Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

North District
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Original Public Report

Report Issue Date: February 27, 2023	
Inspection Number: 2023-1589-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Corporation of the County of Simcoe	
Long Term Care Home and City: Trillium Manor Home for the Aged, Orillia	
Lead Inspector Ryan Goodmurphy (638)	**Inspector Digital Signature**
Additional Inspector(s) Shannon Russell (692) Samantha Fabiilli (000701) also attended the inspection	

INSPECTION SUMMARY

The inspection occurred on the following date(s): February 13 - 17, 2023.

The following intake(s) were completed:
- Seven intakes related to incidents of resident to resident responsive behaviours;
- Two intakes related to the resident to staff communication and response system;
- One complaint related to menu planning and substitutions;
- One complaint related to the dietary department; and
- Three complaints related to the functionality of the resident to staff communication and response system.

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

Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident had occurred, was immediately reported to the Director.

Rationale and Summary
A critical incident report was submitted to the Director which identified that a resident had demonstrated specific responsive behaviours towards another resident, one day earlier. The Director of Resident Care (DORC) acknowledged that they identified this incident when they reviewed the previous day’s progress notes and that the staff member should have reported the incident to the Registered Nurse (RN) or contacted a manager on-call to receive direction on reporting requirements.

Failure to report to the Director as required had no impact on and did not present a risk to the two residents' health, safety, or quality of life.

Sources: Critical Incident System (CIS) report; the resident’s progress notes; interviews with the DORC and other staff. [638]

WRITTEN NOTIFICATION: Security of Drug Supply

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 139. 1.

The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

Rationale and Summary
During the inspection, the Inspector observed a medication cart on a home area unlocked and unattended. The electronic medication administration system (eMAR) was left open on a resident profile and there were medications left on top of the medication cart. Multiple residents were sitting in the area of the unlocked medication cart while the staff member was not present. When the Registered Practical Nurse (RPN) returned, they acknowledged that this was not the expected practice when they

left a medication cart unattended.

Staff failed to ensure the security of drugs when they were not using the medication cart, which posed a moderate risk to the residents if they accessed drugs that were not prescribed.

Sources: Inspector #638's observations on the home area; the home's policy titled: Policies & Procedures: Manual for MediSystem Services Homes last updated June 2022; interviews with the Administrator and the RPN. [638]

WRITTEN NOTIFICATION: Altercations and Other Interactions Between Residents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 59 (b)

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

Rationale and Summary
A resident was identified as having had responsive behaviours towards other residents. The resident was prescribed a pharmacological intervention, which was to be used when the resident demonstrated specific responsive behaviours. Progress notes identified, over a period of time, that the resident demonstrated these specific responsive behaviours on multiple occasions where non-pharmacological interventions were deemed to be ineffective. The eMAR identified that the resident received their prescribed pharmacological intervention on one occasion.

Staff failed to provide the resident with their pharmacological intervention as prescribed by the physician, when the non-pharmacological interventions were ineffective, which placed the other residents at a risk of the resident's responsive behaviours.

Sources: The resident's health care records including; progress notes, care plan, medication orders, eMAR; interviews with the Administrator and other staff. [638]

WRITTEN NOTIFICATION: Menu Planning

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 77 (4)

The licensee has failed to ensure that the planned menu items were offered and available at each meal.

Rationale and Summary
During the inspection, the planned menu items for one of the lunch meal services included cream of cauliflower soup as well as tomato and onion salad. During the meal service it was identified that the aforementioned items were substituted for chicken noodle soup and pureed squash. Staff in each home area identified that they were not made aware of the meal substitutions prior to the meal service and multiple residents stated that they did not receive their meal choices as the menu options had changed. One resident identified that there were frequent changes in the menu and that these changes were not relayed to the residents prior to the meal service.

The Food Service Supervisor (FSS) identified that menu substitutions occurred on occasion and that staff should have updated the posted menu and if the FSS was made aware the electronic menu boards would also have been updated. There was low impact and low risk to the residents when the menu items were substituted without posting the changes.

Sources: Inspector #638's observations of the lunch meal service; the posted menu; the home's policy titled: Dietary Manual-Menu Planning-Menu Substitutions-DMA-10 Effective date: January 2020; interviews with residents, the Food Service Supervisor and other staff. [638]

WRITTEN NOTIFICATION: Communication and Response System

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 20 (g)

The licensee has failed to ensure that the homes resident-staff communication and response system was functioning properly, as the sound to alert staff was not audible to staff.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received three complaints which identified that the resident-staff communication and response system had not been working properly on two of the four units for a period of time. The system notified staff that a resident had activated the call bell by a light illuminating above the door, and by sending an alert to staff phones and a monitor located at the nursing station.

Residents and direct care staff identified that when residents activated their call bell, the light above their door would illuminate; however, it did not send an alert to their portable phones or the monitor at the nursing station. They all indicated they would have had to have been in the hallway to see the light to know who had required assistance. Two residents identified there had been occasions during that

period of time where they had activated the call bell as they required assistance, and no one responded for a period of time. They indicated this had caused them to be upset and concerned for their safety, as they had not felt confident that staff would respond when they required assistance. The DORC and Administrator identified that the call bell system had not been working properly for a period of time.

There was a moderate impact and a moderate risk for residents with the staff resident communication system not functioning properly. This caused concern for resident safety as staff may not have been alerted to residents who required their assistance.

Sources: CIS report; two residents' health care records; the homes internal investigation notes; the homes complaint log; the homes policy titled, "Nurse Call and Roam Alert Systems", #ESS B-15, last revised January 2020; and interviews with PSWs, RPNs, RNs, Maintenance Coordinator, DORC and the Administrator. [692]

WRITTEN NOTIFICATION: Reports Regarding Critical Incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 115 (3) 2. ii

The licensee has failed to ensure that the Director was informed of a breakdown of the homes resident-staff communication and response system no later than one business day after the incident occurred.

Rationale and Summary
The homes resident-staff communication and response system stopped operating properly on two of the four units. The DORC and Administrator identified that the call bell system had not been working properly for a period of time; however, it had not been reported to them until a later date. They both indicated that the incident should have been reported to the Director the following day after the system was noted to be malfunctioning.

There was a low impact and a low risk to residents for the Long-Term Care Home not reporting the concern to the Director immediately.

Sources: CIS report; the homes internal investigation notes; the homes complaint log; the homes policy titled, "Nurse Call and Roam Alert Systems", #ESS B-15, last revised January 2020; and interviews with a RPN, RN, Maintenance Coordinator, DORC, and the Administrator. [692]