



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 19, 2016	2016_505103_0040	012976-16, 014032-16, 018608-16, 021383-16, 025088-16, 026953-16, 030123-16	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale
Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

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)

Inspection Summary/Résumé de l'inspection



The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 12-13, 17-18, 2016.

The following intakes were included in this inspection: Log #012976-16 (medication error), Log #014032-16 (alleged resident to resident abuse), Log #018608-16 (resident elopement), Log #021383-16 (alleged resident to resident abuse), Log #025088-16 (alleged resident to resident abuse), Log #026953-16 (alleged resident to resident abuse), Log #030123-16 (resident elopement).

During the course of the inspection, the inspector(s) spoke with residents, Personal Support workers (PSW), Maintenance worker , Registered Practical Nurses (RPN), the Director of Care (DOC) and the Administrator.

During the course of this inspection, the inspector conducted a full walking tour of the Garden, Orchard, Lake and Cottage houses, made resident observations, and reviewed resident health care records and the home's window audit summary dated June 21, 2016.

The following Inspection Protocols were used during this inspection:

Medication

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

3 WN(s)

0 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :



1. The following finding relates to Logs #030123-16 and #018608-16:

The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters.

Resident #004 resided on an identified unit and had identified diagnoses. The resident health care record was reviewed. On an identified date, a neighbor in the community alerted the Trillium Centre that resident #004 was at their home. According to the staff, the resident had been seen approximately thirty minutes prior to this notification. Upon investigation into the elopement, the home discovered the resident had removed the screen in a co-resident's room and left through the window which was described as wide open. The resident was returned to the home with no injuries.

Resident #011 resided on an identified unit and had identified diagnoses. The resident health care record was reviewed. On an identified date, a PSW entered the resident room and found the window screen had been removed and the resident's window was observed to be wide open. The resident was seen wandering in the cul de sac behind the home and was returned by staff with no injuries. Staff reported the resident had been seen approximately thirty minutes prior to being discovered outside.

Maintenance #106 was interviewed and showed this inspector that a restriction arm is attached to the window and prevents the windows from being opened greater than 15 centimeters. #106 indicated the restriction arm is riveted to the window sill, but when the rivet is depressed it will release the arm and the window can then be fully opened. In the above two incidents the residents eloped through different windows. According to #106, the window manufacturer has been consulted to determine a possible fix. [s. 16.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs



Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The following finding relates to Log #012976-16:

The licensee has failed to ensure a drug was administered to resident #001 in accordance with the directions for use specified by the prescriber.

Resident #001's health care record was reviewed and indicated the resident was prescribed an identified analgesic by mouth twice daily. On an identified date, the resident was administered 12 mg of the identified analgesic in error by RPN #107 instead of the prescribed dose of 0.5mg. The RPN discovered the error and notified the physician and the resident's family. The resident was monitored in accordance with the physician's instructions and required a transfer to hospital . The resident returned to the home the following day and suffered no long lasting effects from the medication error.

The DOC was interviewed and indicated the RPN had administered the incorrect dose from another resident's medication card. The RPN was required to complete a review of the College of Nurses medication administration guidelines. [s. 131. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions



Specifically failed to comply with the following:

- s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,**
- (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).**
 - (b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).**
 - (c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).**

Findings/Faits saillants :

1. The following finding relates to Log #012976-16:

The licensee has failed to ensure that a medication incident involving resident #001 was documented, reviewed and analyzed.

As outlined in WN #2, resident #001 received an incorrect dose of an identified analgesic. The DOC was asked to provide a copy of this medication incident, but was unable to find any documentation to support the incident had been documented. The home's multidisciplinary, quarterly review of medication incidents were reviewed for the period of March to May 2016 and June to August 2016, but this incident was not included in the reviews.

The legislation requires that all medication incidents are documented, reviewed and analyzed to prevent similar errors from reoccurring. [s. 135. (2)]



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

Issued on this 19th day of October, 2016

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

Original report signed by the inspector.



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée
Inspection de soins de longue durée**

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : DARLENE MURPHY (103)

Inspection No. /

No de l'inspection : 2016_505103_0040

Log No. /

Registre no: 012976-16, 014032-16, 018608-16, 021383-16, 025088-16, 026953-16, 030123-16

Type of Inspection /

Genre

d'inspection:

Critical Incident System

Report Date(s) /

Date(s) du Rapport : Oct 19, 2016

Licensee /

Titulaire de permis :

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8

LTC Home /

Foyer de SLD :

Trillium Retirement and Care Community
800 EDGAR STREET, KINGSTON, ON, K7M-8S4

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Bonnie George



**Ministry of Health and
Long-Term Care**

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*

**Ministère de la Santé et
des Soins de longue durée**

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

Order # /

Ordre no : 001

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee is hereby ordered to:

- complete a home wide audit of all resident accessible windows that open to the outside of the home,
- ensure all resident accessible windows that open to the outside of the home have screens and cannot be opened more than 15 centimeters.

Grounds / Motifs :



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*

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

1. The following finding relates to Logs #030123-16 and #018608-16:

The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters.

Resident #004 resided on an identified unit and had identified diagnoses. The resident health care record was reviewed. On an identified date, a neighbor in the community alerted the Trillium Centre that resident #004 was at their home. According to the staff, the resident had been seen approximately thirty minutes prior to this notification. Upon investigation into the elopement, the home discovered the resident had removed the screen in a co-resident's room and left through the window which was described as wide open. The resident was returned to the home with no injuries.

Resident #011 resided on an identified unit and had identified diagnoses. The resident health care record was reviewed. On an identified date, a PSW entered the resident room and found the window screen had been removed and the resident's window was observed to be wide open. The resident was seen wandering in the cul de sac behind the home and was returned by staff with no injuries. Staff reported the resident had been seen approximately thirty minutes prior to being discovered outside.

Maintenance #106 was interviewed and showed this inspector that a restriction arm is attached to the window and prevents the windows from being opened greater than 15 centimeters. #106 indicated the restriction arm is riveted to the window sill, but when the rivet is depressed it will release the arm and the window can then be fully opened. In the above two incidents the residents eloped through different windows. According to #106, the window manufacturer has been consulted to determine a possible fix.

(103)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :** Nov 25, 2016



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et
des Soins de longue durée**

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

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 services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603



**Ministry of Health and
Long-Term Care**

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*

**Ministère de la Santé et
des Soins de longue durée**

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

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 tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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.



**Ministry of Health and
Long-Term Care**

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*

**Ministère de la Santé et
des Soins de longue durée**

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11^e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



**Ministry of Health and
Long-Term Care**

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*

**Ministère de la Santé et
des Soins de longue durée**

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19th day of October, 2016

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : DARLENE MURPHY

Service Area Office /

Bureau régional de services : Ottawa Service Area Office