

Ministry of Long-Term Care

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

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: July 30, 2025

Inspection Number: 2025-1059-0005

Inspection Type:

Critical Incident

Licensee: S & R Nursing Homes Ltd.

Long Term Care Home and City: Trillium Villa Nursing Home, Sarnia

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 23-25, and 28-30, 2025.

The following intake(s) were inspected:

- Critical Incident (CI) #2217-000016-25 related to falls prevention and management; and
- CI #2217-000017-25 related falls prevention and management.

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

Skin and Wound Prevention and Management
Pain Management
Falls Prevention and Management

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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 (1) (a)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee failed to ensure that there was a written plan of care that set out the planned care for an area of altered skin integrity for a resident.

The resident acquired a new area of altered skin integrity in the home. An assessment was completed related to this area of altered skin integrity which documented they had a treatment in place.

The home's skin and wound program policy directed staff to document treatments and the weekly re-assessment schedule in the electronic Treatment Administration Record (eTAR) and also ensure the plan of care included current treatments and interventions when a new area of altered skin was discovered.

The residents eTAR was not updated to include the weekly re-assessment orders in place until ten days after the area of altered skin integrity was first identified, and did not include any orders related to this treatment being in place. Also, their care plan was not updated to include this area of altered skin integrity until this date and did not include any direction related to this treatment being in place.

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Sources: the resident's clinical record, including their care plan, progress notes, skin and wound evaluations, orders, eTAR; the home's skin and wound program policy; and staff interviews.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

s. 6 (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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that a resident was reassessed and their plan of care reviewed and revised when their ambulation and transfer care needs changed.

A) The resident's Power of Attorney (POA) spoke with registered staff and requested that specific transfer care interventions be implemented for them. The registered staff member documented this change in the Personal Support Worker (PSW) communication binder located at the nursing station, however did not update their kardex to reflect this change.

PSW staff indicated they would refer to a residents kardex to find information related to a residents transfer care needs. Two days after their POA requested these specific transfer care interventions be implemented for them, a PSW provided them care that was not consistent with these transfer care needs. This resulted in an incident occurring that put the residents safety at risk.

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Sources: CI report and the home's documentation related to the incident; the resident's clinical record, including their care plan and progress notes; and staff interviews.

B) The resident's care plan directed staff to provide specific care related to transferring and ambulation. The resident experienced a change in their status which affected their ability to transfer and ambulate safely.

Registered nursing staff did not initiate a referral for physiotherapy to reassess their ambulation and transfer status or complete a reassessment of their mobility and transfer care needs until approximately three weeks after they first experienced a change in their status. At this time they were reassessed to required a change to their ambulation and transfer care needs.

Sources: the resident's clinical record, including their care plan, assessments, and progress notes; and staff interviews.

WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to ensure that the falls prevention and management program was implemented in the home when a resident had a fall and they did not include

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their Power of Attorney (POA) in the post fall management process.

In accordance with O.Reg. 242/22 s. 11(1)(b), where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any program the licensee was required to ensure that the program was complied with.

The home's falls prevention and management policy, which was part of their program related to falls prevention and management, directed staff to include the residents Substitute Decision Maker (SDM) in the post fall management process when they had fallen.

A resident fell and their POA was not notified of this fall until two days later.

Sources: CI report; the home's falls prevention and management policy; the resident's clinical record, including their progress notes; and staff interviews.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

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,

(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that when a resident exhibited an area of altered skin

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integrity it was reassessed weekly.

The home's skin and wound program policy directed staff to reassess areas of altered skin integrity at least weekly until resolved using the skin and wound application in PointClickCare(PCC).

The resident acquired a new area of altered skin integrity and an initial skin and wound assessment was completed related to this area. Registered staff first attempted to re-assess the area ten days after it was first acquired, but were unable to document an assessment due to an error with the skin and wound application. There was no subsequent re-assessment completed until 17 days after the area was first acquired, at which time the area had resolved.

Sources: the resident's clinical record, including their care plan, progress notes, skin and wound evaluations, orders, eTAR; the home's skin and wound program policy; and staff interviews.

COMPLIANCE ORDER CO #001 Duty to protect

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

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A) Review and revise the home's pain management program policy, to ensure that clear direction is provided to registered nursing staff on the process for referring and communicating with primary care providers regarding a resident with unrelieved pain. The review and revisions must be documented and maintained in the home, including the dates of the review, who participated in the review, and a summary of the revisions.

B) Ensure all members of the registered nursing staff on the affected home area are re-trained on the home's pain management program policy. A record must be kept of the date the training was provided, who attended the training, and the training contents. As soon as practicable, ensure the remainder of the registered nursing staff on the other home areas are also trained on the updated policy.

C) (1) Establish a written protocol or algorithm (decision-making tool) for sending a resident to an external resource for a specific type of assessment if it is suspected that a resident may have an injury. The protocol must include options for when the home is unable to procure external resources to assist with assessing the resident in the home within the timeframe ordered by the primary care provider.

(2) Established a written protocol or procedure to ensure that the specific external assessment is completed in a timely manner, including the expected timeframe for completing the assessment.

(3) Develop and implement an auditing tool to ensure the specific external assessment is completed as ordered, including any deficiencies identified and corrective action taken, as applicable. The audits will be completed once per week until the compliance order is complied by an inspector.

Grounds

The licensee has failed to ensure that a resident was protected from neglect after an incident occurred which resulted in a significant change in their condition.

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Section 7 of O.Reg. 246/22 defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home's pain management program and head injury routine policies directed registered staff to contact a resident's primary care provider when they had unrelieved pain and to report any changes in status or unusual signs with the resident to them.

The resident was documented to have shown signs of an injury with a change in their condition after an incident and an order was placed for further assessment from an external resource. The external assessment was not completed until eight days later and during this time the resident was noted to have unrelieved and ineffective pain management, showed further signs of injury and had changes in their behaviour and neurological status.

Registered staff did not communicate changes from the resident's baseline status during this time to their primary care provider to address the issue and were unable to articulate the reason for the delay in completing the external assessment. Two weeks later the resident passed away related to complications from the injury sustained as a result of the incident.

The management team in the home confirmed that the resident did not receive care consistent with their needs and was not provided with the treatment, care, services or assistance required for their health, safety or well-being when the external assessment was delayed and when registered staff did not communicate with the primary care providers about the resident's change in status.

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When staff did not ensure the resident received the external assessment in a timely manner and did not communicate to a primary care provider that the resident had unrelieved pain and a change in their condition, the resident experienced a delay in treatment, inadequate pain management and subsequently passed away related to the injury.

Sources: the resident's clinical record; the home's pain management and head injury routine policies; and staff interviews.

This order must be complied with by September 26, 2025

COMPLIANCE ORDER CO #002 Required programs

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A) Review and revise the home's head injury routine policy to ensure clear direction is provided to registered nursing staff on the process for referring and communicating with the primary care providers for any changes of condition, including but not limited to, assessments, and significant changes in condition. A

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documented record must be maintained of the review and revisions made, including the dates of the review, who participated in the review, and a summary of the revisions.

B) Ensure that all members of the registered nursing team working on the affected home area, are retrained on the home's head injury routine policy and expectations for completing scheduled monitoring and documenting as required by this policy. A record must be kept of the date the training was provided, who attended the training, the contents of the training, and who provided the training.

C) Develop and implement a process for completing weekly audits for two different resident's that have had an unwitnessed fall or fall which resulted in a suspected injury to their head to ensure the home's head injury routine policy is followed. A documented record must be maintained of the audits completed, which includes the date of the audit, the person who conducted the audit, the resident and the fall incident the audit was related to, any inconsistencies with the home's head injury routine policy identified, and any corrective actions taken as a result of the audit. These audits must continue until this compliance order is complied by an inspector.

Grounds

The licensee failed to ensure that the falls prevention and management program was implemented in the home when two residents had unwitnessed falls and scheduled monitoring was not completed in accordance with the home's head injury routine policy.

In accordance with O.Reg. 242/22 s. 11(1)(b), where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy the licensee was required to ensure that the policy was complied with.

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The home's falls prevention and management and head injury routine policies, which were part of their program related to falls prevention and management, directed staff to follow a head injury routine when a resident had an unwitnessed fall and to initiate and complete documentation on a paper head injury routine. The paper head injury routine directed staff not to chart "sleeping" and to wake the resident to complete the head injury assessment.

A) A resident had four unwitnessed falls and paper head injury routines were initiated after these falls, however documentation showed that monitoring had not been completed as scheduled on 11 occurrences as they were sleeping or it had been missed.

Sources: the home's falls prevention and management and head injury routine policies; the resident's clinical record, including their progress notes and head injury routines; and staff interviews.

B) A resident had five unwitnessed falls and paper head injury routines were initiated after these falls, however documentation showed that monitoring had not been completed on all prescribed intervals as expected.

Sources: the home's falls prevention and management and head injury routine policies; the resident's clinical record; and staff interviews.

This order must be complied with by September 26, 2025

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP 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, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

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e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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