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

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| **Report Issue Date:** August 7, 2024. |
| **Inspection Number:** 2024-1589-0002 |
| **Inspection Type:**<br>Critical Incident |
| **Licensee:** Corporation of the County of Simcoe |
| **Long Term Care Home and City:** Trillium Manor Home for the Aged, Orillia |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 15-19, and 22-24, 2024.

The following intake(s) were inspected:

- Eight intakes related to allegations of resident to resident abuse; and,
- One intake related to a resident fall resulting in injury.

The following intake was completed during the inspection:

- One intake related to a resident fall with injury.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

# INSPECTION RESULTS

## Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented. Specifically, the licensee did not ensure point-of-care signage for two residents which indicated enhanced IPAC control measures were in place, as required by Additional Requirement 9.1 (e) under the IPAC Standard.

**Rationale and Summary**
During the inspection, it was noted that a resident's door had signage directing staff to utilize additional IPAC precautions, and had the additional personal protective equipment (PPE) present. It was also noted that another resident's door had signage directing staff to utilize additional IPAC precautions, however, no additional PPE was available.

The IPAC Lead confirmed that one resident had been removed from the additional

precautions listed on the door, and still required other additional precautions to be utilized; and that the second resident had no longer required additional precautions, however the sign had remained in place.

The Inspector later observed that the first resident's room had the appropriate precaution sign with available PPE, and that the second resident room had no additional precaution signage or PPE available; as the IPAC Lead had confirmed was the accurate status of the IPAC control measures in place for each resident.

There was low impact when the licensee failed to ensure the point-of-care signage indicated which enhanced IPAC control measures were in place or removed for the residents.

**Sources:** Inspector observations; IPAC Standard for Long-Term Care Homes April 2022, progress notes for the resident; and interview with the IPAC Lead.

Date Remedy Implemented: July 18, 2024

## WRITTEN NOTIFICATION: Integration of Assessments, Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (4) (b)**
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different

aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

**Rationale and Summary**
A record review for a resident indicated that specific documentation was required to be completed twice daily, however, the documentation had significant gaps during certain shifts.

A Registered Nurse (RN) indicated that the documentation was expected to be completed in full, at the intervals specified. The Director of Care (DOC) acknowledged that the implementation of the documentation for the resident was not consistent as it was required to be completed by staff in full each day, and reviewed and signed off by the nursing staff at the end of each shift, three times per day.

There was low risk when the licensee failed to ensure that staff and others involved in the resident's care collaborated in the implementation of the plan of care, so the aspects of care were integrated, consistent, and complemented each other.

**Sources:** Medication record and additional charting for the resident; the home's policy; and interviews with the RPN, DOC , and other staff.

## WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (7)**
Plan of care
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.

The licensee has failed to ensure that the care set out for a resident in their plan of care was provided.

**Rationale and Summary**
A resident had a specific intervention in their plan of care, however, it was noted that the intervention was not being implemented as it should have been. The home provided a summary which indicated that over a five week period, there were several times that the resident did not have the intervention in place.

The DOC indicated that the care set out in a resident' plan of care should have been implemented consistently, and it had not been.

There was risk of harm to residents.

**Sources**: A resident's care plan and progress notes; schedules provided by the home; and, interview with the DOC.

## WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (10) (c)**
Plan of care
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,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that when a resident's plan of care was no longer

effective, the plan of care was reviewed and revised.

**Rationale and Summary**
A resident's the plan of care was not reviewed and revised despite a Personal Support Worker (PSW) having indicated that the staff had implemented interventions to assist in managing the resident's care needs.

The DOC reviewed the resident's plan of care and indicated that the plan of care had not been reviewed or revised.

There was risk to the resident due the lack of interventions in the resident's plan of care.

**Sources**: The resident's progress notes and care plan; high risk round meeting minutes; interview with the PSW, the DOC and other relevant staff.

## WRITTEN NOTIFICATION: Mandatory Reports to the Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

1) The licensee has failed to ensure that the witnessed abuse of a resident by another resident was immediately reported to the Director.

**Rationale and Summary**
Staff witnessed a resident being abused by another resident, however, the incident was not reported until six hours later.

The Administrator indicated that the abuse should have been called in immediately, and six hours after the incident, was not immediate reporting.

**Sources**: The resident's progress notes; Critical Incident (CI); licensee policy; and interview with the Administrator and other relevant staff.

2) The licensee has failed to ensure that alleged abuse or abuse of a resident by anyone that resulted in harm or risk of harm to the resident, was immediately reported to the Director.

**Rationale and Summary**
A CI was submitted to the Director related to a resident to resident allegation of abuse that had happened the day prior to the report. The DOC acknowledged and recalled that the report was submitted late to the Director.

**Sources:** CI; interview with the DOC.

3) The licensee has failed to ensure that allegations of resident to resident abuse were reported to the Director.

**Rationale and Summary**
Progress notes for a resident identified allegations of the resident being involved in potential abuse situations, however, there was no indication that the allegations had been reported to the Director.

The DOC confirmed that the allegations should have been reported to the Director immediately, and had not been.

**Sources**: The resident's progress notes; LTC.net portal; licensee policy; and interview with the DOC and other relevant staff.

## WRITTEN NOTIFICATION: Responsive Behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)**
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(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.

The licensee has failed to ensure that two residents were assessed and that the residents' responses to interventions were documented.

### Rationale and Summary

Two residents had inconsistent documentation, with periods of up to 24 hours not being completed. There was no review or analysis of the documentation.

The DOC indicated that the documentation was to be completed in its entirely, and then reviewed and analyzed. The DOC acknowledged that there was significant gaps in the residents; documentation and no review or analysis after it was completed.

There was potential impact on the residents, as the licensee was unable to analyze interventions implemented for the residents to determine if they were effective or not.

**Sources:** The residents' progress notes; the residents' documentation; interview with the DOC, and other relevant staff.

## WRITTEN NOTIFICATION: Responsive Behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 59 (b)**
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

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

Two residents were known to display responsive behaviours towards each other, however, it was not identified in their plans of care.

Further it was noted, that despite having interventions in place for both residents, the intervention was not always effective or present, resulting in both residents

displaying responsive behaviours towards each other and other residents.

The DOC indicated that the intervention should have taken place before the residents were able to display responsive behaviours towards one another, and other residents to prevent potentially harmful interactions between residents. The DOC further indicated that both plans of care for the two residents should have identified to staff that they were known to frequently display behaviours towards one another, so that staff could take steps to minimize the risk of the behaviours taking place.

There was impact on residents involved, as both residents displayed responsive behaviours towards co-residents.

**Sources:** Residents progress notes and care plans; CIs; licensee policy; and interview with the DOC, and other relevant staff.

## WRITTEN NOTIFICATION: Hand Hygiene

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the IPAC standard was implemented in the home related to hand hygiene.

### Rationale and Summary

The Inspector observed that a PSW missed moments of hand hygiene when interacting with residents. The PSW confirmed that they had missed moments of hand hygiene.

**Sources:** Inspector observations; hand hygiene policy; and interview with the PSW and IPAC Lead.

## WRITTEN NOTIFICATION: Required Reports

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.**
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed within one business day of a resident sustaining a fall that resulted in an injury and transfer to hospital with significant change in the resident's status.

### Rationale and Summary

A resident sustained a fall that resulted in a injury, and transfer to hospital, however, the DOC acknowledged that the CI had not been reported within one business day.

**Sources**: The resident's progress notes; CI; licensee policy; and interview with the DOC, and other relevant staff.