Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Telephone: 613-569-5602
Facsimile: 613-569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4ième étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of inspection/Genre d'inspection
August 30, 2010-September 2 2010	2010_124_2790_30Aug12000 9 & 2010_143_2790_01Sep13261 8	Critical Incidents-log # O-001194

Licensee/Titulaire
Specialty Care East Inc.
400 Applewood Crescent
Suite110
Vaughan, ON
L4K 0C3
Fax: 905-695-2940

Long-Term Care Home/Foyer de soins de longue durée
Trillium Centre
800 Edgar Street, Kingston, ON
K7M 8S4
Fax: 613-547-3734

Name of Inspector(s)/Nom de l'inspecteur(s)

Lynda Hamilton (#124) & Paul Miller (#143)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an inspection of two Critical Incidents. The first critical incident involved a witnessed abuse of Resident A by Resident B. The second critical incident involved an incident between Resident B and Resident C.

During the course of the inspection, the inspectors spoke with the Medical Advisor, the Administrator, Director of Clinical Services, Associate Director of Care, a Registered Practical Nurse, three Personal Support Workers and Detective Constable with the Kingston City Police.

During the course of the inspection, the inspectors reviewed health records of Residents A, B and C, obtained copies of plans of care and progress notes from the three residents' health care records and reviewed the home's Abuse Policy and other policies and procedures.

The following Inspection Protocols were used during this inspection: Responsive Behaviors Inspection Protocol and Prevention of Abuse and Neglect Inspection Protocol

Findings of Non-Compliance were found during this inspection. The following action was taken:

8 WN
1 VPC
5 CO: CO # 001, 002, 003, 004 and 005.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN # 1: The Licensee has failed to comply with: LTCHA, 2007, S.O.2007 c.8, s.24(1)
A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. 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.

Findings:

1. Abuse of a resident resulting in harm or risk of harm to a resident was not immediately reported to the Director
2. An incident of abuse to Resident A by Resident B occurred at approximately 0715. This incident was witnessed.

3. A Detective Constable of the Kinston City Police force reported to the Inspectors Paul Miller and Lynda Hamilton that the Kingston City Police dispatch received a call from the home at 1124 hours on the day of the incident.
4. The Detective Constable also confirmed that police records indicated that Resident A's substitute decision maker was notified of the incident by the Director of Clinical Services at 1052 hours on the day of the incident.
5. Ministry received a call at approximately 1300 hours from the Director of Clinical Services of the home. A telephone discussion occurred with the Duty Inspector, Lynda Hamilton, advising the Ministry of Health and Long Term Care of the incidents of abuse. At a later date, the Administrator, in her Summary of Events document indicated that the MOH was contacted at "1110 not able to speak with anyone and therefore left a message." The Director of Clinical Services stated that she had reported the incident to the Ministry by voice mail at approximately 1100 hours and described her voice message as "this is the Director of Clinical Services from Trillium and I have a mandatory report to make and would like a Duty Inspector to call me back."

Compliance Order #001 was faxed to the licensee on September 22, 2010.

Inspector ID #:	#124 & #143

WN # 2: The Licensee has failed to comply with O. Reg. 79/10 s. 98
Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Findings:

1. A witnessed incident of abuse of a resident was not immediately reported to the police.
2. At approximately 0715 a witnessed incident of abuse occurred involving Resident A and Resident B.
3. A Detective Constable of the Kingston City Police force reported to Inspector Paul Miller and Lynda Hamilton that the Kingston City Police dispatch received a call from the home at 1124 on the day of the incident.

Compliance Order # 002 was faxed to the licensee on September 22, 2010.

Inspector ID #:	#124 & #143

WN #3: The Licensee has failed to comply with O. Reg. 79/10 s. 97(1)
Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Findings:

1. A witnessed incident of abuse of a resident was not reported to the Substitute Decision Maker immediately upon the licensee becoming aware of the witnessed incident of abuse.
2. At 0715 there was an incident of abuse involving Resident A.
3. Information obtained from the Detective Constable of the Kingston City Police, police records,

indicated that Resident A's substitute decision maker was notified of the incident at 1052 on the day of the incident.

Compliance Order # 003 was faxed to the licensee on September 22, 2010.

Inspector ID #:	#124 & #143

WN # 4: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007 c.8, s.20(1)
Without in any way restricting the generality of the duty provided for in section 19, 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.

Findings:

1. The Long Term Care Home's abuse policies were not implemented and complied with related to immediately notifying police, Ministry of Health and Long Term Care and the resident's substitute decision makers and the Executor of the Estates after the incidents of abuse.
2. Policy VII-G-10.00 Nursing Checklist for Reporting and Investigating Alleged Abuse directed the Charge RN/DOC to provide information to the police.
3. The home's abuse policy stated that immediately upon notification of abuse, assess, provide medical intervention and request a full medical assessment. The incident of abuse occurred at 0715 hours and the medical assessment occurred between 1400-1500 hours on the day of the incident.
4. The home's abuse policy stated to remove the suspected individual from resident access. This did not occur and a second incident occurred at approximately 1000 hours on the same day involving Resident B and Resident C.

Compliance Order # 004 was faxed to the licensee on September 22, 2010.

Inspector ID #:	#124 & #143

WN # 5: The Licensee has failed to comply with: LTCHA, 2007, S.O.2007 c.8, s.20(2)(d)

At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;

(b) shall clearly set out what constitutes abuse and neglect;

(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;

(d) shall contain an explanation of the duty under section 24 to make mandatory reports;

(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

(f) shall set out the consequences for those who abuse or neglect residents;

(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and

(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings:
1. The home's policy #I-F-44.00, Reportable Matters originally issued in June 2010 related to incidents with respect to alleged, suspected or witnessed abuse of a resident but did not include an explanation of the duty under Section 24 of the Act to make mandatory reports.
2. An additional policy of the home VII-G-10.00, Abuse or Suspected Abuse of a Resident dated September 2007, related to the abuse or suspected abuse of a resident. This policy also did not contain an explanation of the duty under Section 24 of the Act to make mandatory reports.

Compliance Order #005 was faxed to the licensee on September 22, 2010.

Inspector ID #:	124 & 143

WN #6 : The Licensee has failed to comply with: LTCHA, 2007 S.O.2007, c.8, s.6(10)(b)
(10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective.

Findings:
1. Resident B's plan of care identified inappropriate behaviour.
2. The resident did not receive care to meet his identified needs on the day of the incident.

VPC-pursuant to LTCHA, 2007, S.O.2007 c.8 s.152(2) the licensee is hereby requested to prepare a written plan of corrective action for achieving compliance meeting the requirements that residents are reassessed and their plans of care reviewed when the residents' care needs change.

Inspector ID #:	124 & 143

WN # 7: The Licensee has failed to comply with LTCHA, 2007 S.O.2007 s. 76 (5)
Every licensee of a long-term care home shall ensure that every person mentioned in subsection (1) receives training that is provided for in the regulations in areas other than those provided for in subsection (2), at times or at intervals provided for in the regulations.

Findings:
1. The Director of Clinical Services reported that annual in-services for all staff did not address mandatory reporting requirements as required under section 24 of the LTCHA, 2007, S.O. 2007.

2. The Director of Clinical Services reported that staff was aware of the internal process for reporting of abuse.

Inspector ID #:	143

WN #8 : The Licensee has failed to comply with: LTCHA, 2007, S.O.2007 c.8, s. 76(2)3
Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

Findings:

1. The Administrator stated that not all staff attended the home's general orientation program which included abuse training, prior to performing their responsibilities.
2. The Director of Clinical Services reported that not all staff received abuse training prior to performing their responsibilities. She also reported that there are a few recent hires who are working who have not completed orientation, which included two personal support workers, one registered practical nurse, one cook and one dietary aid and were hired after July 1, 2010.

Inspector ID #:	124 & 143

[

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Lynda Hamilton
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Jan. 31, 2011

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Paul Miller	**Inspector ID #**	143
Log #:	Log # O-001194		
Inspection Report #:	2010_124_2790_30Aug120009 & 2010_143_2790_01Sep132618		
Type of Inspection:	Critical Incidents		
Date of Inspection:	August 30, 2010-September 2, 2010		
Licensee:	Specialty Care East Inc. 400 Applewood Crescent Suite110 Vaughan, ON L4K 0C3 Fax: 905-695-2940		
LTC Home:	Trillium Centre 800 Edgar Street Kingston, ON K7M 8S4 Fax: 613-547-3734		
Name of Administrator:	Jennifer Powley		

To [Name of Licensee], you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(b)
Pursuant to: The Licensee has failed to comply with: LTCHA, 2007, S.O.2007 c.8, s.24(1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. 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.			

Order: The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirement that abuse of a resident resulting in harm or risk of harm to a resident is immediately reported to the Director. The plan is to be submitted to Inspector: Paul Miller, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 347 Preston Street, 4th Floor, Ottawa ON K1S 3J4, Fax 613-569-9670.

Grounds:

1. Abuse of a resident resulting in harm or risk of harm to a resident was not immediately reported to the Director
2. An incident of abuse to Resident A by Resident B occurred at approximately 0715. This incident was witnessed.
3. A Detective Constable of the Kinston City Police force reported to the Inspectors Paul Miller and Lynda Hamilton that the Kingston City Police dispatch received a call from the home at 1124 hours on the day of the incident.
4. The Detective Constable also confirmed that police records indicated that Resident A's substitute decision maker was notified of the incident by the Director of Clinical Services at 1052 hours on the day of the incident.
5. Ministry received a call at approximately 1300 hours from the Director of Clinical Services of the home. A telephone discussion occurred with the Duty Inspector, Lynda Hamilton, advising the Ministry of Health and Long Term Care of the incidents of abuse. At a later date, the Administrator, in her Summary of Events document indicated that the MOH was contacted at "1110 not able to speak with anyone and therefore left a message." The Director of Clinical Services stated that she had reported the incident to the Ministry by voice mail at approximately 1100 hours and described her voice message as "this is the Director of Clinical Services from Trillium and I have a mandatory report to make and would like a Duty Inspector to call me back."

Compliance Order # 001 was faxed to the licensee on Sept 22, 2010.

This order must be complied with by:	October 1, 2010

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: The Licensee has failed to comply with O. Reg. 79/10 s. 98

Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Order: The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirement that any alleged, suspected or witnessed abuse of a resident is immediately reported to the police. The plan is to be submitted to Inspector: Paul Miller, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 347 Preston Street, 4th Floor, Ottawa ON K1S 3J4, Fax 613-569-9670.

Grounds:

1. A witnessed incident of abuse of a resident was not immediately reported to the police.
2. At approximately 0715 a witnessed incident of abuse occurred involving Resident A and Resident B.
3. A Detective Constable of the Kingston City Police force reported to Inspector Paul Miller and Lynda Hamilton that the Kingston City Police dispatch received a call from the home at 1124 on the day of the incident.

Compliance Order # 002 was faxed to the licensee on September 22, 2010.

This order must be complied with by:	October 1, 2010

Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: The Licensee has failed to comply with O. Reg. 79/10 s. 97(1)

Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident
or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Order: The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirement that any alleged, suspected or witnessed incident of abuse that has resulted in physical injury or pain to the resident or that causes distress to the resident is immediately reported to the resident's substitute decision maker and any other person specified by the resident. The plan is to be submitted to Inspector: Paul Miller, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 347 Preston Street, 4th Floor, Ottawa ON K1S 3J4, Fax 613-569-9670.

Grounds:

1. A witnessed incident of abuse of a resident was not reported to the Substitute Decision Maker immediately upon the licensee becoming aware of the witnessed incident of abuse.
2. At 0715 there was an incident of abuse involving Resident A.
3. Information obtained from the Detective Constable of the Kingston City Police, police records, indicated that Resident A's substitute decision maker was notified of the incident at 1052 on the day of the incident.

Compliance Order # 003 was faxed to the licensee on September 22, 2010.

This order must be complied with by:	October 1, 2010		
Order #:	004	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: The Licensee has failed to comply with LTCHA, 2007, S.O.2007 c.8, s.20(1)

Without in any way restricting the generality of the duty provided for in section 19, 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.

Order:
The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that their Abuse policy is complied with, subject to Order #005. The plan is to be submitted to Inspector: Paul Miller, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 347 Preston Street, 4th Floor, Ottawa ON K1S 3J4, Fax 613-569-9670.

Grounds:

1. The Long Term Care Home's abuse policies were not implemented and complied with related to immediately notifying police, Ministry of Health and Long Term Care and the resident's substitute decision makers and the Executor of the Estates after the incidents of abuse.
2. Policy VII-G-10.00 Nursing Checklist for Reporting and Investigating Alleged Abuse directed the Charge RN/DOC to provide information to the police.
3. The home's abuse policy stated that immediately upon notification of abuse, assess, provide medical intervention and request a full medical assessment. The incident of abuse occurred at 0715 hours and the medical assessment occurred between 1400-1500 hours on the day of the incident.
4. The home's abuse policy stated to remove the suspected individual from resident access. This did not occur and a second incident occurred at approximately 1000 hours on the same day involving Resident B and Resident C.

Compliance Order # 004 was faxed to the licensee on September 22, 2010.

This order must be complied with by:	October 22, 2010

Order #:	005	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: The Licensee has failed to comply with: LTCHA, 2007, S.O.2007 c.8, s.20(2)(d)

At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,

(a) shall provide that abuse and neglect are not to be tolerated;

(b) shall clearly set out what constitutes abuse and neglect;

(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; (d) shall contain an explanation of the duty under section 24 to make mandatory reports; (e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; (f) shall set out the consequences for those who abuse or neglect residents; (g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and (h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).
Order: The licensee shall include in their policy to promote zero tolerance of abuse and neglect of residents an explanation of the duty under Section 24 of the Act to make mandatory reports.
Grounds: The home's policy #I-F-44.00, Reportable Matters originally issued in June 2010 related to incidents with respect to alleged, suspected or witnessed abuse of a resident but did not include an explanation of the duty under Section 24 of the Act to make mandatory reports. 2. An additional policy of the home VII-G-10.00, Abuse or Suspected Abuse of a Resident dated September 2007, related to the abuse or suspected abuse of a resident. This policy also did not contain an explanation of the duty under Section 24 of the Act to make mandatory reports. Compliance Order #005 was faxed to the licensee on September 22, 2010.

This order must be complied with by:	October 1, 2010

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007*.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order 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 or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

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

Issued on this 22nd day of September, 2010.	
Signature of Inspector:	
Name of Inspector:	Paul Miller
Service Area Office:	Ottawa Service Area Office