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

Ottawa District
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Original Public Report

Report Issue Date: January 26, 2024	
Inspection Number: 2024-1281-0001	
Inspection Type: Complaint Critical Incident	
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP	
Long Term Care Home and City: Trillium Community & Retirement Living, Kingston	
Lead Inspector Darlene Murphy (103)	**Inspector Digital Signature** Darlene Murphy Digitally signed by Darlene Murphy Date: 2024.02.01 09:39:21 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 16-18, 2024.

The following intake(s) were inspected:

- Intake: #00099958 (CIS #2790-000047-23) - resident fall that resulted in an injury,
- Intake: #00105775 -letter of complaint related to resident care.

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

Medication Management
Infection Prevention and Control
Palliative Care
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Care and Services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 11 (1) (a)

Nursing and personal support services

s. 11 (1) Every licensee of a long-term care home shall ensure that there is,

(a) an organized program of nursing services for the home to meet the assessed needs of the residents.

In accordance with O. Reg 246/22, s. 11 (1) (b), the home is required to have policies for the palliative care program that are complied with.

Specifically, the licensee failed to comply with their palliative care policy, "Interdisciplinary Palliative Care Approach", last revised September 2022, by failing to provide care to a resident in accordance with the policy.

Rationale and Summary:
A resident's health care record was reviewed for a period of two weeks during which time the resident's condition showed a steady decline.

A Personal Support Worker (PSW) was interviewed and stated family members raised concerns that the resident was having difficulty breathing and requested medication to make the resident more comfortable. The PSW stated the resident looked distressed at that time and called the Registered Practical Nurse (RPN). According to the PSW, the RPN was covering more than one resident unit and did not arrive for approximately one hour.

The RPN stated they recalled the resident had excess secretions and stated they advised the family the home may have medication on-site that could be ordered to assist with these secretions. The RPN administered an analgesic subcutaneously to assist in alleviating the resident's distress, and later assessed the dose as having been ineffective.

The RPN stated they did not contact the physician on-call to advise them of the resident's change in condition and stated they did not notify the Registered Nurse (RN) working that evening to further assess the resident. At the end of the shift, the RPN documented the resident was still having difficulty breathing, the family were requesting more medication to calm the resident and to continue to monitor.

The PSW stated they believed the RPN had attempted to call the RN that evening but was unsuccessful. The PSW stated the resident's family were upset by the delay in care and lack of additional measures to alleviate the resident's struggles to breathe. The PSW stated the RN was later located by the family at which time the family asked the RN about possible medications to assist the resident's breathing and to assess the resident. There was a further delay in assessment as the RN

informed the family, they had to attend to something prior to assessing the resident.

The RN stated they assessed the resident around 2330 hours and contacted the on-call physician for additional pain medication which was administered twice overnight. According to the RN, the resident settled through the night and passed away the next morning.

Staff failed to provide end-of-life care to the resident in accordance with the home's palliative policy which indicates goals of care are focused on pain and symptom management at end-of-life. The policy further directs staff to contact the physician as required for any changes in the resident's condition.

The Palliative care team (PCT) lead was interviewed to review the home's palliative program. They indicated as residents approach end-of-life, an up-to-date interdisciplinary plan of care is put into place to reflect end-of-life wishes and care needs of the resident and that a health care wishes assessment will be completed. The PCT lead indicated this is important for ensuring all team members are aware of the resident and family care needs during the end stage of death.

The PCT lead stated staff from each discipline are responsible for the completion of this plan for their specific area, but no one is assigned to oversee this step is completed. The PCT lead confirmed the end-of-life plan of care, and the health care wishes assessment were not completed for the resident.

Sources:
Resident's health care record, interviews with RN, RPN, PSW, PCT lead. [103]

WRITTEN NOTIFICATION: Reporting and Complaints

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

Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure written complaints that outlined concerns related to a resident's care were investigated and resolved where possible and that a response was provided within 10 business days of the receipt of the complaints.

Rationale and Summary:

On August 22, 2022 and October 28, 2022, emails were sent to the Executive Director (ED) that included concerns related to a resident's care. The ED acknowledged they received the emails and forwarded them to the appropriate department for follow-up. The ED was unable to determine if any actions were taken to address the concerns outlined in the emails and indicated no response was provided to the complainants.

Failure to investigate and resolve resident care related complaints in accordance with the complaints process, puts the resident at risk of harm.

Sources:
Emails dated August 22/22 and October 28/22, interview with the ED. [103]

WRITTEN NOTIFICATION: Reporting and Complaints
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee failed to ensure two written complaints were included in the home's documented record of complaints.

Rationale and Summary:
The home's documented record of complaints for 2022 was reviewed. The record did not contain emails dated August 26, 2022, and October 28, 2022, that outlined concerns related to the resident's care.

Failure to include these complaints in this documented record prevents the home

from accurately analyzing all complaints received for trends and prevents the home from making any necessary improvements in that area.

Sources:
Review of the home's documented record of complaint for 2022, Interview with ED. [103]