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

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

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

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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
Apr 28, 2017	2017_491647_0004	014433-16, 028332-16, 034273-16, 035256-16	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26 Midhurst ON L0L 1X0

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

TRILLIUM MANOR HOME FOR THE AGED
12 GRACE AVENUE ORILLIA ON L3V 2K2

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

JENNIFER BROWN (647), SABRINA GILL (662)

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): March 22, 23, 24, 27, 28, 29, 2017.

The following critical incidents were inspected:
014433-16
028332-16
034273-16
035256-16

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), RAI-MDS Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Family Members, and Substitute Decision Makers.

During the course of the inspection, the inspectors conducted observations in the home and resident home areas, observations of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents are protected from abuse.

The home contacted the ACTIONline on an identified date and subsequently submitted a Critical Incident Report (CIS) on an identified date which had indicated that an identified resident had been witnessed by staff exhibiting inappropriate responsive behaviours toward a cognitively impaired resident while sitting in the hallway.

The home submitted another CIS on an identified date which had indicated that there had been another incident of the same.

A record review of the above mentioned resident indicated that at the time of admission there had been no previous history of inappropriate responsive behaviour. The record review further indicated that there had not been any previous inappropriate responsive behaviour towards any previous residents or staff prior to the incident that had been reported on the identified date mentioned above.

Interviews with a direct care staff member and registered staff all indicated that the above mentioned resident had identified responsive behaviours. The staff members indicated that the resident would enter the common rooms where other residents had been sitting and would exhibit inappropriate identified responsive behaviours. The direct care staff mentioned above had not witnessed resident having inappropriate responsive behaviours prior to the incident reported by the home.

A review of the written plan of care for the identified resident did not identify that the resident had inappropriate responsive behaviours. A further review of the written plan of care indicated that there had been no revision to the written plan of care after the first incident of inappropriate responsive behaviours on the first identified date mentioned above where resident had been witnessed exhibiting inappropriate responsive behaviours toward a cognitively impaired resident.

A further review of the written plan of care for the identified resident indicated that the written plan of care had remained unchanged and not revised even after the second incident of inappropriate responsive behaviours mentioned above.

An interview with a registered staff member indicated that the written plan of care is used to provide staff with information related to care plan focus, goals, interventions and any risks for all residents. The registered staff member further confirmed that the written plan of care for the identified resident did not include any focus, goal, interventions or risks relating to the inappropriate responsive behaviours mentioned above or the risk of inappropriate responsive behaviours to other cognitively impaired residents who are not

able to provide consent.

It had been confirmed during an interview with the Director of Care (DOC) that the expectation of the home is to protect all residents from abuse. The DOC acknowledged during the above mentioned interview that both of the identified residents had been the recipients of resident's identified responsive behaviours and would not have been able to provide consent prior to the incidents. The DOC further acknowledged that there had been no interventions put into place after the first incident of inappropriate responsive behaviours to the first identified resident and therefore had not protected the second identified resident from abuse.

2. The home submitted a CIS on an identified date which had indicated that there had been an incident of sexual abuse towards an identified resident.

A review of the above mentioned CIS indicated that an identified resident had been witnessed by staff to be exhibiting inappropriate responsive behaviours toward a cognitively impaired resident.

A record review indicated that from the time the identified resident had been admitted to the time of discharge, the identified resident had been observed to express identified inappropriate responsive behaviours.

On two occasions, the identified resident had been witnessed to be exiting other resident rooms and on one occasion had been observed to be in an inappropriate manner.

The above mentioned record review further indicated that on an identified date, the identified resident had been witnessed by staff to be exhibiting inappropriate responsive behaviours toward an identified resident. Staff assisted and removed the resident from the area. Staff returned the identified resident to the lounge and later returned to find the identified resident exhibiting an identified inappropriate responsive behaviour toward the cognitively impaired resident again.

Interviews with a direct care staff member and a registered staff member indicated that the identified resident mentioned above had been known to have inappropriate responsive behaviours towards identified residents. The above mentioned staff further indicated that all staff had been informed that the resident was not to be near specific identified residents.

A review of the written plan of care for the identified resident did not identify that the resident had inappropriate responsive behaviours. A further review of the written plan of care for the identified resident indicated that there had been no revision to the written plan of care to include any inappropriate responsive behaviours before the above mentioned incident. A further review of the written plan of care for the identified resident indicated that the written plan of care had remained unchanged and not revised even after the above mentioned incident.

An interview with a registered staff member indicated that the written plan of care for all residents are to be revised at minimum quarterly or as health conditions change. The registered staff member further confirmed that the written plan of care for the resident had not included inappropriate responsive behaviours and had not been revised to include any focus, goal, interventions or risks relating to the inappropriate responsive behaviour mentioned above.

An interview with a registered staff member indicated that the written plan of care is used to provide staff with information related to care plan focus, goals, interventions and any risks for all residents. The registered staff member further confirmed that the written plan of care for the identified resident had not been revised to include any focus, goal, interventions or risks relating to the inappropriate responsive behaviour mentioned above or the risk of abuse to other residents.

It had been confirmed during an interview with the DOC that the expectation of the home is to protect all residents from abuse. The DOC acknowledged during the above mentioned interview that the identified resident had been abused by the identified resident as the resident was cognitively impaired and unable to provide consent. The DOC further acknowledged that there had been no interventions put into place after the first incident to an identified resident and therefore had not protected the other identified resident from being abused.

3. Review of a CIS submitted to the Ministry of Health and Long Term Care (MOHLTC) by the home revealed that on an identified date and time, an identified resident was seen leaving another resident's room.

A review of the above mentioned resident's written care plan revealed that the resident had exhibited inappropriate responsive behaviours towards identified residents. The directions to staff were to remind the identified resident that his/her behaviour was unacceptable.

A review of the above mentioned resident's progress notes from an identified time frame, revealed six incidents between the two residents identified above relating to inappropriate responsive behaviour. A review of the identified resident's clinical records identified the resident to be cognitively impaired. Interviews with direct care staff members and registered staff members indicated that the resident had inappropriate responsive behaviours towards identified residents. The direct care staff further revealed that the resident was known to have prior behaviours and would exhibit responsive behaviours towards identified residents. A registered staff member indicated that the above mentioned resident was known to exhibit inappropriate identified responsive behaviours toward other residents and the resident would exhibit further identified behaviours when a staff member intervened.

The direct care staff members further indicated that the identified resident's behaviours pose a risk to the safety of residents as he/she may continue to exhibit inappropriate responsive behaviours.

A review of the home's high risk rounds meeting notes from an identified period of time revealed that the above mentioned resident's behaviours were discussed at these meetings, and the resident had been placed on an identified monitoring system however no further interventions were discussed or identified.

An interview with the DOC indicated that the home's expectation on the prevention of abuse is to take every reasonable effort to ensure the safety and security of residents. The DOC further revealed that the identified resident's behaviours were discussed at high risk rounds and at that time staff did not perceive the identified resident's behaviours as a risk. The DOC indicated that the home could not demonstrate that the resident had consented to the identified act by the other identified resident on the identified dates, and this incident should have been reported as consent was not obtained. The DOC further indicated that the resident's behaviours on the identified dates constituted abuse.

The DOC acknowledged that the home did not protect the identified resident who was cognitively impaired from abuse from the above mentioned resident.

The severity of the non-compliance and the severity of harm and risk was actual harm or risk.

The scope of the non-compliance is isolated.

A review of the compliance history revealed the home was issued a previous non-compliance related to the Long Term Care Homes Act, O. Reg. c8, s.19(1):
-Critical Incident System inspection 2014_369153_0004 carried out July 15, 2014, home was served a voluntary plan of correction.

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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee has failed to ensure that, for each resident demonstrating responsive behaviours (b) strategies are developed and implemented to respond to these behaviours.

Review of a CIS submitted to the MOHLTC by the home revealed that on an identified date and time an identified resident had been seen leaving a resident's room.

A review of the identified resident's written care plan revealed that the resident had exhibited inappropriate responsive behaviours towards a couple of residents. The directions to staff were to remind him/her that his/her behaviour was unacceptable.

A review of the resident's progress notes from an identified period of time revealed nine incidents of inappropriate responsive behaviour between the two resident's mentioned above.

Interviews with direct care staff members and registered staff members indicated that the identified resident had identified responsive behaviours and would target identified residents. The direct care staff members further revealed that the identified resident was known to have prior behaviours and would identified responsive behaviours. The registered staff member indicated that the identified resident was known to exhibit inappropriate identified responsive behaviours toward other residents and the identified resident would express further identified responsive behaviour when a staff member intervened.

Direct care staff members indicated that the identified resident was known to have inappropriate responsive behaviours towards a specific resident. The direct care staff members further indicated that the identified resident would show an identified responsive behaviour toward specific residents. The direct care staff indicated that the identified resident's behaviors pose a risk to the safety of residents as he/she continues to demonstrate inappropriate responsive behaviours and he/she could continue to exhibit these behaviours.

A review of the home's high risk rounds meeting notes from an identified period of time revealed that the identified resident's behaviors towards another resident were discussed at these meetings, and the identified resident was placed on a monitoring system however no further strategies were discussed or implemented.

An interview with the DOC indicated that the home's expectation when a resident is identified to have any responsive behaviour is that the resident's behaviour will be discussed with the clinical team, behavioural charting would be initiated to identify any triggers and to determine if there are any patterns. A PIECES assessment would be completed and the behaviours should be documented in the progress notes, care plan and triggers, patterns and interventions should be identified. The DOC further revealed that the identified resident's behaviours on the above mentioned identified dates were discussed at high risk rounds and no new strategies were put in place as staff at that time did not perceive that the resident's behaviours to be a risk to other residents. The DOC acknowledged that strategies were not developed or implemented for the identified resident's inappropriate responsive behaviours.

The severity of the non-compliance and the severity of harm and risk was actual harm or risk.

The scope of the non-compliance is isolated.

A review of the compliance history revealed the home had no previous compliance history related to strategies being developed and implemented to respond to responsive behaviours.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

The home submitted CIS on an identified date which had indicated that there had been an incident of abuse towards another identified resident.

A review of the above mentioned CIS indicated that the identified resident had been witnessed by staff to exhibit an inappropriate identified responsive behaviour towards another identified resident.

A record review of the progress notes for an identified period of time indicated that resident had been observed to have identified responsive behaviours toward identified residents. On two occasions, the identified resident had been witnessed to be exiting other resident rooms. On another identified date the progress notes indicated that resident had been witnessed by staff to be exhibiting inappropriate identified responsive behaviours toward an identified resident. Staff assisted the resident and removed him/her from the area. Staff returned the identified resident to the lounge and later returned to find the identified resident exhibiting inappropriate identified responsive behaviour towards the same resident.

After the identified incident the home initiated a monitoring system to observe the identified resident's behaviors. A review of the documented monitoring system from an identified period of time, indicated that there had been no observation of the identified resident's behaviors on 50 shifts during the day shift, 36 shifts during the evening shift and on 48 shifts during the night shift.
Interviews with direct care staff and registered staff indicated that all staff are to document on the monitoring system as the information would then be used to strategize on interventions and patterns for the exhibited inappropriate responsive behaviours.

An interview with the DOC confirmed the use of the monitoring system as a way to trend the data of the behaviours and collaborate with staff and external partners to establish interventions to manage the inappropriate responsive behaviours. The DOC acknowledged during the interview that staff had not documented on the behaviours of the identified resident on the shifts mentioned above and therefore had not provided the care set out in the plan of care as specified in the plan.

2. The licensee has failed to ensure that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

The home contacted the ACTIONline on an identified date and subsequently submitted a CIS which had indicated that an identified resident had been witnessed by staff exhibiting inappropriate identified responsive behaviour toward an identified resident in the hallway.

The home submitted another CIS on an identified date which had indicated that the above mentioned identified resident had exhibited the same identified inappropriate responsive behaviour again to another identified resident.

A record review indicated that the identified resident had no history of inappropriate responsive behaviour since admission to the home. The record review further indicated that there had not been any previous inappropriate responsive behaviour towards any previous residents or staff prior to the incident that had first been reported.

Interviews with direct care staff and registered staff all indicated that the resident had identified responsive behaviours. The resident becomes bored, he/she will enter the common rooms where other residents may be sitting and exhibit identified responsive behaviours. The direct care staff mentioned above had not witnessed the identified behaviour prior to the incident reported by the home on the identified date.

A review of the written plan of care for the above mentioned resident did not identify that the resident had inappropriate responsive behaviours. A further review of the written plan of care for the identified resident indicated that there had been no revision to the written plan of care after the first incident of inappropriate responsive behaviour where resident had been witnessed to exhibit identified inappropriate behaviour toward an identified resident. A further review of the written plan of care for the resident indicated that the written plan of care had remained unchanged and not revised even after the second incident where the identified resident had been witnessed exhibiting identified inappropriate responsive behaviours towards an identified resident.

An interview with a registered staff member indicated that the written plan of care for all residents are to be revised at minimum quarterly or as health conditions change. The registered staff member further confirmed that the written plan of care for the identified resident had not been revised to include any focus, goal, interventions or risks relating to the inappropriate responsive behaviour mentioned above.

It had been confirmed during an interview with the DOC that the expectation of the home is for staff to revise the written plan of care for each resident when care needs change. The DOC acknowledged that the above mentioned resident's written plan of care had not been revised when his/her care needs changed including interventions to mitigate the risk of abuse towards any resident.

3. The home submitted a CIS on an identified date which had indicated that there had been an incident of abuse towards a resident.

A review of the above mentioned CIS indicated that an identified resident had been witnessed by staff to be exhibiting inappropriate identified responsive behaviour toward an identified resident.

A record review indicated that resident had been admitted with a cognitive impairment. A further record review between a designated period of time indicated that resident had been observed to be exhibiting identified responsive behaviours. On two occasions, resident had been witnessed to be exiting resident rooms.

On an identified date the identified resident had been witnessed by staff to be exhibiting inappropriate responsive behaviours toward an identified resident. Staff separated the residents and later returned to find the identified resident exhibiting identified inappropriate responsive behaviours again.

Interviews with direct care staff and registered staff indicated that the identified resident had been known to have inappropriate responsive behaviours towards identified residents. The above mentioned staff further indicated that all staff had been informed that the above mentioned resident is not to be near identified residents.

A review of the written plan of care for the identified resident indicated that there had been no revision to the written plan of care to include any inappropriate responsive behaviours before the first incident. A further review of the written plan of care for the resident indicated that the written plan of care had remained unchanged and not revised even after the second incident.

An interview with a registered staff member indicated that the written plan of care for all residents are to be revised at minimum quarterly or as health conditions change. The registered staff member further confirmed that the written plan of care for the identified resident had not been revised to include any focus, goal, interventions or risks relating to the inappropriate responsive behaviours mentioned above.

It had been confirmed during an interview with the DOC that the expectation of the home is for staff to revise the written plan of care for each resident when care needs change. The DOC acknowledged that the above mentioned resident's written plan of care had not been revised when his/her care needs changed including interventions to mitigate the

risk of abuse towards any resident.

4. The home contacted the ACTIONline on an identified date, and subsequently submitted a CIS which had indicated that there had been an incident of abuse towards cognitively impaired resident while resident was in the hallway.

Additionally, the home submitted another CIS which had indicated that there had been another incident of abuse towards another cognitively impaired resident while sitting in the hallway.

A record review indicated that resident had been admitted with no previous history of inappropriate responsive behaviour. The record review further indicated that there had not been any previous inappropriate responsive behaviour towards any previous residents or staff prior to the incident mentioned above.

Interviews with registered staff and direct care staff all indicated that the identified resident remains to himself/herself in his/her room unless he/she is bored. When resident becomes bored, he/she will enter the common rooms where other residents had been sitting and will exhibit identified inappropriate responsive behaviour.

The direct care staff mentioned above had not witnessed resident being inappropriate prior to the incident reported by the home on the identified date mentioned above.

A review of the written plan of care for the identified resident indicated that there had been no indication of inappropriate behaviour and no revision of the written plan of care after the first incident, where resident had been witnessed to exhibit inappropriate identified responsive behaviours towards identified residents. A further review of the written plan of care for the identified resident indicated that the written plan of care had remained unchanged and not revised even after the second incident as mentioned above.

An interview with a registered staff member indicated that the written plan of care for all residents are to be revised at minimum quarterly or as health conditions change. The registered staff further confirmed that the written plan of care for the identified resident had not been revised to include any focus, goal, interventions or risks relating to the inappropriate identified behavior mentioned above.

It had been confirmed during an interview with the DOC that the expectation of the home is for staff to revise the plan of care for each resident when care needs change. The DOC acknowledged that the above mentioned resident's plan of care had not been reassessed or revised when his/her care needs changed including interventions to mitigate the risk of abuse towards any resident.

5. The home submitted a CIS on an identified date which had indicated that there had been an incident of abuse towards an identified resident.

A review of the above mentioned CIS indicated that an identified resident had been witnessed by staff to exhibit an identified responsive behaviour toward an identified resident.

A record review indicated that resident had been admitted with a cognitive impairment. A further record review between an identified period of time indicated that resident had been observed to exhibit identified inappropriate responsive behaviours toward an identified resident. On two occasions, resident had been witnessed to be exiting other residents rooms.

The progress notes indicated that on an identified date, the identified resident had been witnessed by staff to be exhibiting identified inappropriate responsive behaviours toward identified residents. Staff removed and assisted the identified resident. Staff returned the resident to the lounge and later returned to find the identified resident exhibiting the same identified inappropriate responsive behaviours towards the same identified resident.

Interviews with a direct care staff member and a registered staff member indicated that the identified resident had been known to have inappropriate identified responsive behaviors towards identified residents. The above mentioned staff further indicated that the written plan of care stated that staff had been informed that the identified resident was not to be near specific identified residents.

A review of the written plan of care for the identified resident did not identify that the resident had identified inappropriate responsive behaviors. A further review of the written plan of care for the identified resident indicated that there had been no revision to the written plan of care to include any identified responsive behaviors before the incident on an identified date. A further review of the written plan of care for the identified resident indicated that the written plan of care had remained unchanged and not revised even after the incident on an identified date as mentioned above.

An interview with a registered staff member indicated that the written plan of care for all residents are to be revised at minimum quarterly or as health conditions change. The registered staff member further confirmed that the written plan of care for the above mentioned identified resident had not been revised to include any focus, goal, interventions or risks relating to the inappropriate identified behavior mentioned above.

It had been confirmed during an interview with the DOC that the expectation of the home is for staff to reassess and revise the plan of care for each resident when care needs change. The DOC acknowledged that the above mentioned resident's plan of care had not been reassessed or revised when his/her care needs changed including interventions to mitigate the risk of abuse towards any resident.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care provided to the resident as specified in the plan and to ensure that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 5th day of May, 2017

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

Original report signed by the inspector.

Ontario

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

Ministére 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

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) :	JENNIFER BROWN (647), SABRINA GILL (662)
Inspection No. / No de l'inspection :	2017_491647_0004
Log No. / Registre no:	014433-16, 028332-16, 034273-16, 035256-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 28, 2017
Licensee / Titulaire de permis :	CORPORATION OF THE COUNTY OF SIMCOE 1110 Highway 26, Midhurst, ON, L0L-1X0
LTC Home / Foyer de SLD :	TRILLIUM MANOR HOME FOR THE AGED 12 GRACE AVENUE, ORILLIA, ON, L3V-2K2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janice McCuaig

To CORPORATION OF THE COUNTY OF SIMCOE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

Upon a receipt of this order the licensee shall,

1. The licensee shall develop and submit a plan that includes the following requirements and the person responsible for completing the tasks. The plan is to be submitted to jennifer.brown6@ontario.ca by May 26, 2017 and implemented by July 28, 2017.

2. Provide re-education and training to all staff in the home on the home's policy to promote zero tolerance of abuse and neglect of residents. A copy of staff's sign-in sheet for those attending the session and the dates be kept on file.

3. Ensure all staff are educated on how to identify and report resident to resident abuse.

4. Ensure that resident #010 is assessed for consent and interventions are implemented to ensure safety of co residents.

5. The policy review and training shall include all definitions of abuse, and not be limited to resident to resident abuse, as identified within the home's abuse policy and within the Long-Term Care Homes Act, 2007, Ontario Regulations 79/10.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse.

The home contacted the ACTIONline on an identified date and subsequently submitted a Critical Incident Report (CIS) on an identified date which had

indicated that an identified resident had been witnessed by staff exhibiting inappropriate responsive behaviours toward a cognitively impaired resident while sitting in the hallway.

The home submitted another CIS on an identified date which had indicated that there had been another incident of the same.

A record review of the above mentioned resident indicated that at the time of admission there had been no previous history of inappropriate responsive behaviour. The record review further indicated that there had not been any previous inappropriate responsive behaviour towards any previous residents or staff prior to the incident that had been reported on the identified date mentioned above.

Interviews with a direct care staff member and registered staff all indicated that the above mentioned resident had identified responsive behaviours. The staff members indicated that the resident would enter the common rooms where other residents had been sitting and would exhibit inappropriate identified responsive behaviours. The direct care staff mentioned above had not witnessed resident having inappropriate responsive behaviours prior to the incident reported by the home.

A review of the written plan of care for the identified resident did not identify that the resident had inappropriate responsive behaviours. A further review of the written plan of care indicated that there had been no revision to the written plan of care after the first incident of inappropriate responsive behaviours on the first identified date mentioned above where resident had been witnessed exhibiting inappropriate responsive behaviours toward a cognitively impaired resident.

A further review of the written plan of care for the identified resident indicated that the written plan of care had remained unchanged and not revised even after the second incident of inappropriate responsive behaviours mentioned above.

An interview with a registered staff member indicated that the written plan of care is used to provide staff with information related to care plan focus, goals, interventions and any risks for all residents. The registered staff member further confirmed that the written plan of care for the identified resident did not include any focus, goal, interventions or risks relating to the inappropriate responsive behaviours mentioned above or the risk of inappropriate responsive behaviours

to other cognitively impaired residents who are not able to provide consent.

It had been confirmed during an interview with the Director of Care (DOC) that the expectation of the home is to protect all residents from abuse. The DOC acknowledged during the above mentioned interview that both of the identified residents had been the recipients of resident's identified responsive behaviours and would not have been able to provide consent prior to the incidents. The DOC further acknowledged that there had been no interventions put into place after the first incident of inappropriate responsive behaviours to the first identified resident and therefore had not protected the second identified resident from abuse.

2. The home submitted a CIS on an identified date which had indicated that there had been an incident of sexual abuse towards an identified resident.

A review of the above mentioned CIS indicated that an identified resident had been witnessed by staff to be exhibiting inappropriate responsive behaviours toward a cognitively impaired resident.

A record review indicated that from the time the identified resident had been admitted to the time of discharge, the identified resident had been observed to express identified inappropriate responsive behaviours.

On two occasions, the identified resident had been witnessed to be exiting other resident rooms and on one occasion had been observed to be in an inappropriate manner.

The above mentioned record review further indicated that on an identified date, the identified resident had been witnessed by staff to be exhibiting inappropriate responsive behaviours toward an identified resident. Staff assisted and removed the resident from the area. Staff returned the identified resident to the lounge and later returned to find the identified resident exhibiting an identified inappropriate responsive behaviour toward the cognitively impaired resident again.

Interviews with a direct care staff member and a registered staff member indicated that the identified resident mentioned above had been known to have inappropriate responsive behaviours towards identified residents. The above mentioned staff further indicated that all staff had been informed that the

resident was not to be near specific identified residents.

A review of the written plan of care for the identified resident did not identify that the resident had inappropriate responsive behaviours. A further review of the written plan of care for the identified resident indicated that there had been no revision to the written plan of care to include any inappropriate responsive behaviours before the above mentioned incident. A further review of the written plan of care for the identified resident indicated that the written plan of care had remained unchanged and not revised even after the above mentioned incident.

An interview with a registered staff member indicated that the written plan of care for all residents are to be revised at minimum quarterly or as health conditions change. The registered staff member further confirmed that the written plan of care for the resident had not included inappropriate responsive behaviours and had not been revised to include any focus, goal, interventions or risks relating to the inappropriate responsive behaviour mentioned above.

An interview with a registered staff member indicated that the written plan of care is used to provide staff with information related to care plan focus, goals, interventions and any risks for all residents. The registered staff member further confirmed that the written plan of care for the identified resident had not been revised to include any focus, goal, interventions or risks relating to the inappropriate responsive behaviour mentioned above or the risk of abuse to other residents.

It had been confirmed during an interview with the DOC that the expectation of the home is to protect all residents from abuse. The DOC acknowledged during the above mentioned interview that the identified resident had been abused by the identified resident as the resident was cognitively impaired and unable to provide consent. The DOC further acknowledged that there had been no interventions put into place after the first incident to an identified resident and therefore had not protected the other identified resident from being abused.

3. Review of a CIS submitted to the Ministry of Health and Long Term Care (MOHLTC) by the home revealed that on an identified date and time, an identified resident was seen leaving another resident's room.

A review of the above mentioned resident's written care plan revealed that the resident had exhibited inappropriate responsive behaviours towards identified

residents. The directions to staff were to remind the identified resident that his/her behaviour was unacceptable.

A review of the above mentioned resident's progress notes from an identified time frame, revealed six incidents between the two residents identified above relating to inappropriate responsive behaviour. A review of the identified resident's clinical records identified the resident to be cognitively impaired. Interviews with direct care staff members and registered staff members indicated that the resident had inappropriate responsive behaviours towards identified residents. The direct care staff further revealed that the resident was known to have prior behaviours and would exhibit responsive behaviours towards identified residents. A registered staff member indicated that the above mentioned resident was known to exhibit inappropriate identified responsive behaviours toward other residents and the resident would exhibit further identified behaviours when a staff member intervened.

The direct care staff members further indicated that the identified resident's behaviours pose a risk to the safety of residents as he/she may continue to exhibit inappropriate responsive behaviours.

A review of the home's high risk rounds meeting notes from an identified period of time revealed that the above mentioned resident's behaviours were discussed at these meetings, and the resident had been placed on an identified monitoring system however no further interventions were discussed or identified.

An interview with the DOC indicated that the home's expectation on the prevention of abuse is to take every reasonable effort to ensure the safety and security of residents. The DOC further revealed that the identified resident's behaviours were discussed at high risk rounds and at that time staff did not perceive the identified resident's behaviours as a risk. The DOC indicated that the home could not demonstrate that the resident had consented to the identified act by the other identified resident on the identified dates, and this incident should have been reported as consent was not obtained. The DOC further indicated that the resident's behaviours on the identified dates constituted abuse.

The DOC acknowledged that the home did not protect the identified resident who was cognitively impaired from abuse from the above mentioned resident.

The severity of the non-compliance and the severity of harm and risk was actual harm or risk.

The scope of the non-compliance is isolated.

A review of the compliance history revealed the home was issued a previous non-compliance related to the Long Term Care Homes Act, O. Reg. c.8, s.19(1): -Critical Incident System inspection 2014_369153_0004 carried out July 15, 2014, home was served a voluntary plan of correction. (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 28, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

Upon receipt of this order the licensee shall:

1. Conduct a meeting with all direct care staff on the home area that resident #010 resides.
2. The meeting shall allow for the collaboration and participation of all direct care staff in the development and implementation of strategies that will respond to resident #010's identified responsive behaviours.
3. Continue to conduct meetings with the direct care staff monthly, to ensure that all developed strategies are relevant and current to respond to the responsive behaviour needs of resident #010.

Grounds / Motifs :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours (b) strategies are developed and implemented to respond to these behaviours.

Review of a CIS submitted to the MOHLTC by the home revealed that on an identified date and time an identified resident had been seen leaving a resident's room.

A review of the identified resident's written care plan revealed that the resident had exhibited inappropriate responsive behaviours towards a couple of

residents. The directions to staff were to remind him/her that his/her behaviour was unacceptable.

A review of the resident's progress notes from an identified period of time revealed nine incidents of inappropriate responsive behaviour between the two resident's mentioned above.

Interviews with direct care staff members and registered staff members indicated that the identified resident had identified responsive behaviours and would target identified residents. The direct care staff members further revealed that the identified resident was known to have prior behaviours and would identified responsive behaviours. The registered staff member indicated that the identified resident was known to exhibit inappropriate identified responsive behaviours toward other residents and the identified resident would express further identified responsive behaviour when a staff member intervened.

Direct care staff members indicated that the identified resident was known to have inappropriate responsive behaviours towards a specific resident. The direct care staff members further indicated that the identified resident would show an identified responsive behaviour toward specific residents. The direct care staff indicated that the identified resident's behaviors pose a risk to the safety of residents as he/she continues to demonstrate inappropriate responsive behaviours and he/she could continue to exhibit these behaviours.

A review of the home's high risk rounds meeting notes from an identified period of time revealed that the identified resident's behaviors towards another resident were discussed at these meetings, and the identified resident was placed on a monitoring system however no further strategies were discussed or implemented.

An interview with the DOC indicated that the home's expectation when a resident is identified to have any responsive behaviour is that the resident's behaviour will be discussed with the clinical team, behavioural charting would be initiated to identify any triggers and to determine if there are any patterns. A PIECES assessment would be completed and the behaviours should be documented in the progress notes, care plan and triggers, patterns and interventions should be identified. The DOC further revealed that the identified resident's behaviours on the above mentioned identified dates were discussed at high risk rounds and no new strategies were put in place as staff at that time

did not perceive that the resident's behaviours to be a risk to other residents. The DOC acknowledged that strategies were not developed or implemented for the identified resident's inappropriate responsive behaviours.

The severity of the non-compliance and the severity of harm and risk was actual harm or risk.

The scope of the non-compliance is isolated.

A review of the compliance history revealed the home had no previous compliance history related to strategies being developed and implemented to respond to responsive behaviours. (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 28, 2017

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

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.

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, 11e 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.

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 28th day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Brown

Service Area Office /
Bureau régional de services : Toronto Service Area Office