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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: March 26, 2024

Inspection Number: 2024-1589-0001

Inspection Type:
Complaint
Critical Incident
Follow-up

Licensee: Corporation of the County of Simcoe

Long Term Care Home and City: Trillium Manor Home for the Aged, Orillia

Lead Inspector	**Inspector Digital Signature**
Jennifer Nicholls (691)	Jennifer J Nicholls Digitally signed by Jennifer J Nicholls Date: 2024.04.02 14:39:25 -04'00'

Additional Inspector(s)
Reji Sivamangalam (739633)
Henry Chong (740836)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 26-29, 2024, and March 1, 2024.The inspection occurred offsite on the following date(s): March 4-6, 2024.

The following intake(s) were inspected:

- One Intake was related to physical abuse of resident by a resident.
- One Intake was related to a fall of resident resulting in injury.
- One Intake was related to a Disease Outbreak.
- One Intake was a complaint related to care concerns of a resident.

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- One Intake related to the Follow-up #:001 from Inspection 2023-1589-0005, that was related to s. 24 (1).
- One Intake was related to Infectious Disease outbreak.
- One Intake that was related to Physical abuse of resident by another resident.
- One Intake that was related to Physical abuse of resident by another resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1589-0005 related to FLTCA, 2021, s. 24 (1) inspected by Jennifer Nicholls (691)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary
The home's skin care program policy indicated that all residents will have the skin assessment tool completed when there is a change in their condition and status.

A review of a resident's clinical records indicated that a new area of altered skin integrity was noted on the resident on a specified date. There was no assessment completed using the skin assessment tool by registered staff.

A Registered Practical Nurse (RPN) stated that when a resident has a new skin concern, an assessment should be completed. A RPN stated that a full assessment was not completed using the skin assessment tool when the resident developed the new areas of altered skin integrity.

There was increased risk to the resident's skin integrity when the assessment was not completed with the appropriate tool.

Sources: A resident's clinical records; Skin Care Program Policy, NPC D-30; interviews with an RPN, and other staff.

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[740836]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure that a specific intervention was provided to a resident to manage their responsive behaviors.

Rationale and Summary
A resident exhibited responsive behaviours and their care plan indicated that they were to have a specific intervention in place to assist in managing responsive behaviors.

On a specified date, during an observation the resident was noted that the specified intervention was not in place.

The PSW acknowledged that the specified intervention for the resident was to be in place.

An RPN and the DOC verified that the specified intervention should have been in place and was not.

Failure to have this specified intervention in place for the resident increased the risk to other residents.

Sources: Inspector Observations, a resident's clinical records, home's One on One (1:1) Supplemental Staffing policy (Policy number: NPC B – 20, Review date on 2024/01/3, interviews with a PSW, an RPN and the DOC.

[739633]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that a specified behavioral assessment and documentation were completed and analyzed for a resident's responsive behaviours.

Rationale and Summary
The specified behavioral assessment was used for documenting a resident's behaviours to identify their behavioural triggers. The assessment required staff to complete the assessment, and documentation for a specified time frame. A review of the specified behavioural assessment showed missing documentation for a number of days, and the analysis of the observation findings was not completed.

The DOC acknowledged that the specified behavioral assessment, and monitoring

was not completed as required.

Failure to complete the specified behavioral assessment placed risk to a resident for not receiving appropriate care as a result of unidentified behavioural triggers.

Sources: A resident's clinical records, and an interview with the DOC.

[739633]