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

Original Public Report	
Report Issue Date: May 15, 2024	
Inspection Number: 2024-1281-0002	
Inspection Type: Critical Incident	
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): April 15, 16, 17, 2024

The following intake(s) were inspected:

- Intake: #00105291 - CIS #2790-000053-23; Intake: #00107628 - CIS#2790-000004-24; Intake: #00107798 - CIS #2790-000005-24 - Disease outbreaks declared.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that they have implemented any standard or protocol issued by the Director with respect to infection prevention and control. Specifically the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022, 9.1 indicates at a minimum, additional precautions shall include point-of-care signage indicating that enhanced IPAC control measures are in place and additional Personal Protective Equipment (PPE) requirements including appropriate selection application, removal and disposal.

Rationale and Summary:
During an observation of the Harbour House Resident Home Area (RHA) on April 15, 2024, there was signage on the entry doors to the unit which read “COVID-19 Outbreak, staff and visitors are required to wear an N95”.

A review of the Line Listing for the current outbreak showed a specific number of residents requiring isolation. Inspector observed that there was no point-of-care

signage indicating that enhanced IPAC control measures were in place, and additional PPE requirements at entry to any of the identified resident rooms; however, there was a cart outside of their rooms containing PPE such as gowns, gloves, and face shields.

During separate interviews with multiple Personal Support Workers (PSWs), it was confirmed that there was no point-of-care signage for additional PPE precautions posted for any residents requiring additional precautions. Staff interviewed advised the current process was to place the signage inside of the isolation carts outside of the room, rather than displayed at point-of-care.

During an interview with the IPAC Lead, it was stated that the expectation is for staff to place signage at the entry of the residents room when additional precautions is required, and to notify the IPAC Lead. It was confirmed that there was no point-of-care signage posted within the RHA.

By not ensuring that an additional precaution sign indicating required precautions posted at entry to rooms, the residents were at increased risk of infection.

Sources: Observation of Harbour House RHA on April 15th, 2024, Review of Line Listing for COVID-19 Outbreak April 2024, Interviews with PSW #106, PSW #107, RPN #105, and IPAC Lead #104 [741726]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is

immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of a an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary
On December 29, 2023, a CIS (Critical Incident System) Report was submitted to the Director in relation to a disease outbreak which was declared on December 28, 2023.

On January 26, 2024, a CIS report was submitted to the Director in relation to a disease outbreak which was declared on January 23, 2024.

On January 29, 2024, a CIS report was submitted to the Director in relation to a disease outbreak which was declared on January 28, 2024.

During an Interview with IPAC Lead #104, it was confirmed the the disease outbreaks were not immediately reported on the date they were declared by the local Public Health Unit.

The risk associated with not immediately informing the Director of disease outbreaks, is that it could delay appropriate follow-up.

Sources: CIS reports #2790-000053-23, # 2790-000004-24, # 2790-000005-24
Interview with IPAC Lead #104. [741726]