Inspection Number: 2023-1281-0003	
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 Stephanie Fitzgerald (741726)	**Inspector Digital Signature** Stephanie A Fitzgerald Digitally signed by Stephanie A Fitzgerald Date: 2023.04.14 12:20:41 -04'00'
Additional Inspector(s) Wendy Brown (602) Polly Gray-Pattemore (740790)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s), and March 7-10, and 13-16, 2023
The following intake(s) were inspected:

- Intake: #00019686 - Complaint regarding staff member
- Intake: #00013799 and Intake: #00017992 – Complaint regarding resident care, treatment not provided per plan of care.
- Intake: #00021096 - Concerns regarding resident plan of care.
- Intake: #00021058/CIR #2790-000009-23 - Unwitnessed fall with injury.
- Intake: #00014876 – CIR #2790-000045-22 regarding resident care, medication administration.
- Intake: #00020079/CIR #2790-000008-23 - Medication administration, adverse reaction
- Intake: #00015311/CIR #2790-000048-22, Intake: #00015950/CIR #2790-000051-22, Intake: #00015950/CIR #2790-000002-23 – all related to controlled substances missing/unaccounted.
- Intake: #00015357 – Alleged 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.
- Intake: #00015764/CIR #2790-000050-22, Intake: #00016284/CIR #2790-000054-22, Intake: #00016654/CIR #2790-000057-22, Intake #00016965/CIR # 2790-000058-22, Intake: #00017791/CIR #2790-000003-23 – all related to alleged resident-to-resident sexual abuse.
- Intake: #00016064/CIR #2790-000053-22, Intake: #00018368/CIR #2790-000005-23 – alleged resident to resident physical abuse.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policies and Records

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee failed to ensure that their written policies related to medication management were complied with.
In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their written policies related to medication management for resident #010 and #011 was complied with. Specifically, staff did not comply with the Medication Management System policies as follows:

a) Ordering Medications Using Digital Pen Procedure 4-2-2; section 8. Verify successful transmission of orders to pharmacy by checking the digital pen portal.
b) Medication Ordering Policy 4-2-1; Procedure B- Processing Prescriber's Orders; section 8. Leave charts with new orders flagged until Nurse Check #2 is completed when receiving the medication
c) Ordering Medications from Emergency Pharmacy Procedure 4-8.
d) The Medication Pass Policy 3-6; section 7. Check for any special instructions and allergies.

Rationale and Summary
1. On a day in November, 2022, resident #010 was prescribed a medication. The medication was not administered until three days later, causing a delay in treatment.

A review of the Critical Incident System (CIS) report, revealed the physician order had not been received by pharmacy, as the digital pen was not functioning appropriately.

During an interview with a Registered Practical Nurse (RPN), it was confirmed that there is a process to

verify if a medication order had been received by pharmacy, if a digital pen was used, however they could not recall the process. The Director of Care (DOC) confirmed the process was to log into the system and see if it was signed for. The DOC indicated that staff are expected to complete the verification process for each digital order. Staff failed to comply with the Ordering Medications Using Digital Pen Procedure 4-2-2, verify successful transmission of orders to pharmacy by checking the digital pen portal.

2. During a review of resident #010's digital prescriber orders, a Registered Nurse (RN) completed the second check on the prescriber's orders, two days after the medication was ordered. Progress Notes revealed that the emergency pharmacy was contacted three days after the medication was ordered, as the drug had not been received. The CIS report documented that the nurse signed for the medication before it had been received by the home.

During interviews, an RPN and the DOC confirmed the nurse who is completing the second check on prescriber orders, should only sign off as completed, once the medication has arrived at the home, and is in the Medication Administration Record (MAR). Staff failed to comply with Medication Ordering Policy 4-2-1, leave charts with new orders flagged until Nurse Check #2 is completed when receiving the medication

3. Ordering Medications from Emergency Pharmacy – Procedure 4-8 outlined that medication needed on an emergency basis are to be supplied in a timely manner according to prior arrangement with a designated Emergency Pharmacy. Resident #010's progress notes documented that the emergency pharmacy was contacted three days after the initial order was received.

During an interview, the DOC confirmed that this medication is considered an emergency medication, and should be ordered from the Emergency Pharmacy if the contracted pharmacy is unavailable. The DOC indicated that the three-day delay from when the initial order was written, and when the Emergency Pharmacy Order Request was sent, was not in accordance with procedure. Staff failed to comply with Ordering Medications from Emergency Pharmacy Procedure 4-8.

4. A Review of the medication incident form for resident #011 indicated that on a day in February, 2023, an RN received and wrote an order for a medication, without checking for allergies. The resident's profile indicated the resident was allergic to the medication; this medication was subsequently administered to the resident by a second RN, who also did not check for allergies prior to administration. Three hours later, the resident experienced adverse symptoms. A physician and the DOC were contacted, and new medication orders were provided. Staff failed to comply with The Medication Pass Policy 3-6; section 7, Check for any special instructions and allergies.

Failure to ensure the policies within the medication management system are complied with, can result in a delay in and/or inappropriate medical treatment of residents. This places residents at risk of

infection, or adverse health effects.

Sources: Ordering Medications Using Digital Pen Procedure 4-2-2, Ordering Medications Policy 4-2-1, Ordering Medications from Emergency Pharmacy Procedure 4-8, and The Medication Pass Policy 3- Interviews with DOC and other staff, CIS reports, Medication Incident form, resident #010 Digital Prescribers Orders and resident #010 and #011's progress notes. [741726] [602].

WRITTEN NOTIFICATION: Administration of Drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to resident #010 in accordance with the directions for use, specified by the prescriber.

Rationale and Summary
On a day in November, 2022, resident #010 was prescribed an medication. The medication was not administered until three days later, causing a delay in treatment. This was confirmed through a review of the CIS report, as well as resident #010's progress notes, which indicated the medication did not arrive to the home until three days after it was ordered.

During an interview with an RPN, it was confirmed that the medication ordered, was considered an emergency medication, and is kept in the Emergency Starter Box (ESB). In a later interview with the DOC, it was confirmed that the initial prescribers order was written on a day in November, yet the medication was not received or administered until three days later. The DOC confirmed that that it was the expectation that an Emergency Pharmacy Order Request should have been completed on the same day, in which the medication was ordered.

Contravention of administering medication in accordance with the directions for use as specified by the provider, could cause a delay in treatment. This places the resident at risk for infection, or other adverse effects.

Sources: CIS report, resident #010 progress notes and interviews with staff and DOC [741726]

WRITTEN NOTIFICATION: Plan of Care

NC #003 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 resident #004 had a written plan of care that set out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
On a day in February, 2023, resident #004 sustained an unwitnessed fall within their room. The resident was transferred to hospital the following day.

A review of the care plan in place at the time of inspection documented that resident #004 was to be transferred with the assistance of two staff, and a mobility aid; the kardex indicated resident #004 was able to independently transfer and ambulate with a mobility aid.

During an interview, an RPN stated that resident #004's transfer status was a one person assist and pivot, with mobility. The RPN also indicated that staff are expected to refer to the printed kardex for care direction. In a subsequent interview, the DOC reviewed the interventions on resident #004's printed Kardex and confirmed the direction was not current, and unclear.

By not ensuring the written plan of care sets out clear directions to staff and others who provide direct care to resident #004 could place the comfort and safety of the resident at risk.

Sources: Resident #004's care plan, kardex, and progress notes; interviews with DOC and other staff. [741726]

WRITTEN NOTIFICATION: Plan of Care - Duty to Comply

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care for resident #004 and #005 was provided as specified in the plan.

Rationale and Summary
1. On a day in February, 2023, resident #004 sustained an unwitnessed fall within their room. The following day, the resident was transferred to hospital.

A review of resident #004's care plan and kardex, at the time of the incident, indicated that a falls prevention intervention, was to be used while the resident was in bed. Observations on March 08, and March 09, 2023, found resident #004 sleeping in bed, without the use of the falls prevention intervention. Interviews with staff confirmed that this resident did not have a the falls prevention intervention in place, as outlined in the plan of care.

2. A review of resident #005's plan of care indicated frequency for care, regarding a required intervention. Complaints regarding care, were made to registered staff, Assistant Director of Care (ADOC) and DOC in November, 2022. A subsequent review of the complaint concerns by DOC, found that the care was not provided as per the plan of care, as evidence by a review of the resident #005's eMARs and progress notes.

Failure to follow a resident's plan of care places a resident at risk for not being provided the care they require.

Sources: Review of resident #004 and #005's care plan, kardex, and progress notes, resident #005's eMARs, resident #005's complaint investigation file; observations of resident #004; interviews with staff, DOC, complainant, ADOC, Administrator, and email documentation. [602] [741726]

WRITTEN NOTIFICATION: Plan of Care - Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee failed to ensure that the care set out in resident #004's falls prevention plan of care was documented.

Rationale and Summary
Review of resident #004's fall prevention plan of care indicated that staff were to perform hourly fall checklists.

A review of the hourly documentation in Point of Care (POC) revealed five documentation entries for a day in February, 2023, and six documentation entries for the following day. In an interview with staff, it was stated that hourly documentation is documented every shift, at the end of the shift. In a subsequent interview, the DOC confirmed the expectation of staff is that hourly documentation is completed hourly.

Failure to document the care set out in the falls plan of care may increase the resident# 008's risk for future falls.

Sources: Resident #004 care plan, kardex, progress notes and POC documentation for hourly checks and interviews with DOC and other staff. [741726]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee failed to ensure that a person who had reasonable grounds to suspect improper or incompetent treatment or care of resident #005 that resulted in harm or risk of harm was reported to the Director.

Rationale and Summary:
A licensee complaint record from November, 2022, indicated multiple concerns had been communicated to direct care staff, ADOC, DOC, and the Administrator regarding resident #005's care needs. Review of the licensee's investigation file, licensee complaint record and resident #006's electronic health record revealed several care concerns, including the frequency it was being provided, the method it was being completed, staff skill set, and accessibility of products.

A complaint was lodged, via the Ministry of Long-term Care's Action Line; the licensee did not inform the Director of the improper/incompetent care of resident #006.

The risk associated with not immediately informing the Director of improper/incompetent care is that it placed the resident risk for further care issues.

Sources: Interviews with the complainant, DOC, ADOC, Administrator, and resident #005's progress notes, electronic Medication Administration Record (eMAR), the investigation file, licensee complaint record and email documentation.[602]