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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: July 6, 2023	
Inspection Number: 2023-1281-0004	
Inspection Type: 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: 2023.07.19 14:39:47 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 15,16,19-22, 26, 27, 2023

The following intake(s) were inspected:

- Intake: #00084137: CI # 2790-000011-23: Unwitnessed fall resulting in injury.
- Intake: #00084778: CI # 2790-000016-23: Unwitnessed fall of resident resulting in injury.
- Intake: #00086381: CI # 2790-000019-23: Resident missing for three hours or greater.

The following intakes were completed in this inspection:
Intake# 00086418, CI# 2790-000021-23 and Intake# 00086647, CI# 2790-000023-23, both related to falls with injury

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

Safe and Secure Home
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care, Documentation

NC #001 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 #001 and resident #003's falls prevention plan of care was documented.

Rationale and Summary:
1. A review of resident #001's fall prevention plan of care indicated that staff were to perform hourly checks on the resident, for falls.

A review of the documentation in Point of Care (POC) revealed 30 blank documentation entries related to frequent monitoring for falls, for March 2023. In an interview with a PSW, it was stated that hourly documentation is documented every four hours, within POC, under the support action "frequent monitoring for falls". In a subsequent interview, DOC #101 and ADOC #102 confirmed the expectation of staff is that hourly assessments are to be documented every four hours, acknowledging the checks have been completed.

2. A review of resident #003's fall prevention plan of care, and Kardex, indicated that staff were to perform frequent checks on the resident, for falls.

A review of the documentation in Point of Care (POC), revealed 16 blank documentation entries related to frequent monitoring of falls, for March 2023. In an interview with a PSW, it was stated that hourly documentation is documented every four hours, within POC, under the support action "frequent monitoring for falls". In a subsequent interview, DOC #101 confirmed the expectation of staff is that hourly assessments are to be documented every four hours, acknowledging the checks have been completed. DOC #101 confirmed the documentation was not completed, as set out in resident #003's plan of care.

Failure to document the care set out in the falls plan of care may increase the resident# 001 and resident #003's risk for future falls.

Sources: Resident # 001 and 003's electronic plan of care and progress notes from PCC, resident #003's Kardex, Documentation Survey Report for resident #001 and #003 from March 2023; interview with Staff, ADOC #102 and DOC #101. [741726]

WRITTEN NOTIFICATION: Directives by Minister

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 (LTCH) to carry out every operational directive was complied with. The licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when they did not complete IPAC audits every two weeks.

In accordance with section 1.1 of the Minister's Directive: COVID-19 response measures for long-term care homes, the licensee was required to ensure that the LTCH was conducting regular Infection prevention and Control (IPAC) audits in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended.

Rationale and Summary
During a review of the LTCH's IPAC Audits, located in an electronic folder on SharePoint, there was noted to be completed self-audits for June 3, and June 19, 2023. There was no evidence of other IPAC Audits being completed prior to June 3, 2023.

On June 19th, 2023, interview with ADOC #103/IPAC Lead confirmed there was no evidence of IPAC audits being completed prior to June 3, 2023, specifically in the month of May 2023, and they were unsure if they were being completed. On June 21, 2023, interviews with ADOC #102 and DOC #101, confirmed that IPAC self-audits for the LTCH were not being completed every two weeks.

By not ensuring measures are taken to prepare for and respond to a COVID-19 outbreak, there was a risk of illness to the residents.

Sources: Record Review of IPAC Self-Audits, Interviews with ADOC/IPAC Lead #103, ADOC #102, and DOC #101. [741726]

WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that their written policy related to falls prevention and management was complied with, for resident #001.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their written policy related to falls prevention and management for resident #001 is complied with. Specifically, staff did not comply with the licensee's Head Injury Routine (HIR) Policy, VII-G-30.20; The HIR will be implemented to initiate a thorough assessment, monitoring, and early detection of complications following a head injury or a possible head injury, ensuring documentation reflects time specific and accurate documentation of head injuries.

Rationale and Summary
On a day in March 2023, a resident had an unwitnessed fall, sustaining injury. The resident was transferred to hospital, where they were later discharged.

A review of the resident's progress notes in Point Click Care (PCC), documented the resident returning from the hospital the following day, however, was later transferred back to the hospital approximately eight hours later, due to symptoms. The resident was transferred back to the home a second time later that evening. A review of the HIR form, shows the first HIR assessment was completed the day following the fall, after the second hospital visit.

Interviews with an RPN and Associate Director of Nursing (ADOC) #102, confirmed the process in place is for a HIR assessment to be completed with any unwitnessed fall, or fall with obvious head injury. It was also confirmed that this process should have been initiated upon the first return from hospital and was not completed.

Sources: Resident's electronic health record, Progress Notes, and assessment history; HIR Form, Head Injury Routine (HIR) Policy, VII-G-30.20; Interviews with RPN and ADOC #102. [741726]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 3.

The licensee has failed to ensure that the Director was informed of a resident who was missing for three

hours or more immediately after the occurrence of the incident.

Rationale and Summary:
On a day in April, a resident appeared at their spouse's primary residence in the evening, with their last time being seen in the home, approximately three hours prior. The home was notified by family approximately one hour after the resident was located.

A review of the resident's progress notes indicated that on a day in April, the resident was last seen by staff attending meal service. Four hours later, staff were notified by family that resident had been located outside of the home. The progress notes identified a critical incident was completed by ADOC#102 the following day.

During an Interview with ADOC #102, it was confirmed the resident was noted to be missing for greater than three hours, and there was a delay from when the incident occurred to when the Critical Incident Report was submitted to the Director on the following day.

Failure to immediately report incidents that may affect the provision of care or the safety, security or well-being of one or more residents, puts the residents at risk of additional harm.

Sources: CI # 2790-000019-23, Resident's progress notes on PCC, Interviews with ADOC #102. [741726]

COMPLIANCE ORDER CO #001 24-hour admission care plan

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 27 (9) (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:

1. Provide training to all registered staff, with a focus on the following: How to review and revise a residents' 24-hour admission plan of care when the resident's care needs change, and
2. Develop and implement a written process to ensure communication between registered staff and direct care staff occurs, when review and revisions are made to a residents 24-hour admission plan of care.

3. Develop and implement a written process to audit each new admission's 24-hour admission plan of care; to ensure the plan of care was reviewed and revised when a resident's care needs changes, and communication between registered staff and direct care staff has occurred.

4. A written record must be kept of everything required under step (1), (2) and (3) of this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order, including dates, topics reviewed, name of instructor, and completed audit tool(s).

Grounds
The licensee has failed to ensure that a resident was reassessed, and the care plan was reviewed and revised when their care needs changed.

Rationale & Summary
On a day in April, a resident was admitted to Long Term Care (LTC). Three days later, the resident eloped the home, and was discovered by family three hours later. The home was notified by family approximately 4 hours after the resident's elopement.

A review of the resident's progress notes, documented several concerns regarding risk of elopement during the initial days following admission. Documentation also showed suggestions to relocate resident to the secured unit.

During a review of the Behavioural Assessment provided by the Southeast Local Health Integration Network (LHIN), prior to admission, it was noted that the resident had a history of elopement.

A review of the resident's 24-hour admission care plan showed there was no evidence of interventions in place in relation to elopement or wandering.

Interviews with registered staff, and ADOC #103 confirmed resident had multiple documented concerns with exit seeking, a near miss, and an elopement prior to the incident. Interviews also confirmed there were no interventions put in place to prevent elopement, despite the known risk.

By not ensuring the resident's care plan was reviewed and revised, when their care needs changed, elopement occurred, which placed the resident at risk of injury

Sources: Review of resident's PCC Progress Notes, Plan Of Care, Pre-admission Behavioural assessment, Interviews with registered staff, and ADOC #102. [741726]

This order must be complied with by

September 20, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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