Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 7, 2017	2017_505103_0049	020267-17, 020537-17, 023062-17, 024978-17	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Trillium Retirement and Care Community
800 EDGAR STREET KINGSTON ON K7M 8S4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 3, 6, 7, 2017

Log #020267-17 (alleged staff to resident abuse),
Log #020537-17 (resident fall resulting in an injury),
Log #023062-17 (alleged staff to resident abuse),
Log #024978-17 (resident fall resulting in an injury).

During the course of the inspection, the inspector(s) spoke with residents, Personal Support workers (PSW), Registered Practical Nurses (RPN), the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector reviewed resident health care records, the critical incidents submitted by the home in regards to the incidents and the home's investigation into the alleged incidents of abuse.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The following finding relates to Log #023062-17:

The licensee has failed to ensure the care set out in resident #003's plan of care was provided to the resident as specified in the plan.

Resident #003 was admitted to the home on a designated date and had designated diagnoses.

On designated date, RPN #109 noted injury to resident #003 around the axilla areas and across the pectoral areas. RPN #109 reported her findings to the DOC and an investigation was initiated.

The DOC was interviewed in regards to the home's investigation and stated on a designated evening, PSW's #107 and #108 had assisted the resident into and out of bed by linking their arms under the resident's axilla area to complete the transfer. The resident was unable to weight bear and as a result, the resident was a total lift. The DOC stated the resident's condition had deteriorated and resident #003 was no longer able to weight bear. The DOC stated the home has a zero lift policy and the staff should have used a ceiling lift for the transfer.

Resident #003's plan of care, in effect at the time of this incident, was reviewed. Under "Transfer" the plan indicated the following:
Staff provide non weight bearing support to transfer.
Resident can no longer weight bear and participate in the transfer.
Transfers are with ceiling lift.

The staff involved were disciplined by the home as a result of this incident. [s. 6. (7)]

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 resident's are transferred in accordance with their plans of care, to be implemented voluntarily.

Issued on this 7th day of November, 2017

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

Original report signed by the inspector.