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
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: December 19, 2023

Inspection Number: 2023-1589-0005

Inspection Type:
Complaint
Critical Incident

Licensee: Corporation of the County of Simcoe

Long Term Care Home and City: Trillium Manor Home for the Aged, Orillia

Lead Inspector	**Inspector Digital Signature**
Shannon Russell (692)	Shannon K Russell Digitally signed by Shannon K Russell Date: 2024.01.12 09:22:30 -05'00'

Additional Inspector(s)
Charlotte Scott (000695)
Loviriza Caluza (687)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6-10, 2023.

The following intake(s) were inspected:

- One intake, related to an unexpected death of a resident;
- A complaint intake, and a CIS intake, both related to improper care of a resident pertaining to falls; and,
- One intake, which was a complaint regarding improper/incompetent care of a resident.

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Residents' Rights and Choices
Falls Prevention and Management

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)
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an allegation of incompetent treatment towards a resident by staff was reported immediately to the Director.

Rationale and Summary
(a) A resident required the assistance of staff with an activity of daily living (ADL). Staff had not provided the assistance to the resident for an extended period, which

resulted in the resident sustaining an injury to a specific area of their body. The long-term care home (LTCH) had not immediately reported the allegation of improper care to the Director.

(b) a resident had a change in status, which required a transfer to the hospital and was admitted with a specified diagnosis. There had been an allegation that registered staff had delayed assessing and treating the resident. The LTCH had not immediately reported the allegation to the Director.

A Director of Care (DOC) identified that all allegations of improper/incompetent care of a resident by staff, were to be immediately reported to the Director.

There was low risk to the resident for not immediately reporting the allegations of resident improper/incompetent care to the Director.

Sources: a resident's health care records; the homes complaint log and internal investigation notes; LTCH portal; the home's policy titled, "Zero Tolerance of Abuse and Neglect", #ADM D-10, last revised August 2023; and interviews with a resident and their substitute decision maker (SDM), direct care and registered staff, and a DOC. [692]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee failed to carry out a policy directive that applied to the LTCH, with

respect to section 1.2 of the Minister's Directive: Covid:19 Measures for LTCH. Specifically, the licensee did not ensure that all staff wore masks in all resident areas indoors as required under the Covid-19 Guidance Document for LTCHs in Ontario, issued November 2, 2023.

Rationale and Summary
On November 2, 2023, the Director issued an update to the Covid:19 Guidance Document for LTCHs in Ontario, to be in effect by November 7, 2023. The update required staff, students, volunteers, and support workers wear masks in all resident areas indoors. Following the implementation of the masking mandate, a staff member was observed in close proximity to residents without a mask on.

A DOC acknowledged if a staff member was not wearing a mask in a resident area indoors on or after November 7, 2023, the Minister's Directive would not be complied with.

There was low impact and risk to the residents when the staff member did not wear a mask in the indoor resident area of the home, as the home was not experiencing a disease outbreak at the time of the incident.

Sources: Inspector observations; Ministers Directive: Covid-19 response measures for LTCHs (effective: August 30, 2023); Covid-19 Guidance Document for LTCHs in Ontario (updated: November 2, 2023); and interviews with staff members and a DOC. [000695]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a Personal Support Worker (PSW) used safe transferring techniques when assisting a resident.

Rationale and Summary
A resident's plan of care identified a specific transfer status for all transfers; however, direct care staff had observed the resident required a different transfer status for a period of time. The change identified had not been reported to registered staff, and the resident was not reassessed.

A DOC acknowledged that the PSW should have reported the change in the resident's care needs to the registered staff and that the resident's transfer status should have been re-assessed and the plan of care updated to reflect the change.

There was moderate impact and risk to the resident when they were not re-assessed, and the resident's transfers were not completed in a safe manner.

Sources: A resident's health care records; and interviews with a PSW, a DOC, and other staff. [000695]

COMPLIANCE ORDER CO #001 Duty to protect

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect

s. 24 (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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Develop and implement a process to audit that the following occurs:
   -Physician Orders are implemented in a timely manner; and,
   -Direct care and registered staff are made aware of a resident's change in condition and/or any follow up action that is required shift to shift.
2. Documentation of the auditing process, including who completed the audits must be maintained. The audits must be continued for at least one month post the compliance due date to ensure sustainability.
3. Identify and implement appropriate corrective action to address any deficiencies identified in the auditing process, including but not limited to retraining. Documentation of the corrective action must be maintained.

Grounds

The licensee has failed to ensure that a resident was protected from neglect by staff.

The Ontario Regulations (O. Reg.) 242/22, s. 7., defines neglect as, "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Rationale and Summary

(a) A resident had been showing signs of an infection, and the registered staff did not complete the physicians' order until 16 days after the onset of symptoms. The

inaction of registered staff resulted in a delay in the resident being diagnosed and treated with the appropriate treatment.

The day following commencement of treatment, the resident had a change in their condition, which required them to be transferred to the hospital; they were admitted with a specific diagnosis, which required further medical treatment. It had been identified that a registered staff had not completed a thorough assessment and did not seek assistance for a period when the resident had first showed signs of a change in their status.

There was a high impact and risk to the resident for the inaction of staff and the delay in receiving the care that they required.

(b) A resident required the assistance of staff for the completion of an ADL. Direct care staff had not communicated that the resident required assistance with the ADL; therefore, the resident had not received the assistance for an extended period. There had been an identified injury, which resulted from the staff not providing the assistance they needed.

A DOC indicated that there had been a lack of communication between staff, which delayed the resident receiving the assistance they required.

There was a moderate impact and risk to the resident for the inaction of staff providing the assistance that the resident required, resulting in an injury to the resident.

(c) A resident identified that a staff member had indicated to them that it had appeared the resident had an infection. There had not been any further follow up completed after identifying a possible infection.

A review of the resident's health care records did not identify that there had been an assessment completed, or treatment implemented regarding the resident having an infection.

Registered staff were not aware that the resident had a concern, until it was brought to their attention. They indicated that staff should have reported the concern immediately, so that the resident would have been assessed and treated in a timely manner.

A DOC indicated that the registered staff were to assess the resident and obtain treatment immediately for any infection when identified.

There was a moderate impact and risk to the resident for the inaction of staff not assessing and implementing treatment, which resulted in a delay of care the resident required.

Sources: Complaint intake; a resident's health care records; the home's policy titled, "Zero Tolerance of Abuse and Neglect", #ADM D-10, last revised August 2023; and interviews with a resident and their SDM, direct care and registered staff, and a DOC. [692]

This order must be complied with by January 19, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

During Inspection #2022_1589_0001 a compliance order for duty to protect was issued on July 11, 2022.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee

requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.

(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.