Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


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

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 22, 2021 | 2021_745690_0023 | 015009-21 | Complaint |

### Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

### 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

TRACY MUCHMAKER (690), SHANNON RUSSELL (692)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): November 22-26, 2021, and November 29, 2021.**

**The following intake was inspected upon during this Complaint inspection:**

**-One intake, which was a complaint related to staffing and care concerns.**

**A Critical Incident System inspection #2021_745690_0024 was conducted concurrently with this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Infection Prevention and Control (IPAC) Specialist, Covid-19 Screener, Personal Support Workers (PSWs), Housekeepers and residents.**

**The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, observed infection prevention and control practices, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.**

**The following Inspection Protocols were used during this inspection:**
**Infection Prevention and Control**
**Personal Support Services**
**Sufficient Staffing**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 33. Bathing**

**Specifically failed to comply with the following:**

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that five residents, were bathed, at a minimum twice a week by the method of their choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition.

A complaint was submitted to the Director related to staffing shortages in the home, and how this had resulted in resident’s not being provided their scheduled tub bath/shower. A review of the home’s complaint log for a three-month period identified that there had been complaints brought forward by families and residents regarding residents not receiving their scheduled bath.

Three residents, indicated that when the home worked below the normal compliment of staff, they had received bed baths in place of a tub bath. The residents indicated that this had not been their choice and that they did not like receiving bed baths in place of a tub bath.

The resident’s bath documentation for a period of two months, identified that five residents did not receive the minimum twice weekly bath by the method of their choice on multiple occasions.

The direct care staff indicated that if a residents' tub bath was missed they were to complete the bath on the next shift or the next day; however, due to staffing levels, staff had not been able to provide the missed baths. The Administrator acknowledged that the identified residents had not been bathed at a minimum of twice a week according to their preference.

The home's failure to ensure that resident's had been bathed at a minimum of twice a week according to their preference resulted in a negative impact on the resident's quality of life.

Sources: A Complaint intake; Follow Up Question Reports; Documentation Survey Reports (for two months; resident health care records including: progress notes, care plan and POC charting for five residents; Interviews with residents, family member, PSW staff, Registered staff, and the Administrator. [s. 33. (1)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents related to COVID-19 active screening for all persons entering the home.

COVID-19 Directive #3 stated that homes must ensure that all individuals are actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the home. The Ministry of Health COVID-19 Screening Tool for Long-term Care Homes and Retirement Homes identified, at a minimum, the questions that needed to be asked when actively screening individuals who enter the home.

On three separate days during the inspection, the COVID-19 Screener did not ask the Inspectors all the questions on the home's screening tool and did not obtain contact information on the first day. Inspector #690 also observed two visitors arrive and the screener did not ask all the questions on the screening tool during the screening process.

Upon review of the home's screening tool that was in use at the time of the inspection, the tool did not include the minimum required questions.

In addition, the Screener, indicated to the Inspector that they were supposed to ask all the questions on the home's screening tool, but they did not always ask them all. The Infection Prevention and Control (IPAC) Specialist, and the Administrator verified that the screener was required to fully complete the home's screening tool and that the home's screening tool did not include the minimum required questions.

Sources: Observations on three separate days, Covid-19 Directive #3, dated July 16, 2021, Ministry of Health COVID-19 Screening Tool for Long-term Care Homes and Retirement Homes, dated August 27, 2021, the home's COVID-19 screening tools, interviews with the Screener, IPAC specialist and the Administrator. [s. 5.]

***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 all persons entering the home are screened for Covid-19 as per Covid-19 Directive #3, to be implemented voluntarily.***

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident’s desired bedtime and rest routines were supported and individualized to promote their comfort, rest and sleep.

A resident's care plan indicated that they liked to be assisted to bed around a specified time. A review of “Documentation Survey Report” for a one month period, identified that the resident was provided evening care between an hour and a half to two and a half hours later than their preferred time. The resident said that they often had to wait to be put to bed for over an hour, and on many occasions up to two hours, after their preferred time which, was not their choice.

Direct care staff indicated that they would do their best to ensure that residents requiring assistance would be assisted to bed at the resident’s desired time. They all indicated that they were aware of the resident's preferred bed time but were not always able to meet their needs which upset the resident.

Sources: A complaint intake; a resident’s health care records; Documentation Survey Report; and interviews with PSW staff, Registered staff, and the Administrator. [s. 41.]

**Issued on this 23rd day of December, 2021**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

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

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | TRACY MUCHMAKER (690), SHANNON RUSSELL (692) |
| **Inspection No. / No de l'inspection :** | 2021_745690_0023 |
| **Log No. / No de registre :** | 015009-21 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Dec 22, 2021 |
| **Licensee / Titulaire de permis :** | Corporation of the County of Simcoe<br>1110 Highway 26, Midhurst, ON, L9X-1N6 |
| **LTC Home / Foyer de SLD :** | Trillium Manor Home for the Aged<br>12 Grace Avenue, Orillia, ON, L3V-2K2 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Tanya Devries-Porter |

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:

Ontario

**Ministry of Long-Term Care**

**Ministère 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

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**Order # / No d'ordre :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

**Order / Ordre :**

The licensee must be compliant with s. 33 (1) of the O. Reg. 79/10.

The licensee shall prepare, submit and implement a plan to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The plan must include, but is not limited to, the following;

a) How the home plans to ensure that five identified residents, are bathed, at minimum, twice a week by the method of his or her choice; and
b) What actions will be taken if a resident misses a bath or shower.

Please submit the written plan, quoting inspection #2021_745690_0023 and Inspector Tracy Muchmaker, by email to SudburySAO.moh@ontario.ca by January 7, 2022.

Please ensure that the submitted written plan does not contain any personal information or personal health information.

**Grounds / Motifs :**

1. The licensee has failed to ensure that five residents, were bathed, at a minimum twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was submitted to the Director related to staffing shortages in the home, and how this had resulted in resident's not being provided their scheduled tub bath/shower. A review of the home's complaint log for a three-month period identified that there had been complaints brought forward by families and residents regarding residents not receiving their scheduled bath.

Three residents, indicated that when the home worked below the normal compliment of staff, they had received bed baths in place of a tub bath. The residents indicated that this had not been their choice and that they did not like receiving bed baths in place of a tub bath.

The resident's bath documentation for a period of two months, identified that five residents did not receive the minimum twice weekly bath by the method of their choice on multiple occasions.

The direct care staff indicated that if a residents' tub bath was missed they were to complete the bath on the next shift or the next day; however, due to staffing levels, staff had not been able to provide the missed baths. The Administrator acknowledged that the identified residents had not been bathed at a minimum of twice a week according to their preference.

The home's failure to ensure that resident's had been bathed at a minimum of twice a week according to their preference resulted in a negative impact on the resident's quality of life.

Sources: A Complaint intake; Follow Up Question Reports; Documentation Survey Reports (for two months; resident health care records including: progress notes, care plan and POC charting for five residents; Interviews with residents, family member, PSW staff, Registered staff, and the Administrator.

An order was made by taking the following factors into account:

Severity: There was minimal risk identified, specifically related to the residents that did not receive their bath or shower twice per week.

Scope: The scope of this non-compliance was widespread as it affected five out

of five residents reviewed.

Compliance History: In the past 36 months, the home did not have any non-compliance under O. Reg. 79/10, s. 33 (1).
(692)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 04, 2022

## 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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON  M7A 1N3
Télécopieur : 416-327-7603

## 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON  M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 22nd day of December, 2021**

**Signature of Inspector /**
**Signature de l’inspecteur :**

**Name of Inspector /**
**Nom de l’inspecteur :** Tracy Muchmaker

**Service Area Office /**
**Bureau régional de services :** Sudbury Service Area Office