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

North District
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Original Public Report

Report Issue Date: July 11, 2023	
Inspection Number: 2023-1589-0004	
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 Samantha Fabiilli (000701)	**Inspector Digital Signature** Samantha Fabiilli Digitally signed by Samantha Fabiilli Date: 2023.07.26 14:45:13 -04'00'
Additional Inspector(s) Tracy Muchmaker (690)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: June 26-29, 2023

The following intakes were completed:

- One intake related to a complaint regarding dining service.
- Two intakes related to falls.
- One intake related to a medication incident/adverse drug reaction involving a resident.

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was revised when care needs changed.

Summary and Rationale
A resident had a fall which resulted in an injury. The resident's falls risk score was identified through assessments.

The resident was observed by the inspector to be requiring specific interventions to complete one of their Activities of Daily Living (ADL)s. The resident's care plan indicated an inaccurate falls risk score, as well as inaccurate requirements for assisting the resident with two of their ADLs.

A Registered Practical Nurse (RPN), and Director of Care (DOC), verified that the resident's care plan had not been revised when their care needs had changed.

Not revising the care plan related to the resident's ADLs, posed a minimal risk to the resident as all staff caring for the resident may not be aware of the current care needs.

Sources: Observations of a resident**;** A resident's assessment and care plan; Interviews with a PSW, RPN, and DOC.
[690]

WRITTEN NOTIFICATION: Dining and snack service

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.

The licensee has failed to ensure that the home's dining service included proper techniques to assist residents with eating.

Rationale and Summary:

Through observing meals, it was identified that staff were standing to provide food and fluids to residents.

A home's policy indicated that care is to be provided as outlined in a specific textbook. In review of the information included in the textbook, it was identified that staff should be sitting, facing the resident, when feeding, as it would provide a more a relaxed setting, and standing could impose a rushed feeling on residents.

A PSW indicated that they were aware that they were to be seated while providing feeding assistance to residents, and they hadn't been seated on a specified day. The administrator confirmed that they would not consider standing while feeding or providing fluids to a resident to be a proper feeding technique.

Standing while feeding residents posed a low risk and low impact, as it may have resulted in residents feeling rushed to complete their meals and may not have provided a relaxed setting.

Sources: Observations of meal service; Interviews with a PSW and Administrator; Review of the homes policy and relevant textbook. [000701]