Ontario

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

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

Ottawa District
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Original Public Report

Report Issue Date: November 06, 2023	
Inspection Number: 2023-1281-0005	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP	
Long Term Care Home and City: Trillium Community & Retirement Living, Kingston	
Lead Inspector Stephanie Fitzgerald (741726)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 12, 16-20, 2023

The following intake(s) were inspected:

- Intake: #00091790 - Follow-up inspection #: 1 - O. Reg. 246/22 - s. 27 (9) (a), in relation to 24-hour admission care plans being reassessed, and revised when a resident's care needs
- Intake: #00094423 - CIR #2790-000036-23 Written complaint to home relating to alleged resident to resident sexual abuse.
- Intake: #00096200 - Complainant with concerns related to alleged resident to resident sexual abuse.
- Intake: #00097837 - AH/2790-000044-23 Witnessed fall with injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1281-0004 related to O. Reg. 246/22, s. 27 (9) (a) inspected by Stephanie Fitzgerald (741726)

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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 a resident's falls prevention plan of care was documented.

Rationale and Summary:
A review of a resident's fall prevention plan of care indicated that the resident was to be checked frequently for falls

A review of the documentation survey report in Point of Care (POC) revealed 20 blank documentation entries related to frequent monitoring for falls, for September 2023.

In an interview with Associate Director of Care (ADOC) #106 and Director of Care (DOC) #101, it was stated that the expectation of staff for high-risk residents, is to add frequent falls checks to the plan of care and document in Point of Care (POC) once every shift that it has been completed. ADOC #106 and DOC #101 confirmed documentation of care for the resident was not completed, as set out in plan of care.

Failure to document the care set out in the falls prevention plan of care, may increase the residents risk for future falls.

Sources: Resident's electronic plan of care Documentation Survey Report for September 2023; interview with ADOC #106 and DOC #101. [741726]

WRITTEN NOTIFICATION: Complaints procedure — license

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that a written complaint concerning the care of a resident was immediately forwarded it to the Director.

Rationale and Summary
On a specified date in August, 2023, the licensee received a written complaint, alleging resident to resident sexual abuse and injury.

A review of the Critical Incident Report (CIR), shows a complaint was received by the licensee on a specific day in August, 2023. The date and time the first written report was submitted to the director, occurred five business days after the incident.

During an interview with Associate Director of Nursing (ADOC) #106, it was confirmed that the complaint was received on a specific date in August, 2023, and was not reported in writing to the Director until five days later. ADOC #106 confirmed the complaint was not immediately forwarded to the Director.

Failure to immediately report a written complaint concerning the care of a resident to the director, can lead to a delay in response and actions taken.

Sources: CI #2790-000036-23, Interview with ADOC #106. [741726]