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

Public Report

Report Issue Date: March 21, 2025
Inspection Number: 2025-1281-0002
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 17-20, 2025

The following intake(s) were inspected:

- Intake: #00135206/ CI#2790-000030-24- Norovirus - Outbreak declared December 22, 2024.
- Intake: #00136037/ CI#2790-000001-25- Parainfluenza Virus - Outbreak declared January 2, 2025.
- Intake: #00140128/ CI#2790-000005-25- Influenza A - Outbreak declared February 16, 2025.
- Intake: #00141106/ CI#2790-000006-25 - Group A Streptococcus - Outbreak declared February 27, 2025.
- Intake: #00138849/ CI#2790-000003-25 - alleged improper/incompetent treatment of a resident related to resident rights.

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse/Neglect - Policy to promote zero-tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that their written policy related to promoting zero tolerance of abuse of a resident was complied with.

A review of the licensee's Prevention of Abuse and Neglect policy indicated: All residents have the right to dignity, respect, freedom from neglect and to be protected from abuse. Abuse and neglect are not tolerated in any circumstance. The policy further indicates that all team members with reasonable grounds to suspect abuse has occurred are required to immediately report abuse.

On a specified date a nursing staff physically blocked a resident from ambulating with their walker and then forcefully removed their walker. The nurse subsequently confiscated the walker leaving the resident at risk of falling. The incident resulted in visible bruising to the resident's hands. This incident was witnessed by two Personal

Support Worker staff and was not immediately reported to the Ministry of Long-Term Care and/or the home's Executive Director or designate as outlined in policy.

Sources: Review of the home's Prevention of Abuse and Neglect Policy, a Critical Incident (CI) report, investigation file documentation, and interviews with the Director of Care (DOC).

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to have their lifestyle and choices respected.

The licensee has failed to ensure that a resident's right to lifestyle and choices was respected.

On a specified date, a nursing staff took a residents recent purchase against the residents wishes. The nurse subsequently refused to let the resident go outside, and confiscated their walker despite the resident's repeated requests to have the walker returned.

A letter authored by the Executive Director regarding the confiscation of the resident's property and removal of the walker, indicated the home considered the nurses actions inappropriate, constituted forcible confinement, and was in violation of the resident's rights.

Sources: Review of the home's Prevention of Abuse and Neglect Policy, CI report, in home guidelines, investigation file documentation, and interviews with the DOC.