Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 8, 2015	2015_396103_0037	O-002039-15	Resident Quality Inspection

Licensee/Titulaire de permis

~~SPECIALTY CARE EAST INC.~~ The Royale Development GP Corporation as a general partner of the Royal Development LP.
400 Applewood Crescent Suite110 VAUGHAN ON L4K 0C3

Long-Term Care Home/Foyer de soins de longue durée

~~TRILLIUM CENTRE~~ Trillium Retirement and Care Community
800 EDGAR STREET KINGSTON ON K7M 8S4

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

DARLENE MURPHY (103), JESSICA PATTISON (197), PAUL MILLER (143), WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 1-5, 2015

The following logs were included with this inspection: O-002000-15, O-002042-15 and O-002126-15 (critical incidents) and O-002163-15 (complaint).

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, Resident Council President, Family Council President, Program Manager, a Restorative care worker, a Dietary aide, a Housekeeping aide, Maintenance and Building Services Manager, Registered Dietitian, Director of Resident and Family Services, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Nurse Practitioner (NP), Assistant Directors of Care, Director of Care, and Administrator.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9(2) in that the written policy related to doors leading to secure outside areas does not state when the doors must be unlocked or locked to permit or restrict unsupervised access.

On June 1, 2015 during the initial tour of the home, it was noted that the Ridge building has a secure outdoor area accessible to residents.

On June 3, 2015, the Administrator provided Inspector #197 with a policy titled "Outside Area Security", policy # VII-H-10.10 last revised January 2015. This policy does not indicate when the doors to the outdoor secure area must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

On June 4, 2015, RN #S124 and RPN #S125 were asked when the door to the outdoor secure area is unlocked/locked. RN #124 stated that the door is open during the day and locked at night around 1900 hours. She also stated that it is locked during the cold weather months and when it's windy. She stated that the doors are then re-opened in the morning when residents want to go out, but that there is no set time. Both staff indicated that there was no written policy related to when the door should be unlocked/locked.

On June 4, 2015, ADOC #S105 stated that the doors leading to the outdoor secure area in the Ridge building are locked at 2200 hours each night and that programming staff open the doors at approximately 0830 hours each morning. She confirmed that there is no written policy related to when the door should be unlocked/locked. [s. 9. (2)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 24 (1) in that a the person who had reasonable grounds to suspect that neglect of a resident had occurred, did not immediately report the suspicion and the information upon which it was based to the Director.

On an identified date, the home investigated an allegation of staff to resident neglect. The investigation was immediately initiated and resulted in the reprimand of two staff members. The incident was not reported to the Director until four days after the incident had occurred.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure all of the required information was posted in a conspicuous and easily accessible location.

The long term care home's policy to minimize the restraining of residents, and how a copy of this policy can be obtained, was not posted in either the Ridge or the Court Buildings. [s. 79. (3) (g)]

Issued on this 8th day of June, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.